

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Wednesday, October 3, 2007
10:52 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, J.D., Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
MITRA BEHROOZI, J.D.
JOHN M. BERTKO, F.S.A., M.A.A.A.
KAREN R. BORMAN, M.D.
RONALD D. CASTELLANOS, M.D.
FRANCIS J. CROSSON, M.D.
THOMAS M. DEAN, M.D.
NANCY-ANN DePARLE, J.D.
DAVID F. DURENBERGER, J.D.
JACK M. EBELER, M.P.A.
JENNIE CHIN HANSEN, R.N., M.S.N., F.A.A.N
NANCY M. KANE, D.B.A.
ARNOLD MILSTEIN, M.D., M.P.H.
WILLIAM J. SCANLON, Ph.D.
BRUCE STUART, PH.D.
NICHOLAS J. WOLTER, M.D.

AGENDA	PAGE
Bundled payment for services around a hospitalization -- Anne Mutti and Craig Lisk	3
Relationship between volume and physician investment in facilities and ancillary services -- Ariel Winter and Jeff Stensland	50
Public Comment	77
Valuing physician services -- Kevin Hayes	78
Hospital construction spending trends -- Jeff Stensland and David Glass	122
Hospital outlier payment reform -- Julian Pettengill and Craig Lisk	145
Expanding the unit of payment in the outpatient PPS -- Dan Zabinski	188
Medicare Advantage: Special Needs Plans -- Jennifer Podulka	211
Public Comment	251

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

2 MR. HACKBARTH: Our first topic for this morning
3 is bundling payment for services around a hospitalization.

4 MS. MUTTI: In this presentation we begin to
5 explore bundling payment for services delivered around a
6 hospitalization. I'll start by talking about the rationale
7 and incentives of bundling and then go on to some of the
8 specific design issues that come into play.

9 Among the advantages of bundling payment are that
10 it can reward improved coordination in care across providers
11 and across a patient's course of care, depending on how it's
12 designed. We have some bundled payments in fee-for-service
13 Medicare already. For example, DRG payment bundles all the
14 hospital services during an admission. We also have a 90-
15 day surgical global payment.

16 So a next step could be to bundle payment for a
17 broader array of services around a hospitalization. Here
18 we're thinking of like the hospital services plus the
19 physician services or maybe even other services in addition
20 beyond the stay.

21 This would be the first time that we're bundling
22 payment across separate providers. So it's a little

1 different than the bundling that we've done so far.

2 There are several reasons why it might be a good
3 next step. first, it would bundle payment for care around a
4 very clear cogent episode of care and make it much more
5 reasonable to hold multiple providers jointly accountable.

6 Second, it engages the two most influential types
7 of providers in collaboratively figuring out to more
8 efficiently deliver care. It thereby begins to foster
9 systemness, getting us away from the fragmentation we have
10 in the system today.

11 This systemness, even if motivated to meet rather
12 limited goals, can be the foundation upon which to build.
13 For example, if we start bundling care only during the stay
14 but in the future extend the bundle beyond the stay, the
15 initial policy step is an investment. It's an investment
16 because taking that step can ultimately enable broader
17 reform that should result in greater coordination of care,
18 better quality of care, and more savings than is anticipated
19 by taking the first step alone.

20 Third, there's value in engaging hospitals in
21 identifying cost savings rather than just focusing on the
22 physicians' power of the pen alone. Hospitals' managerial

1 and financial resources can be an asset in enabling delivery
2 system reforms. But it may only be an asset if they have
3 the incentives -- if the incentives for restructuring also
4 apply to them.

5 Paying a bundled payment for care during a
6 hospitalization means that instead of paying the hospital a
7 DRG payment and paying physicians their usual payment, the
8 two entities would have to come together. The two groups
9 would come together, accept that bundled payment, maybe
10 performing a PHO here, a physician hospital organization.
11 And then they would have the discussion on how they were
12 going to pay themselves. They could come up with an
13 entirely new way of paying themselves.

14 So we find ourselves asking the question of what
15 behavior would hospitals and physicians agree to reward,
16 given this newfound flexibility? First, we might think that
17 providers would have the incentive to reduce unnecessary
18 physician services. For example, perhaps the number of
19 consults given or provided during an admission. We saw this
20 in the CABG demonstration that was in the 1990s. They did
21 constrain the number of consults.

22 Research shows that there is wide variation in the

1 number of physician services delivered during a
2 hospitalization across hospitals. But the amount of money
3 that Medicare spends on physician services is relatively
4 small compared to that whole episode. So the savings that
5 we might see here on constraining the volume of physician
6 services during the stay may be relatively small to
7 moderate. We're going to come back to that point with more
8 specific data in just a few minutes.

9 Second, because the bundled payment allows for
10 shared accountability, or in other words gainsharing,
11 hospitals can compensate physicians for using fewer
12 resources during the stay. So we might see some hospital
13 savings materialize here. This may be because physicians
14 are helping to reduce the length of stay, they're reducing
15 the use of the ICU or the length of stay in the ICU, or
16 maybe being more judicious in their use of hospital
17 supplies. So this presents a pretty significant opportunity
18 for savings.

19 Third, we might see if the bundled payment was for
20 all care delivered during the hospital plus some time after
21 the discharge, we might see that providers would be
22 encouraged to evaluate how they could get some savings in

1 readmissions or post-acute care, whether there was a better
2 way to be delivering that care.

3 Savings here can be fairly significant, especially
4 considering our work earlier in the spring where we were
5 looking at readmissions and found that readmissions within
6 30 days of discharge accounts for about \$15 billion in
7 Medicare spending and as much as 80 percent of those
8 readmissions are considered potentially avoidable.

9 There are other less desirable ways though that
10 providers might react to the incentives of a bundled
11 payment. First, providers may respond by increasing volume,
12 especially for high margin services. A higher volume can
13 reduce the unit cost of each service by spreading fixed
14 costs over a higher number of inpatient stays, improving the
15 margin on the bundle. A higher margin creates a win-win
16 situation because both the hospital and the physician can
17 get a bigger piece of a bigger pie.

18 In this sense, bundling payment could simply
19 create another way to financially reward physicians for
20 their loyalty and their referrals and, in turn, increase
21 Medicare spending and possibly compromise the access to the
22 mix of services that beneficiaries really need.

1 A second concern is that some hospitals may be far
2 more able to pay physicians higher rates than others. So as
3 hospitals compete for physicians it is possible that some
4 hospitals will be feel forced to redirect money needed for
5 patient care to physicians in order to attract the desired
6 mix.

7 Third, aligning economic incentives between
8 hospitals and physicians allows for the possibility that
9 providers will seek to profit by providing inappropriately
10 low levels of service, stinting, in, which compromises the
11 quality of patient care. Similarly, providers could respond
12 by bundling. For example, that might mean delay some
13 physician visits beyond the widow of the bundle that the
14 payment covers. Obviously, this could compromise access to
15 care and could also mean that Medicare pays twice for the
16 same service, once in the bundle and once again after the
17 bundle has ended.

18 We could consider some policies to limit these
19 adverse incentives for that threat of volume growth.
20 Perhaps we could regulate the arrangements between hospitals
21 and physicians or penalize high admission or readmission
22 rates. For the concerns about stinting, perhaps we could

1 use incentives to perform well on quality measures.

2 These ideas would all need some more thought but
3 at the moment I just want to leave you with the idea that
4 the incentives here are kind of a mixed bag and that they
5 would need to be navigated very carefully as we go forward.

6 Now to better eliminate the opportunities for
7 savings that I promised earlier, Craig will present our
8 analysis of Medicare spending for specific types of
9 hospitalization episodes.

10 MR. LISK: We've done an exercise looking through
11 Medicare claims to identify episodes that combine hospital
12 and physician services provided during a hospital stay. So
13 we can look at variation in Medicare spending for certain
14 conditions.

15 Our spending numbers reflect national rates for
16 hospital care and physician services, so our numbers do not
17 reflect differences in payment rates that may be
18 attributable to the area wage index, the IME adjustment, DSH
19 adjustment, and physicians GPCIs, for instance. We have
20 also risk adjusted our spending numbers, using APR-DRGs to
21 control for difference in spending that may be due to
22 patient severity.

1 So let's turn to the above slide. Here we show
2 average risk-adjusted spending during a hospital stay for
3 chronic obstructive pulmonary disease, or COPD. We have
4 limited our analysis to hospitals that had at least 10 COPD
5 cases in our analysis file, which is based on a 5 percent
6 sample of Medicare beneficiaries over a three-year period.

7 In this slide, we show spending for the lowest 25
8 percent of hospitals, the average spending across all COPD
9 hospital episodes, and the average spending for the 25
10 percent, the top 25 percent of hospitals. What we see is
11 that average spending for COPD in the top quartile of
12 hospitals is \$255 more or about 5 percent higher than the
13 average for all COPD cases. The differences in spending
14 attributable to hospital payments is small. The biggest
15 factor contributing to payment differences is due to
16 spending on physician services which again, if we compare to
17 the average, are 48.5 percent higher or \$217 more in the top
18 quartile compared to the average.

19 Some of this difference is attributable to more
20 physician encounters, the top quartile hospitals receiving
21 40 percent more on average, 9.4 encounters during the stay,
22 compared to an average of 6.7 on average. Hospitals in the

1 bottom quartile had only five physician encounters during
2 the hospital stay.

3 So if we now move on and look at the hospital stay
4 plus services provided 15 days after discharge, we see much
5 bigger differences in spending. In this chart we include
6 hospital spending, physician spending during the hospital
7 stay, spending for the hospital services and physician
8 services during the readmission, spending for post-acute
9 care and then other spending, which includes spending for
10 outpatient services and physician services that are not
11 provided during a hospital stay or readmission.

12 When we expand the episode to include the period
13 15 days after discharge, we find that spending for hospitals
14 in the top quartile are 18 percent higher on average. The
15 biggest factors contributing to this difference in spending
16 are readmissions back to the hospital followed by spending
17 on post-acute care services. In both instances, hospitals
18 in the top quartile had a much higher incidence of
19 readmissions and use of post-acute care than average. In
20 the top quartile, on average, 20 percent of beneficiaries
21 with COPD were readmitted within 15 days compared to an
22 overall average of 13 percent and only 5 percent for

1 hospitals in the bottom quartile.

2 For post-acute care, we find that on average 25
3 percent of cases used a post-acute care provider after a
4 COPD stay but in the top quartile this was 36 percent.

5 When we expand the bundle to include 15 days past
6 discharge, we see smaller differences in physician spending
7 during the hospital stay in terms of its factor in
8 contributing to differences in spending. It's 11.5 percent
9 higher or \$49 more in the top quartile compared to the
10 average.

11 We have also done this analysis for congestive
12 heart failure, which we show in this next slide. If we look
13 at the hospital stay, you see very similar results to what
14 we showed for COPD. Episode spending in the top quartile is
15 about 5 percent higher than average, with most of the
16 variation due to differences in physician spending.

17 For CHF episodes that extend 15 days past
18 discharge from the hospital, we also see similar results to
19 what we saw for COPD. Spending for CHF in the top quartile
20 of hospitals is 16 percent higher with the biggest
21 contributors to the variation again coming from readmissions
22 followed by use and spending on post-acute care services.

1 Now Anne will talk some about design issues in
2 potentially developing a bundle payment.

3 MS. MUTTI: To simplify our discussion on design
4 issues, we focused on certain design options and made
5 certain choices in there. They are merely intended to be
6 illustrative and to help focus our conversation, so
7 certainly they can be revisited.

8 To start with, we've assume that we'll bundle
9 payment for a select number of high-cost frequent
10 conditions, maybe like CHF, COPD, CABG surgery -- we haven't
11 specified, but that's the idea -- as opposed while
12 conditions. Also, we've assumed that the payment will be
13 for care just during the inpatient stay, as opposed to the
14 inpatient stay plus some period after discharge.

15 In the paper we then explored two options on how
16 the bundled payment can be set. We chose to explore here
17 the implications of setting the rate at the national average
18 of Medicare spending for the admission. This would be
19 similar to how DRG payments were determined. The payment
20 could then be adjusted for case-mix and geographic
21 characteristics like wages and other cost-of-living
22 differences, similar to how physician and hospital payments

1 are adjusted today.

2 The advantage to this approach is simplicity. The
3 base payment would be the same for everyone. It would
4 reward efficient hospitals and physicians because they would
5 be retaining the difference between the bundle and their
6 costs. If it were set at the national average like we've
7 mentioned here it would not achieve any savings for
8 Medicare. If it were set below the average it would begin
9 to hopefully get some savings for Medicare.

10 The disadvantages of this approach become more
11 apparent as we consider the budget implications of the
12 proposal and we'll come to that issue in just a moment.

13 Next we'll explore the last question of how could
14 the bundled payment be implemented? Here we focus on three
15 options which, are a little more clear to see in the next
16 slide.

17 The first is a mandatory scenario where all
18 hospitals and their physicians would have to accept a
19 bundled payment for the selected conditions in order to
20 receive Medicare payment for those conditions. This
21 approach would be straightforward and fairly predictable,
22 has fairly predictable budget implications. However, it

1 raises the question as to whether in all the diverse
2 communities around the country, the hospitals and physicians
3 would indeed be able to come together, accept the payment,
4 and agree on how they were going to share it.

5 If, in a given community, they could not come
6 together and as a consequence Medicare no longer pays for
7 care during the admission for those selected conditions, you
8 can imagine there might be an access issue. This may
9 particularly be at play when beneficiaries cannot readily go
10 to another hospital or it's an emergency situation.

11 Another option is to make the acceptance of the
12 bundled payment voluntary. Here the big challenge is
13 managing the risk that this option will increase Medicare
14 spending. I'll get to this on the next slide but first let
15 me note that our third option that we'll discuss in the last
16 part of the presentation is virtual bundling. Maybe that
17 will be a little more clear in a minute or two.

18 Going back to the voluntary option, why are we
19 concerned about the budget implications? This illustration
20 hopefully will make that a little bit more clear. You can
21 see on the left a vertical line with ascending dollar values
22 attached with \$5,000 bolded in the middle. These are

1 hypothetical combined physician and hospital payments for
2 inpatient care under current law. The national average
3 payment is \$5,000, and in our illustration here that has
4 become the new payment under bundling.

5 Plenty of hospitals and physicians provide
6 inpatient care for less than the \$5,000 and plenty provide
7 it for more than the \$5,000. Those hospitals and physicians
8 providing the care for less than \$5,000 have a strong
9 incentive to participate, that is accept the \$5,000 payment,
10 because they will be paid a higher aggregate amount than
11 they current receive. But those with payments currently
12 above the \$5,000 have little incentive to participate since
13 they will now receive a lower aggregate payment from
14 Medicare. So to the extent that the low-cost providers
15 volunteer and the high cost once don't, Medicare would pay
16 more than it currently does.

17 For this reason a penalty, perhaps on the fee-for-
18 service payments to hospitals and physician services during
19 the inpatient stay, would be necessary to make this policy
20 come close to being budget neutral.

21 So how could the penalty be designed? First,
22 perhaps it could apply to both the hospital and physicians.

1 This would help encourage both to work toward accepting the
2 bundle payment.

3 A second design consideration is whether the
4 penalty could apply to all providers not accepting the
5 bundled payment or just those that are relatively high cost?

6 Another consideration in designing a penalty is
7 how great the payment differential should be between those
8 accepting the bundled payment and does who remain in fee-
9 for-service. This difference can be affected by the
10 specific percentage reduction in payment rates -- 5 percent,
11 7 percent, 10 percent penalty -- as well as by the type of
12 cases subject to the penalty. Would it be for all stays or
13 would it be just for high cost stays for those selected
14 conditions?

15 These design decisions can have selection effects.
16 That is they can perhaps influence where a physician sends
17 the patient in order to maximize his or her own revenue. As
18 a result it would likely be difficult to assure that the
19 penalty would achieve overall budget neutrality.

20 To illustrate some of these design choices, let's
21 compare the situation of three different hospitals and how
22 they might be affected under a voluntary bundling options.

1 First, we have hospital A. It's a relatively low cost
2 efficient hospital and it chooses to accept the bundled
3 payment, which again is this national average of my
4 hypothetical \$5,000. The dots on the scattergram or say CHF
5 cases and their relative spending to Medicare under current
6 law. By accepting the bundled payment, hospital A wins on
7 all of those below the \$5,000 line and loses on all of those
8 above the \$5,000 line relative to current law.

9 Hospital B has the exact same distribution of CHF
10 cases as hospital A. It, too, is efficient but its market
11 dynamics prevent it from being ready to accept the bundled
12 payment.

13 Hospital C is inefficient and chooses not to
14 accept the bundled payment.

15 So as we consider the penalty for nonparticipants,
16 should hospital B be penalized for not receiving a bundle
17 regardless of the fact that it is an efficient hospital? If
18 so, we could apply a penalty across all cases just like we
19 would for hospital C. The impact on hospital B and C would
20 be roughly comparable, even though their relative efficiency
21 is quite different.

22 Alternatively, we could let hospital B, our

1 efficient fee-for-service hospital, continue to be paid as
2 under current law, applying no penalty. Compared to
3 hospital A, it wouldn't have the wins on its low-cost cases
4 but it wouldn't take the losses on its high-cost cases.
5 Hospital A's choice to accept the bundle would still present
6 some greater opportunities though. Unlike hospital B,
7 hospital A has the greater potential to improve its margins
8 over time because it gains by moving more of its cases to
9 below the \$5,000 line. Still though, this approach weakens
10 the incentive to accept the bundle relative to the first
11 design I explained.

12 Now let's turn to the third option for
13 implementation. We call it virtual bundling. Under this
14 approach hospitals and physicians would not receive a
15 bundled payment. They wouldn't even have the option of
16 receiving a bundled payment. But instead all hospitals and
17 physicians would be subject to a penalty. You could also
18 design a reward in this scheme, too. The penalty or reward
19 would be based upon their relative spending for care
20 delivered during the hospitalization.

21 This may sound a little familiar because it's
22 designed very similar to the P4P things that we've talked

1 about in the past. This approach gives all physicians and
2 hospitals an incentive to come together and figure out what
3 service patterns are leading them to be relatively high cost
4 and subject them to the penalty. If the penalty adjustments
5 were accompanied by an explanation of how their pattern of
6 care differed from others, this approach provides the needed
7 feedback for providers to improve their performance.

8 Because virtual bundling retains the current
9 policy that Medicare sets physician fees rather than having
10 hospitals and physicians negotiate them, it avoids some of
11 the propensity to increase the volume of episodes or bundles
12 that I discussed earlier. It also means that providers will
13 not have to develop a billing infrastructure themselves,
14 which may be necessary under bundling and could represent a
15 new administrative expense.

16 I don't want to go too fast on that point. It
17 kind of comes in here at the end. But you could imagine
18 that in some situations that the hospital or the PHO will
19 have to be able to accept bills and pay those bills from
20 physicians that are practicing in the community that are not
21 employed. That might be a new administrative activity for
22 them.

1 Among the disadvantages of virtual bundling is
2 that it might not provide sufficient incentive to integrate
3 the delivery system. Another consideration is that virtual
4 bundling does not, in itself, allow for gainsharing. So in
5 order for providers to have the opportunity for those
6 savings, gainsharing would have to be permitted concurrently
7 and separately.

8 We've covered a lot of ground here. There was
9 more ground that we covered in the paper. I think there's
10 probably plenty to talk about.

11 But in particular, we'd certainly like to know if
12 there are any of the roads on our decision tree that we
13 didn't take that you'd like us to take? And if you have any
14 preferences among the options that we did explore?

15 MR. HACKBARTH: What I propose to do is break the
16 discussion into two parts: a brief period just to ask
17 clarifying questions. Then what I would like to do is
18 structure the remaining portion around the decision tree,
19 the slide on page nine, and go through those design choices
20 one by one and invite comments on each one. That will allow
21 us to have a little clearer picture of what people think.

22 Bob, do you want to ask a clarifying question?

1 DR. REISCHAUER: One clarify question and then a
2 statement that is relevant to the whole ball of wax after
3 that.

4 The clarifying question has to do with the top and
5 bottom quintiles. I was very surprised by these numbers
6 after reading the draft. I was wondering, these are taken
7 from the six cities or whatever it is that we did? This is
8 national?

9 MR. LISK: This is national.

10 DR. REISCHAUER: Is there a regional pattern of
11 top and bottom quintile or a regional/metropolitan area/non-
12 metropolitan area? Are we seeing practice patterns here?

13 MR. LISK: Some of it would be some practice
14 pattern effects. We haven't shown that and we can come back
15 to you more with some of that next time if you want.

16 DR. REISCHAUER: I think that affects the
17 viability of something like this tremendously. If top and
18 bottom quintiles are scattered evenly in every geographic
19 areas, it's more viable than it is if you find sharp
20 differences.

21 This sort of leads to my second point which is I
22 was blown away by how small the differences were with

1 respect to what we were originally examining which is the
2 period in the hospital. And thinking boy, this isn't worth
3 the wax to go forward if we're only talking about \$200, 5
4 percent. And then even you hold out the hope that if you
5 expand the length of time then it becomes a game worth
6 playing. I see yes, it is a lot more money but it's all
7 concentrated in two areas: readmissions and post-acute care.
8 Is that reflecting availability of different types of post-
9 acute care in different regions of the country or proclivity
10 to send people to post-acute care? And readmissions, these
11 are two "problems" that there are a lot easier ways to solve
12 than to go through this kind of exercise.

13 P4P, with respect to readmissions --

14 MR. HACKBARTH: I was with you until the last
15 point because I'm not sure that you're wrong but I'm not
16 sure you're right either. We discussed the readmission idea
17 last year and let's adjust the hospital payment to reflect
18 readmission experience at that particular institution.

19 One of the concerns I had about that approach is
20 it's a hospital problem. It's not a physician problem.
21 It's just a hospital and we'll penalize the hospital.

22 What this approach does is say it's a

1 hospital/physician potentially post-acute care provider
2 problem, and you need to bring the three together to solve
3 it. I think that's more consistent with the real clinical
4 world, at least as I understand it as a layman, than just a
5 hospital adjustment. So I'm not sure that there are simpler
6 ways to get at readmissions and post-acute experience.

7 DR. KANE: I think on roads not taken, I thought
8 the reason we were interested in bundling wasn't just to
9 reduce the variability in what it is, but to actually reduce
10 what is. So for instance, if you bundled the physician,
11 lose the hospitalization, the gainsharing opportunities
12 become more possible, the ordering of a single medical
13 device, creating drug regimens that are cost-effective. And
14 it's hard to imagine what the impact is because if you don't
15 have it.

16 But when you've got is what is, and I think the
17 whole point I thought of bundling was that you get the
18 physicians to gain when they actually reduce their use of
19 hospital services because they're on the team and their
20 incentives are aligned, as opposed to that there is
21 variability in there and therefore we'll get everybody down
22 to the average.

1 I just think the thing has been framed in a way
2 that I wasn't expecting and missing, I think, the whole
3 point, which is aligning physicians with the hospital
4 incentives should lead to much greater opportunities to
5 lower the average and lower the bottom quartile.

6 MR. HACKBARTH: And lower the costs that are in
7 the hospital portion of the bundle. And to the extent that
8 you succeed in doing that, then potentially you can reduce
9 your payments.

10 I'm inclined to agree with Nancy, that it's not
11 just the physician visits that are the variable, but even if
12 your unit of payment is just the single hospital admission.

13 MS. MUTTI: Actually, I tried to acknowledge that
14 up front, that there was a number of responses we'd see.
15 They might come down on the physician visits. You might see
16 the gainsharing. It's just a matter of who that savings
17 accrues to. You could capture it by doing 40 percent of the
18 national average and assume that some of that savings goes
19 back to Medicare or does it stay with hospital. It's just a
20 design issue that we didn't quite get to quite yet because
21 we had so many others to talk about.

22 DR. MILLER: You did make the point about ICU,

1 length of stay, that type of stuff. I think also what
2 they're trying to say is there's variation in different sets
3 of services. So you have -- whatever opportunity you get
4 from the average, and additional opportunity to the extent
5 that variation reflects some variation in practice and not
6 say a linkage to supply or something like that.

7 So I think the data is also to imply there's still
8 relative opportunities, even if you're getting some impact
9 on the average by including different groups of services.

10 MR. HACKBARTH: A couple of more minutes we're
11 staying at the high level and then we'll go through the
12 design choices.

13 DR. CASTELLANOS: Bob, I agree you. When you look
14 at the numbers, it really doesn't look like there's a big
15 savings. But I think the real value here is getting the
16 physician and the hospital working together.

17 As Nancy said, what it does is it gets the doctor
18 and the hospital to take responsibility and be held
19 accountable both for cost and quality. Quite honestly, the
20 physician is not used to taking responsibility for costs and
21 really not responsibility to know what is appropriate and
22 what's not appropriate.

1 Again, I'm going to go back to a point that I've
2 made with SGR and IME. I think what we need to do is
3 establish in the medical school and in the training programs
4 some form of education discussing evidence-based medicine,
5 care coordination, comparative effectiveness, and bundling.
6 As a physician, we have no experience with that and no
7 education today. And I think this is the direction that we
8 need to go. We need to get the hospitals and the physicians
9 talking and working together.

10 I think, as Nancy said, this is just the first
11 step and there's going to be a lot of benefit from this on
12 the downstream effect.

13 DR. WOLTER: I just wanted to agree with the issue
14 that there probably is more to this than just the physician
15 visits, whether it's drug formulary decisions or, in some
16 cases, technology decisions, that sort of thing.

17 But it does seem like the real goal is going to be
18 to get to something that goes beyond just the admission and
19 to somehow look at how do we deal with readmissions. Or how
20 do we even get to a point where ACOs have registries of
21 certain groups like patients with CHF, and they're sort of
22 managing a population and even admission rates -- before we

1 get to readmissions -- might be something that you would try
2 to get to look at over time. But you have to walk before
3 you run.

4 And so I think getting started would have value.
5 If it does cause organizations to form that can then take
6 accountability for longer episodes or annual care, we can
7 get to that. But we need to get things going.

8 DR. DEAN: This may fall in the roads not taken
9 category but it sort of follows up on what Ron said. We
10 focus so almost exclusively on payment alterations, whereas
11 I think just access to this data may bring about some
12 behavioral changes.

13 I mean, Just for instance there's a system in our
14 area that just instituted a very sophisticated electronic
15 monitoring system for all of their ICU patients where all of
16 this data is fed into computers that monitor every little
17 change. And they have shown some dramatic decreases in both
18 mortality and length of stay in ICUs just by better handling
19 of the data.

20 I think as physicians, we oftentimes don't realize
21 how our practices compare and how they actually -- we sort
22 of assume we're all in Garrison Keillor's Lake Wobegone,

1 we're all above average.

2 In fact, if we have better access to just the
3 data, I think it would be a start and maybe a lot simpler
4 than playing with these payment systems.

5 MR. HACKBARTH: We have recommended that we begin
6 feeding back to physicians on a confidential basis certain
7 types of data, including data about how their episode cost
8 experience compares to others.

9 DR. DEAN: [off microphone] And just the whole
10 readmission thing, and obviously that's a very important
11 factor and has big financial -- just to let people know
12 what's happening, I think is important.

13 MR. HACKBARTH: Karen, and, then we'll move on to
14 the design decisions.

15 DR. BORMAN: As you dig more deeply into the
16 patterns of the quintiles and so forth, there could be
17 interest in figuring out whether the variation not only is
18 geographically related but also can you parse it out to some
19 -- within physician visits are you counting everything
20 that's under Part B? that is, can you parse it a little bit
21 in lab and radiology services as opposed to other Part B
22 things. Or does that get down to a level of detail that

1 just makes the analysis too complex?

2 MR. LISK: We can parse it some. I'm not sure, in
3 terms of lab versus -- I think we actually have radiology as
4 one of the factors and consultants versus evaluation
5 management and other services.

6 I've taken a preliminary look at actually those,
7 but haven't presented them at this meeting.

8 MR. HACKBARTH: Okay, would you put up the
9 decision tree slide?

10 What I thought we would do is just so proceed down
11 the decision tree and invite comments on each step, the
12 first step being to focus on particular conditions where
13 there's a lot of money and perhaps a unique both financial
14 and clinical opportunity. That's an approach that Nick has
15 eloquently advocated in the past. I think there's agreement
16 on that but let me just check if people feel comfortable
17 with that step.

18 Then let's go what episode of care. We've also
19 touched already on this one a bit but let's have a little
20 bit more discussion.

21 Nancy-Ann?

22 MS. DePARLE: Everything I've heard, including

1 what Bob said but others as well, is that it should be
2 broader than just the hospitalization itself, I think. That
3 adds complexity but to get to what the real problem is, it
4 seems like it needs to be broader.

5 DR. MILSTEIN: I agree with that and I want to
6 endorse Nick's comments of it's the hospitalization plus
7 some substantial period following, and that we also
8 integrate into the incentive system relative probability of
9 admission in the first place there are means of doing that.

10 DR. REISCHAUER: I agree with the extended period.
11 And one reason I would is that if we restrict it just to the
12 hospital stay there's going to be, in a sense, an artificial
13 incentive for hospitals to hire more hospitalists and to
14 bring this all under their control. Which may be fine, but
15 it's not reflective of what the situation really is over the
16 longer run. And what you want to do is bring in that post-
17 acute care into the coordination that is taking place.

18 MR. EBELER: I would just echo what's been said.
19 I guess the only point would be that if analytically and for
20 practical purposes one needs to start during the
21 hospitalization, I just think it would be very important
22 that we point that we're absolutely heading towards the

1 beyond the hospitalization.

2 DR. KANE: In terms of trying to build structures
3 between the hospitals and the docs that they can achieve
4 this, I'm just wondering on your very first thing about just
5 a few conditions or select conditions, whether that makes
6 sense. Once you've got the umbrella, don't you kind of want
7 it to be used for the most number possible? For instance,
8 if the two conditions just aren't enough volume to make it
9 worth the effort to invest into the umbrella, then you might
10 just have a problem. I mean, Medicare is what, 25, 30,
11 maybe up to 40 percent of a hospital's business. But if the
12 particular two or three conditions you pick aren't enough to
13 get a critical mass under the umbrella, it just may be a
14 nonstarter. Is there a problem with saying why not try
15 bundling almost everything?

16 The other piece of it is if you leave pieces out
17 of the umbrella and the bundle, might they be way -- the
18 sort of safety valve. So if someone's not making enough
19 money they find a way to do it outside the bundle?

20 I guess I'm talking about why not do all
21 conditions, at least all except the last 2 percent or
22 something? And you could have outlier issues to give

1 insurance.

2 But it's hard to create the structures that go
3 after the savings. And if you're going to do it, even just
4 saying it's on one condition and not the others I think can
5 create bigger problems than just saying it's all -- I just
6 think we ought to talk about the downside of selecting--

7 MR. HACKBARTH: Those are important questions and
8 I'm sorry to speed by them.

9 When talking about the not all conditions, you
10 kept saying two. I'm not sure it necessarily is limited to
11 two. My recollection of the data is, in fact, Medicare
12 admissions are pretty concentrated. They're a relatively
13 small number of conditions that account for a pretty high
14 percentage. Could Anne or Craig -- of the dollars, yes.
15 Could you refresh our recollection on that?

16 MS. MUTTI: Actually, we did this looking at the
17 top 20 DRGs and how much they contributed to the dollars
18 here. We did that last September and I don't have the
19 number here. But you're right, it was quite high.

20 I would just also make one point, too, that the
21 CABG demonstration showed a little bit lot of what you're
22 talking about, in terms of if you focused just on certain

1 DRGs you get some slippage. Like some of those consults
2 moved off those conditions but went to other conditions. So
3 there's a concern there. But I can get back to you with the
4 data on the number.

5 DR. MILLER: The only other thing I would add to
6 this, and Nick I'm going to say something that I think
7 you've said so tell me if this is wrong. I'm not pushing
8 one way or the other.

9 I think you've also said that the ability for the
10 physicians and the hospitals to come together to have an
11 effect, in terms of the evidence and what works, is more
12 developed for some admissions than others. I don't know if
13 you want to make that point or whether I missed the point
14 entirely?

15 DR. WOLTER: I think that's probably true. There
16 is more evidence base for certain things in terms of what
17 are the practices that have some literature behind them that
18 create a much higher likelihood of success. I think that's
19 probably true.

20 MR. HACKBARTH: To the extent that is true, part
21 of what you're trying to do is give people a sense of
22 possibility that oh, there's evidence that I can turn to

1 and best practices. And I can succeed at this game,
2 particularly if it's a voluntary system. If it's across the
3 board and a lot of these things I have no clue where we
4 would start, that may seem a less inviting opportunity then
5 to go after some high-cost, high opportunity areas where
6 there's a fair amount of evidence.

7 DR. WOLTER: It just occurred to me that there is
8 the issue of the specific diagnosis. But if there were some
9 organizational forms that evolve to accept payment, you
10 could see fairly quickly other things being addressed. I
11 mean, 2 percent of hospital payment now is related to the
12 reporting of certain measures. That's going to be
13 expanding. And it's likely that the payment will become
14 related to actually how you perform on those measures, not
15 just reporting the measures.

16 So once you start having this ACO, if they get
17 together around this DRG concept, they'll probably be
18 working on drug interactions. They'll probably be working
19 on post-op infections. They'll probably be working on MRSA,
20 because all of those things are winding their way into P4P.

21 You can see the potential for a lot of value add
22 here. And if we could get some kind of gainsharing

1 legislation so that hospitals could more easily share that
2 performance of their payment that's related to quality and
3 safety, it could really accelerate the effectiveness of
4 this.

5 DR. CROSSON: I would support expanding the model
6 beyond the hospitalization for the reasons that have been
7 said. I think the notion that it could be expanded enough,
8 as Nick was describing, to actually have utility in
9 preventing hospitalizations -- whether those are
10 readmissions or perhaps beyond that -- is worth much more
11 than the marginal impact within the hospitalization, not
12 just from the perspective of the cost but from the
13 perspective of the quality of life, the quality of care, the
14 risk of hospital-acquired infections and all of the other
15 things that go along with the quality part of the spectrum.

16 So that really is something to go for.

17 DR. SCANLON: I was going to say that in thinking
18 about expanding it beyond the hospitalization, I think we
19 have to look into how that has implications for some of the
20 other decisions that we make. Potentially, it's an issue of
21 redefining the condition, the DRG that we're talking about
22 because we want homogeneity in terms of what they might be

1 using outside.

2 There's also the issue which is that post-acute
3 care is not uniformly available and so there's a question of
4 what does that imply about national average of Medicare
5 spending as an appropriate payment level? And then also
6 this whole issue voluntary versus mandatory.

7 There is, I think, a cascade that is going to come
8 about depending upon how you define the bundle that you are
9 going to try and target.

10 MS. HANSEN: Just the concurrence of both the post
11 and then, where possible, the pre.

12 One other thing about -- I'm struck by the
13 selection of the common diseases of CHF or COPD and I think
14 the comorbidity component of the most expensive DRGs. I
15 just wonder if there's a way to take a look at the breakdown
16 of not only the clinical diagnosis but in kind of the more
17 common bundles that tend to occur, especially for those
18 people who are 75 and older. Because the Medicare
19 population spans a large age range and there are probably
20 more complexities.

21 If you can do it and have an impact on the more
22 complex comorbid older population, some of the lessons

1 learned from that would be easier actually on the less
2 complex single diagnosis or causes for hospitalization.

3 MR. HACKBARTH: Before we get too far beyond
4 Bill's comment, for the benefit of the audience let me just
5 put this in context. I don't want people to interpret what
6 we're doing now as making definitive design decisions and
7 we're making a recommendation at this point. What we're
8 trying to do is structure this so that the staff can
9 systematically go through the issues and identify the sort
10 of things that Bill alluded to, but do that in a focused way
11 as opposed to having to sort of do it generically for
12 bundled payments in general.

13 So we are still quite a distance from MedPAC
14 recommending this. We're just trying to organize the
15 staff's work.

16 Bob, you had a comment?

17 DR. REISCHAUER: I just had a question for Craig.
18 Do we know anything about the correlation condition-to-
19 condition, hospital ranking? If you're in the top quintile
20 for one thing are you likely to be in the top quintile for
21 the other? Because this has some ramifications for how
22 broad this should be, especially if you have a voluntary

1 system, an incentive to go into it.

2 MR. LISK: That's a good idea. We have not done
3 that at this point.

4 MR. HACKBARTH: Okay, let's move on to the next
5 level of decision, and how could the bundled payment be
6 sent. Questions, thoughts about that?

7 Is there anybody who thinks that the hospital-
8 specific approach might be the way to go?

9 MS. DePARLE: I think I have a clarifying
10 question. I thought it fell under the last bucket but maybe
11 it's here.

12 Anne, you spent some time in the last year talking
13 about the heart bypass demo, and there's some references to
14 it in this chapter as well. In that one, remind me how we
15 set the payments.

16 MS. MUTTI: It was hospital-specific, so they came
17 up with a baseline combined payment for each hospital and
18 then negotiated a percentage discount off of that. That
19 would be their payment rate.

20 This was considered a pretty labor-intensive
21 process because the facilities and the physicians got very
22 involved in making sure that there was no errors in the

1 claims base that they were using to arrive at that baseline,
2 and in some ways it makes you a little leery about doing
3 that on a national basis, calculating. That was the concern
4 that we raised in the paper and that we've heard from the
5 staff that worked on it.

6 MS. DePARLE: It was mandatory within a certain
7 geography or not mandatory?

8 MS. MUTTI: It was not mandatory. It was a
9 demonstration and the facilities came forward and
10 volunteered to participate in the demonstration.

11 MS. DePARLE: I guess where I'm going is you
12 raised in the paper some disturbing suggestions about
13 incentives that physicians might have to go around these
14 DRGs, as you suggested, or to increase volume of people
15 getting the surgery in order to make up the difference if
16 the payment levels were set lower than the national average
17 or if it were mandatory, I guess, either of those two
18 things.

19 MS. MUTTI: Right, just sort of the generic. Once
20 you have the incentives aligned between the hospitals and
21 physicians and get they're sharing the payment. If they did
22 more, there's potentially a bigger margin on each service

1 and then they have more to share with one another.

2 MS. DePARLE: I guess I wondered do we have
3 evidence about that from this demo?

4 MS. MUTTI: Of whether that happened in the demo,
5 I think I saw where you were going. I don't recall that
6 that did happen.

7 MS. DePARLE: Neither do I. And I thought there
8 were savings to Medicare from the demo. Was that wrong?

9 MS. MUTTI: Yes, there definitely was. First of
10 all, we negotiated a lower -- there was that percentage
11 discount there. They also noticed that they got some
12 savings in the post-discharge period, too, that some of the
13 post-acute care spending came down.

14 MS. DePARLE: Where I've gone with this is at the
15 risk of -- Anne's right that it's probably more
16 administratively difficult but we do have something that
17 worked.

18 DR. CROSSON: Well, this will reverberate a bit
19 when we get down to the voluntary versus mandatory question
20 but -- and it's not an issue of whether it should be
21 hospital-specific or national average -- but since in other
22 payment areas we like to conform to the principle of paying

1 at the level of an efficient provider would that not suggest
2 that at least over time we would want to do something less
3 than -- and again if we end up with something that's
4 mandatory -- something less than average?

5 MS. BEHROOZI: Given everything that we know about
6 regional variations in spending that wouldn't be corrected
7 by application of the wage index, which I think you
8 indicated you would adjust the national average by, you
9 raise in the paper -- and I think it's worth echoing this --
10 that you could have some situations where the average would
11 be higher than what would otherwise be the average in that
12 region or for that hospital, and the impact on
13 beneficiaries' copayments, I think, is a really significant
14 factor. To make it better overall, we would really
15 disadvantage some individuals.

16 MS. MUTTI: I'm glad you brought that up because I
17 couldn't figure out how to fit it into the presentation, but
18 it was a point.

19 MR. HACKBARTH: The variation that exists across
20 region -- let's assume for the sake of argument that we're
21 talking about admission plus 15 days. Is the regional
22 variation predominantly at that level or more in terms of

1 the number of admissions to begin with?

2 MR. LISK: There are differences in higher
3 utilization of let's say physician services in Miami
4 compared to Washington state, Seattle, Washington for
5 instance.

6 MR. HACKBARTH: During the inpatient stay there
7 are specialists, and...

8 MR. LISK: And there's differences in between
9 Boston and Seattle in the use of post-acute care, as well.
10 So you have those variations that are built-in regionally
11 that we know about.

12 MR. HACKBARTH: It would be interesting if there's
13 some way that we could sort of get a sense of magnitude of
14 the regional variation on these variables as opposed to
15 others.

16 DR. KANE: Isn't there something in between
17 hospital-specific and national then, that's being suggested
18 by this conversation?

19 MR. HACKBARTH: Any thoughts? Did you think at
20 all about that, having regional targets?

21 MS. MUTTI: The thought crossed our minds but we
22 have not gone into that. So we could certainly do that for

1 coming back the next time.

2 DR. REISCHAUER: My guess is the variance between
3 regions between rural and urban areas is as great as across
4 regions. Or it's big, anyway.

5 DR. MILLER: The way I took Nancy's comment is to
6 perhaps think about whether you would start the policy by
7 having it blended between the hospital-specific and the
8 national, as opposed to introducing a regional thought in
9 there. That's the way I took your comment as something to
10 think about.

11 MR. HACKBARTH: Although then that implies doing
12 all of the work that --

13 DR. REISCHAUER: Maximizing complexity.

14 MR. HACKBARTH: For a limited payoff, and that
15 it's going to be phased out relatively quickly doing all
16 these hospital-specific calculations.

17 MR. HACKBARTH: I don't know how to do this but if
18 there's a way that you can help us get a grip on the amount
19 of regional variations at different levels of unit of
20 service, that might inform this discussion somewhat.

21 Other comments on this issue of hospital-specific
22 versus national average?

1 DR. DEAN: The question, we talk about variation
2 among facilities but somewhere we need to factor in the
3 quality issues, as well, because just taking an average, are
4 the low-cost providers also getting good outcomes? Or in
5 fact, does it take a bigger investment to get a long-term --
6 I suppose that relates, too, to what episode you look at.
7 If you're looking at a longer-term episode, then that comes
8 in -- it has an effect. Whereas, if you're looking just at
9 hospitalization, there's all sorts of misleading things that
10 could happen.

11 MR. HACKBARTH: At the highest level we've not
12 found that more expenditures per beneficiary correlates with
13 higher quality. That relationship could be different as you
14 move to lower levels of analysis, smaller units.

15 DR. DEAN: And it may change from one condition to
16 another, too, I would suspect.

17 DR. KANE: Didn't we find, for instance in
18 Minneapolis, that had a higher something -- cost per AMI.
19 But that if you looked across multiple years they had -- the
20 ultimate cost was lower because they were less likely to be
21 readmitted after that one. Yes, fewer episodes.

22 MR. HACKBARTH: Let's move to this last issue,

1 mandatory versus voluntary versus virtual. Thoughts on
2 that?

3 MR. EBELER: Start off with two. One is, I don't
4 understand how you can make this work on a voluntary basis.
5 Again, the only caveat I would state there is a little bit
6 what I said about episodes of care, and I think we were just
7 discussing on how you set the payment. It may well be we're
8 talking about where we're headed and what's the phasing
9 strategy. But it strikes me that long-term you can't make
10 this work on a voluntary basis.

11 If there's an explicit phasing from that to
12 something else, that's different. But I don't get it.

13 MR. HACKBARTH: So one approach is to start
14 voluntary and say in three years we're going mandatory and
15 everybody's on notice.

16 Another approach -- I'm not necessarily advocating
17 this -- might just give everybody three years notice that
18 it's going to be mandatory for everybody. So you've got
19 three years to organize yourself, look at your data, we'll
20 provide you data, and you've got a period to prepare. We're
21 not just going to drop this on you overnight.

22 MR. EBELER: I don't mean to imply that I would

1 start voluntary. My basic point is I don't think voluntary
2 can work. Again, I think you need to build to it.

3 DR. CROSSON: Just on that point, I think another
4 notion might very well be to start with the virtual
5 bundling, which is easier. It doesn't have the value of
6 allowing the gainsharing, or shared savings. And then move
7 to mandatory. At which point, possibly, people will say
8 hey, this is better actually than what we've had up to this
9 point.

10 DR. STUART: I'd like to echo both of those
11 together. I don't think that virtual bundling is going to
12 work either. The reason is that there's no way in which you
13 can align a particular physician's incentive if that
14 physician happens to be paid less because his peers were
15 less efficient than they were in other areas. There's just
16 no way to do that.

17 And it still would be each individual physician's
18 best interest to provide more services because at the margin
19 they would receive a higher payment. So I think that
20 actually neither the voluntary nor the virtual is going to
21 work.

22 The point about giving people warning is what you

1 really want to do. You want to get the behavior aligned.

2 If you give people enough data and time to do it, than

3 you're likely to have a better result as a consequence.

4 DR. KANE: I think the way the virtual could work
5 and it would maybe just be data overload, but it would be
6 monitoring the bundle. If some usage inside the hospital
7 went down then the physician got paid more. So that's the
8 way I think -- like the British gatekeeper thing, that's how
9 they did it. They monitored it and they called it
10 indicative budget. But if it turned out that patient's
11 hospitalization experience was cheaper, the physician got a
12 reward for that.

13 DR. BORMAN: I'm not sure if this is the question
14 where it belongs but I've been struggling where it should
15 go. One of the things I would be interested in is some
16 information about outliers, particularly at the high end.
17 Are there some common characteristics within these specified
18 things that we could then help to use to make better
19 decisions about what will be effective or where these people
20 are going wrong. We're starting to get towards some of it
21 with this nice analysis, but I think the top 5 percent over,
22 what are the common features of those places? And maybe

1 that will, in part, say it's rural or it's whatever. But I
2 think those are the people where you want to figure out what
3 they're doing wrong.

4 And also, it's a group where you can perhaps first
5 target the sticks. Because at some point, in addition to
6 the gainsharing carrot, there's the stick. And if you're at
7 the outlier, that's where it's much more clean to apply the
8 initial penalty. And I think that we're losing sight in
9 some of these things of our ability to use outlier behavior
10 and learn from it but also implement it at the outlier end.

11 DR. MILSTEIN: I'd like to support the solution of
12 virtual bundling. I think per some of the other comments
13 that Jay and Nancy have made, I think it would be a lot
14 simpler. It would certainly generate a lot less in the way
15 of legal bills for the health care industry to implement
16 this because you wouldn't need a lot of new contractual
17 relationships between doctors and hospitals.

18 And I think until such time as we get a sense as
19 to how all this is all going to work, I think doing it in a
20 way that implies leaner implementation costs would be
21 advantageous. And I think per Nancy's suggestion I think
22 virtual bundling could work well.

1 MR. HACKBARTH: Okay, we're sort of at different
2 places on the last issue so I'm afraid you're going to have
3 to do work on multiple different fronts here and we'll leave
4 it for now. I'm sure we'll see you folks again next month.

5 Our next item is the relationship between volume
6 and physician investment in facilities and ancillary
7 services.

8 MR. WINTER: Good morning, almost good afternoon.

9 At the strategic planning meeting this past
10 summer, Commissioners asked us to examine whether physician
11 ownership of health care facilities is associated with
12 higher volume of services. This presentation will discuss
13 physician investment in ancillary services, ASCs, and
14 specialty hospitals. We will review the literature on the
15 relationship between physician ownership and volume of
16 services. Then Jeff will describe our plan to study the
17 relationship between physician ownership of imaging
18 equipment and use of imaging services.

19 We'll start by looking at some of the trends. The
20 number of physician-owned specialty hospitals more than
21 doubled from 2002 to 2006 from roughly 50 hospitals to over
22 120. The number of ambulatory surgical centers increased by

1 over 50 percent from 2000 to 2006 from around 3,000 to
2 4,700. Based on an industry survey, most ASCs have at least
3 some physician ownership.

4 According to interviews with stakeholders, some
5 physician practices are hiring physical and occupational
6 therapists and then referring patients to them. This factor
7 may be contributing to increases in outpatient therapy use.
8 According to a survey MedPAC sponsored last year, 19 percent
9 of physicians reported that they had increased the use of
10 imaging in their offices in the past year. The growth of
11 imaging performed in physician offices could be one of
12 several factors driving the increase in spending for imaging
13 under the physician fee schedule.

14 There is a long-standing debate over the merits of
15 physician investment in ancillary services and facilities.
16 On the one hand, ownership gives physicians a financial
17 stake in a facility and more opportunity to control how it
18 is operated. Physician owners may be more motivated to
19 reduce costs and improve quality.

20 In addition, when patients receive diagnostic
21 tests in their physicians office, the test results should be
22 available faster, thus improving patient care.

1 Physician owners also provide capital to expand
2 health care capacity.

3 On the other hand, physician ownership creates
4 financial incentives that could improperly influence the
5 clinical judgment of some physicians. For example, some
6 physicians may steer more profitable patients to the
7 facility they own and less profitable patients to other
8 facilities, which could create an unlevel competitive
9 playing field. In addition, some physician owners may refer
10 patients for more services than are necessary.

11 Physician ownership could lead to more services in
12 a market in two ways. The first way is by adding health
13 care capacity to the market. Researchers at Dartmouth
14 Medical School have found wide geographic variations in the
15 use of supply sensitive care such as inpatient days,
16 physician visits, diagnostic tests, and minor procedures.
17 There is often a lack of evidence-based guidelines on how
18 frequently and for what indications these type of services
19 should be provided. Variations on the use of these services
20 appear to be related to the capacity of the local health
21 care system. Thus, for example, a new imaging center may
22 increase the number of MRI and CT scans in the market.

1 A second way that ownership could lead to more
2 volume is by creating financial incentives for physicians to
3 refer patients for more tests and procedures, as we
4 mentioned in the previous slide. We recognize that
5 physicians are usually motivated by professional ethics and
6 their patient's best interest when recommending services.
7 However, financial incentives could, at times, influence
8 behavior, particularly there's not strong evidence to guide
9 physicians and patients.

10 Some economists have developed a theory of
11 physician induced demand. According to this theory,
12 physicians generally have more information than the patient
13 about the patient's condition and the relative benefits and
14 costs of alternative treatments. Thus, physicians may
15 recommend services that differ from what the patient would
16 choose if he or she had the same information and knowledge
17 as the physician. This may occur if some physicians do not
18 discuss the risks and benefits of the treatment with
19 patients, if they're motivated by financial self-interest,
20 or if they act in ways to limit their malpractice liability,
21 for example by ordering additional diagnostic tests.
22 Induced demand may also be more likely to occur in

1 situations where there are not evidence-based guidelines.

2 Researchers have discussed several factors that
3 could affect physicians willingness and ability to induce
4 demand. Physicians professionalism and adherence to ethical
5 standards play an important role in limiting induced demand.
6 One example is the development of clinical guidelines for
7 the appropriate use of certain imaging studies, which an
8 expert panel discussed at our September meeting.

9 Other factors include the limit on an individual
10 physician's time and workload, that is a physician can only
11 treat a limited number of patients per day; whether the
12 physician has convenient access to a facility; the patient's
13 knowledge of their condition and alternative treatment; and
14 the cost-sharing and riskiness of the service. As cost
15 sharing and risks increase, it becomes harder to induce
16 demand.

17 The literature describes two types of induced
18 demand. The first is direct inducement, in which the
19 physician orders more services which he or she then directly
20 provide, such as angioplasty. Physicians who engage in
21 direct inducement are constrained by the limits of their
22 time and workload.

1 The second type is indirect inducement, when the
2 physician order services which he or she does not personally
3 provide, such as diagnostic tests. For this type of
4 inducement, physicians can generate income that is not
5 constrained by the number of hours they are able to work
6 each day. Thus indirect inducement has probably more
7 potential for increasing volume.

8 This table illustrates the evidence of additional
9 volume associated with different types of physician
10 ownership. The first row shows investment in ancillary
11 services, whether a separate facility or part of a physician
12 practice. Use of ancillary services could be subject to
13 indirect induced demand, because these services are
14 generally performed by nonphysician professionals such as
15 technicians and therapists rather than physicians
16 themselves. The physician's financial incentive would be
17 the fee for the ancillary service and there may also be a
18 professional fee for the interpretation of a diagnostic
19 test. There is strong evidence in the literature that
20 ownership is associated with higher volume of ancillary
21 services, although whether the additional services are
22 appropriate and improve patient outcomes has not been

1 explored.

2 The second row relates to physician investment in
3 ASCs. Assuming that physician owners of an ASC perform
4 procedures in the ASC, the use of ASC services could be
5 subject to direct induced demand. In this case, the
6 physician investor's ability to induce demand would be
7 constrained by their time and workload. The financial
8 incentive for physician owners would be both the
9 professional and facility fees for the procedure. The
10 relationship between ASC ownership and volume has not been
11 studied to date.

12 The last row is physician ownership of a specialty
13 hospital. If the owners are surgeons or other physicians
14 who perform services in the hospital, they receive the
15 professional fee and a portion of the facility fee. In
16 these circumstances, there could be direct induced demand.
17 If, however, the owners do use the hospital but instead
18 refer patients to other physicians who use the hospital,
19 there could be indirect induced demand. In this case, the
20 owners would receive a portion of the facility fee.

21 According to studies by MedPAC and other
22 researchers, the opening of physician-owned specialty

1 hospitals results in more surgeries in the market. However,
2 the effects on volume are fairly modest, perhaps because
3 there are limits on the time available to physician
4 investors who practice in their hospital as well as patient
5 concerns over receiving invasive procedures.

6 In past work we have looked at the impact of
7 physician ownership of specialty hospitals on volume of
8 services. So today we'll focus more on physician investment
9 in imaging and other ancillary services.

10 A study by GAO in 1994 found that physicians in
11 Florida who were investors in diagnostic imaging centers
12 referred their Medicare patients more frequently for imaging
13 studies such as MRI and CT scans than other physicians. GAO
14 also found that physicians with imaging equipment in their
15 offices ordered studies more frequently than physicians who
16 referred patients to outside facilities, even when
17 controlling for physician specialty.

18 For example, cardiologists who performed
19 echocardiography in their offices ordered 2.5 times as many
20 echocardiograms for their patients as other cardiologists.
21 However, the report did not control for differences in
22 patients' conditions or health status, nor did it address

1 whether the additional services were appropriate.

2 Another study in JAMA adjusted for differences in
3 patients' clinical conditions by examining the use of
4 imaging for 10 common clinical problems, such as chest pain,
5 knee pain, low back pain, and congestive heart failure. The
6 authors found that physicians who performed imaging services
7 in their offices were much more likely to use imaging for a
8 given episode than physicians who referred their patients to
9 a radiologist. The results were similar when the
10 researchers controlled for physician specialty.

11 In addition, imaging spending per episode was
12 higher for self-referring physicians than for other
13 physicians. This study did not control for severity of
14 illness within each condition and did not examine whether
15 the additional imaging studies were appropriate.

16 Other studies have found that physician ownership
17 of clinical labs and physical therapy facilities is
18 associated with additional lab tests and physical therapy
19 visits. However, these articles did not control for
20 differences in case-mix or health status.

21 Now we'll move on to Jeff.

22 DR. STENSLAND: Why are we doing a new imaging

1 study? Well, most of the existing studies that Ariel just
2 talked about are more than 10 years old and they do not
3 reflect the recent rapid growth in imaging. So we are
4 proposing to take a new look at the effect of self-referral
5 on imaging volumes using more recent data. We will also
6 look at utilization by type of episode, for example
7 comparing the imaging costs for a patient with a migraine
8 headache that visits a physician with a CT scan to one that
9 visits a physician without a CT scanner.

10 The questions we propose to ask are first, how
11 variable is the volume of imaging across markets? Second,
12 do patients receive more imaging when their physician owns
13 the equipment? And third, is there a market level
14 correlation between self-referral and the level of imaging?

15 We first plan to group claims into episodes. For
16 example, an episode would be a low back pain episode or
17 maybe a migraine headache episode. Then we will assign
18 these claims to physicians based on which physician receives
19 a plurality of the E&M visit dollars. Then that we
20 determine whether the assigned physician owns imaging
21 equipment, again using claims data. Finally, we compare the
22 imaging use between the episodes attributed to physician

1 practices with imaging equipment, compared to physician
2 practices without imaging equipment.

3 As we move through the process, we will be
4 investigating some other issues such as the ETG risk
5 adjuster. We also recognize that radiologists can induced
6 demand by recommending follow-up studies. That induced
7 demand will be reflected in the control group, which is the
8 group of physicians that do not have imaging equipment, and
9 may reduce the differences that we find between utilization
10 for self-referring physicians and physicians that refer to a
11 radiologist. We'll be exploring ways to investigate the
12 magnitude of this problem.

13 We'll also be investigating other covariates such
14 as whether the practice is a for-profit enterprise or a
15 nonprofit group practice.

16 In terms of the data we're going to use, we have
17 two different datasets. One is 100 percent of Medicare
18 claims in six markets. This is the Boston, Miami, Orange
19 County, Greenville, Minneapolis, and Phoenix markets that
20 we've talked about in other studies. This dataset will
21 allow us to compare utilization across markets and across
22 types of providers in these markets.

1 However, we would also like to have a national
2 estimate of differences in utilization on ownership of
3 imaging equipment. In an effort to obtain a national
4 estimate, we will investigate using the 5 percent sample of
5 Medicare beneficiaries. This is the dataset that Craig
6 showed you earlier. However, we are somewhat concerned that
7 the 5 percent sample may not be sufficient to accurately
8 determine who owns imaging equipment. So this is one of the
9 other issues we'll be investigating as we move through this
10 process.

11 The questions we have for you are we would just
12 like to know if you have any questions on the literature and
13 if you have any suggestions for us regarding our analysis
14 plan.

15 Thank you.

16 MS. DePARLE: Thanks. I think this plan is a good
17 one and it's something that several of us have been
18 discussing and asking for for some time.

19 To go back to the page -- I think it's two before
20 this -- where you talk about the work plan. My only concern
21 is that in answering this question or trying to answer the
22 question of whether patients receive more imaging when their

1 physician owns the equipment -- and it's an important
2 question to get answered. Imaging reimbursement has been
3 slashed in the DRA a couple of years ago, in part because of
4 the growth. So this is an important underlying question,
5 whether self-referral is a part of it. I happen to believe
6 it is but we should see.

7 But I think we'll be left with still perhaps an
8 even more important question and one that we need to get to.
9 I'm wondering the extent to which we can get to it through
10 this work. And that is the one that, Karen, you're looking
11 at me and it's actually you who made me think of this.

12 It's one that Dr. Borman has raised and that was
13 raised a little bit by the panel that we heard at our last
14 meeting. And I've been mulling it ever since. I don't
15 remember which guy it was, but one of the managed care guys
16 who was using RBMs said, I think in response to a question
17 from you, Glenn. Someone said what did you find or what
18 were some of the high level findings.

19 He said we found that one of the most utilized
20 tests was that docs were ordering four images of the abdomen
21 when they had unexplained abdominal pain, and that just
22 seemed wrong to us -- I'm paraphrasing him -- it seemed like

1 too many. Why would you need four?

2 But then when they dug into it they found that
3 looking at ACR, looking at gastroenterologists, whatever the
4 different specialties were, there was no evidence-based
5 protocol on which images do you need when you have that
6 diagnosis or unexplained phenomenon.

7 And he ended up saying we arbitrarily decided to
8 tell our RBM which ones to deny or something.

9 I found that troubling, because I understand his
10 concern about the four images not being necessary. That's
11 the same thing, I think, we would think. And yet we know
12 that Medicare can't make a policy where we arbitrarily make
13 a decision about it. We have to have some evidence, which
14 is part of what the panel was about.

15 It made me think of something Karen had said which
16 is that she, in her residency training, would routinely see
17 that when a patient had -- was it a high fever, Karen -- a
18 fever of unexplained origin, I think you said -- that the
19 protocol was open them up, what we would call exploratory
20 surgery, look in there.

21 I guess I'm wondering, since I think the bigger
22 issue here is when is imaging appropriate and when is it

1 not? Is there any way to look at data from I'll just say
2 for kicks when Karen was in residency training? Some time
3 period when you could find a DRG that would be exploratory
4 surgery or something that would be a proxy for that. And
5 see whether, in fact, it's true that some of this imaging
6 that's going on is certainly growth and in some ways it's
7 concerning growth. But it might be replacing some things
8 that would be even less desirable.

9 So again, this is an important issue but are we
10 really going to get to the appropriateness issue? Because
11 some of the imaging that is going on is actually
12 appropriate. Some of it isn't. How do we tease those two
13 questions apart?

14 DR. STENSLAND: Is this a question to clarify?
15 You're saying if -- we're going to be looking at the
16 different levels of imaging. So let's say somebody does
17 more imaging of MRIs of the knee when somebody comes in with
18 knee pain and that eliminates some exploratory knee surgery.
19 But we're going to look at is there a difference between the
20 amount of that with people that own imaging equipment and
21 those that don't. Are you saying --

22 MS. DePARLE: I'm saying what you're looking at is

1 an important question that we need to know the answer to.
2 But I think we also need to look at this other question of
3 when is it appropriate and when is it not? And that's on
4 the table. It's sort of what we began discussing at the
5 last meeting, I think. And I don't know whether it's
6 possible to construct a study of that or to add that into
7 your work plan. But I do think that's something I want to
8 know about imaging in particular and the growth. When is it
9 appropriate and when is it not?

10 If it's true, and I think Karen has certainly seen
11 this in her practice, that it is in some cases replacing
12 what would have otherwise opening someone up to look around,
13 then that might be something we would say gee, that's not so
14 troubling after all.

15 MR. HACKBARTH: A couple of thoughts about this,
16 Nancy-Ann. You're absolutely right and the paper points out
17 that we're not going to have appropriateness standards. But
18 the episode-based tool, I think, does shed some useful
19 information on this. So if you look at episodes of care and
20 you find that the high imaging episodes also have fewer
21 hospitalizations or fewer episodes of surgery, that would be
22 useful information to know. If you're just looking at

1 claims without an episode grouper, it's hard to disentangle
2 those things. But that's one of the useful aspects of
3 episode groupers, I think.

4 And then within that tool, we will be comparing
5 physicians that own the imaging equipment to the averages.
6 And unless you believe it's only the ones that own the
7 equipment that are practicing the most advanced medicine --
8 which I don't think is a really implausible hypothesis --
9 you've sort of neutralized the question that you're talking
10 about in this analysis. That physicians who don't own are
11 doing the best imaging available and avoiding exploratory
12 surgery at the same rate as everybody else. The variable in
13 which they differ is ownership.

14 So we're not answering the question directly, and
15 you're right to ask it very directly. But I think we can
16 draw some important inferences using episode-based analysis.

17 MS. DePARLE: I think that's right. I guess I
18 wondered, though, if there was a simpler way -- and I know
19 it wouldn't answer everything -- but just to look at some
20 historical data, if there are DRGs that are proxies for
21 exploratory surgery. I don't know whether there are. And
22 to see if that has declined over time as we've seen imaging

1 grow.

2 It could be for some totally different reason. I
3 understand you couldn't connected the two necessarily, but
4 I'd be interested in seeing that.

5 DR. BORMAN: Just a brief comment on that. I
6 think there are numerous similar instances of advanced
7 imaging and related procedures have supplanted more invasive
8 procedures. For example, to bring it out of the dark ages
9 of my residency and something that probably more people in
10 the room will grasp, we now do CT-guided biopsy of a lot of
11 things that before might have required an open operation or
12 now perhaps a minimally invasive approach. I think that we
13 all assume that doing it in a biopsy kind of way is
14 necessarily better because we think there's inherent value
15 in not having this operation.

16 But I have to tell you, I'm not sure if we put the
17 finances to it that every time that it would be true sheerly
18 on a cost level, particularly using today's system of
19 payments.

20 So I think that maybe starts to migrate to the
21 comparative effectiveness world of things that we're trying
22 to get to as opposed to do this particular question which

1 does come back more to ownership. Maybe it is a can of
2 worms that goes into the CE basket and is still an important
3 can of worms. It's just that when you open a can of worms,
4 the only way to get them all back in is to get a bigger can;
5 right? So we've got to be careful when we get into that
6 one.

7 But there are some specific things you could track
8 in terms of rates of thoracotomy or thoracoscopy, for
9 example, compared to percutaneous lung biopsy. There
10 certainly have been a number of things that have been
11 supplanted, and your point is well taken.

12 MR. EBELER: If you go back one more slide,
13 imaging volume work plan, I have two questions.

14 The third point, it just talks about this market
15 level correlation. Is the question you're getting at there
16 whether there is a point at which the number of physicians
17 who have ownership interests, and then you see that self-
18 referral? Is there a point at which the practice in that
19 market changes and even those who don't own increase volume?
20 Is what you're getting at there almost a tipping phenomenon?
21 Is that what that is driving to or not?

22 DR. STENSLAND: I was thinking that was more just

1 another way to control it. Say if we do find that
2 physicians with imaging equipment are doing more imaging
3 than the ones without, somebody may come back and say well,
4 maybe they are just specializing certain types of patients
5 within that type of episode that need imaging or people that
6 need imaging or like imaging are more likely to go to them.

7 I think we can get around that phenomenon if you
8 look at it on an industry-wide level of saying in the market
9 as a whole, do these markets tend to have more imaging if
10 the physicians tend to own imaging equipment? Because then
11 the market level as a whole, you get around that question of
12 saying maybe there's just some people filtering to certain
13 physicians within the market.

14 MR. EBELER: I would wonder whether there was sort
15 of a matter of practice tipping phenomenon that may occur in
16 some markets.

17 The second question is whether you're going to be
18 able to look at trend data. The presumption here is you're
19 looking at a rising growth rate of pretty substantial
20 proportions and whether an increase in the number of
21 ownership and therefore self-referral is accelerating an
22 already rising trend. The question of a point in time

1 analysis or a trend analysis. Can you get to trend at all
2 here or not?

3 DR. STENSLAND: We only have two years of data so
4 it's a mini-trend, but it's not a great trend.

5 MR. EBELER: Thank you.

6 DR. WOLTER: I just had a few things. On the
7 imaging study, it would seem like we would want to
8 differentiate practicing physician-owned imaging from
9 radiologist-owned imaging, just for the nuance of
10 understanding that, since traditionally radiologists are not
11 likely to be referring. They may add studies or something
12 but it's little different, if we can do that.

13 And then also I would be interested, I don't know
14 if we can do this either, there are group practices that are
15 of significant size that might own imaging. But the
16 physicians compensation model would be completely separate.
17 In other words, there would be no payment related to
18 referrals for imaging.

19 So I don't know how you'd get into that but it's
20 an important issue, because I think that we, of course, talk
21 about accountable care organizations and maybe group
22 practices have a way of looking at things that's more team

1 oriented. But that whole issue, I think, if we could get at
2 it would have some value.

3 Sort of related to that, you know, several years
4 ago at the retreat we had a presentation on sort of the
5 current status of all of the Stark regulations. I thought
6 that was pretty useful, although I can't remember a lot of
7 it now. I wonder if we should remind ourselves about that,
8 especially since we've had the new formulation, I guess
9 Stark III, that has recently come along. Would it help us
10 to understand all that?

11 Related to that, it might be helpful for us to
12 hear from you about some of these creative arrangements that
13 are out there where you can send a patient and for the half
14 hour that they are getting a study, you are an owner of the
15 CAT scan, and that sort of thing. I think those would be
16 interesting things to learn about. It's called an under-
17 arrangement and I think some of it is going to be dealt with
18 with some of the new regs, but again I'm not 100 percent
19 certain.

20 This is a little bit related to Jack's question,
21 the trend issue. I was quite interested in that McKinsey
22 study from January that said that even after you adjust for

1 wealth, spending in this country annually on physicians is
2 about \$67 billion above these advanced European countries.
3 And about \$7 billion of that is related to these new equity
4 ownership trends.

5 So how might we, even if it's a mini-trend, at
6 least create a baseline for ourselves looking at where this
7 phenomenon might be going.

8 Those are just a few questions that occurred to
9 me.

10 DR. CASTELLANOS: I thought it was an excellent
11 presentation.

12 One of the things when you're doing the study, I
13 reflect on myself. If there's any way you can look at what
14 the ordering pattern, in the other words what the doctor
15 ordered before he owned a machine and what he ordered after
16 he had ownership. Because I don't think my pattern has
17 changed and I do own a machine. But I think that would be a
18 lot more prevalent and really tell you if there was a
19 difference in ownership.

20 I think if it's at all possible to get that data,
21 I think it may be interesting.

22 DR. STENSLAND: We'd like to. If we can get

1 another year of episode data then we'll have three years
2 that we can look at physicians who bought the equipment in
3 the middle year. For those who bought it in the middle
4 year, we could look at the trends before and after. But we
5 want to have that third year initially. We'll start with
6 the two years, '02 and '03.

7 That's a good point.

8 DR. CASTELLANOS: The other point is, and again I
9 think bob made a good point earlier this morning in the
10 executive session. The real problem is not the ownership
11 but the utilization or the appropriate utilization and the
12 quality. And Ariel, I'm just going to bring this up as an
13 example. I know you mentioned the cardiac hospitals having
14 a 6 percent increase in volume. What perhaps you didn't
15 mention was that when Mark McClellan gave his report to
16 Congress, he found that the cardiac hospitals had fewer
17 complications, a low mortality even when adjusted for
18 severity. He noticed that the cardiac hospitals delivered a
19 high quality of care that was as good or better than the
20 competitive hospitals.

21 So just because you have increased volume does not
22 insinuate that you don't have increased quality or

1 appropriateness.

2 I think we really got to this last month when we
3 had the panel. I think we all saw what the American College
4 of Cardiology was doing, where they are putting down
5 appropriateness for equipment and appropriateness for
6 imaging. I think that's the direction we need to go.

7 MR. HACKBARTH: You may be right about the CMS
8 report on specialty hospitals. It's been a while. That's
9 not what I remember their finding being on the quality.
10 Jeff?

11 DR. STENSLAND: I can kind of give you the quick
12 rundown. There was three different studies out there. One
13 was the University of Iowa folks and Peter Cram. And he
14 basically said when you control for your volume, it's about
15 equal.

16 Then the CMS folks did say it looks about equal or
17 better. This was some RTI folks that did the work for them
18 in their initial work. There was, I think, some lowering of
19 hospital mortality and some other benefits on there.

20 But then there's been a more recent study by those
21 same RTI folks who did the work for CMS. They're saying now
22 when we look at it, we also see there tends to be more

1 readmissions from physician-owned hospitals.

2 So it's not that these things are all
3 incompatible. It could be that the hospital maybe did have
4 lower infection rates or lower in-hospital mortality but
5 also have higher readmission rates.

6 So it's kind of a mixed bag when it comes to
7 quality, when you look across the three different studies.

8 DR. REISCHAUER: The data probably aren't refined
9 enough to do this, but I was trying to think of how to
10 answer Nancy-Anne's questions. If you could imagine a grid,
11 a four component grid, in which you had owners of equipment
12 and not owners, and then sort of highest quintile of use,
13 lowest quintile of use. and then you filled in total episode
14 cost in each of the four boxes. You could see if there was,
15 in a sense, a saving from using a lot of it. And then
16 whether that was uniform across owners and nonowners.

17 And if you had outcome information, you could also
18 fill in the four boxes with outcome measures. And then
19 you'd answer the two questions that you raised.

20 MR. WINTER: Just one clarifying question. So
21 when you talk about looking at the relationship between use
22 of imaging and ownership and then total use of resources for

1 the episode? Is that what you're referring to?

2 DR. REISCHAUER: Yes.

3 MR. WINTER: We can do that with the data.

4 In terms of linking to the outcomes, there are
5 some outcome measures or some quality measures rather for
6 some of the episodes. But we'll have to explore further
7 whether those apply to the episodes we would be focusing on
8 and whether we can track them with claims data.

9 DR. KANE: Just a quick comment. If the study is
10 on the relationship between physician ownership and volume,
11 this is a study on the relationship between physician
12 ownership of imaging equipment. I'm just wondering can you
13 do the same thing in the physical therapy domain? Because
14 wouldn't it be a similar thing, where the bill comes out of
15 the same provider number? It seems like it might be good to
16 not make your results just totally based on imaging but
17 perhaps to reinforce or -- I don't know which way it would
18 go. It might be good to have more than imaging in there if
19 you can and if it's not a huge add-on to your load to have
20 those who owned the physical therapy practices.

21 And that is, by the way, one of the practice
22 growing areas under the SGR. So it may be useful to throw

1 that in if it's not a huge work add-on.

2 DR. STENSLAND: we thought about this a little bit.
3 Carol knows more this than I do. But I believe that if an
4 independent therapist is employed by the physician, the
5 independent therapist can bill under their own provider
6 numbers. So it's more difficult to track the employment
7 patterns. But there may be something I'm not aware of.
8 I'll talk to Carol about that some more.

9 DR. MILLER: I don't think we're going to have
10 anything for the fall, but there is a couple people who are
11 taking a look at this issue. Because I think the problem
12 that you've identified is correct. And we're trying to
13 unpack it a little bit just to see what's there before we
14 can even get to then what could we study here.

15 So there's a little bit of background activity.
16 If it works out, it would show up to you in the spring.

17 MR. HACKBARTH: Thank you. Good work.

18 We'll now have a brief public comment period
19 before lunch.

20 Okay, we will reconvene at 1:30.

21 [Whereupon, at 12:29 p.m., the meeting was
22 recessed, to reconvene at 1:30 p.m. this same day.]

1 Just further, by way of background, we want to
2 look at some of the elements of the fee schedule. What I'd
3 like to do is kind of locate where we'll be doing this work.
4 Recall that the fee schedule includes relative value units
5 for the different types of inputs used in furnishing
6 physician services. This would be the physician work,
7 practice expense, and professional liability insurance. In
8 calculating fees in this payment system, the relative value
9 units are adjusted for geographic differences in practice
10 costs. They are then added together and multiplied by
11 something called the conversion factor, which just converts
12 the adjusted RVUs, puts them in dollar terms.

13 The work we have in mind here would concern those
14 work RVUs arguably. One of the more important elements of
15 the payment system, accounting for about 52 percent of
16 spending under the fee schedule.

17 We should also point out before getting into the
18 details here that the Commission has in mind some other work
19 on physician payment issues for this year. Some of that
20 work involves encouraging generalists in primary care and
21 surgery and that, too, could involve the fee schedule as
22 well as medical training initiatives and medical home

1 programs. We also anticipate some further work on policies
2 that would account for the comparative effectiveness of
3 services. So future meetings will address these issues.

4 We also want to, one last detail on the
5 background, I mentioned that the Commission had made some
6 recommendations in March 2006. Let me just kind of give a
7 brief recap of what those were about.

8 For that report the Commission had evaluated the
9 process for reviewing the RVUs every five years and had
10 concluded that CMS must take a more central role in
11 identifying services that may be misvalued, especially ones
12 that are overvalued.

13 The way things stand right now CMS is required by
14 law to review the RVUs at least every five years to
15 determine whether some revisions to them are necessary.
16 This process is known as the five-year review. In
17 conducting these reviews, CMS relies heavily on the
18 assistance of the Medical Association Specialty Society
19 Relative Value Update Committee, or RUC.

20 In 2006, the Commission recommended that CMS
21 reduce its reliance on physician specialty societies by
22 establishing a standing panel that would provide expertise

1 not in place of the RUC but in addition to it. The
2 Commission also recommended ways to identify services in
3 need of review and urged CMS to establish a process for
4 reviewing all services at least periodically.

5 Looking at the reviews that have been conducted so
6 far they have consisted of CMS publishing -- requesting
7 public comment on potentially misvalued services, physician
8 speciality societies and others proposing services for
9 review, CMS sending a list of services and supporting
10 evidence to the RUC. This would be services that had been
11 identified during the public comment period, as well as
12 other services that CMS itself had identified.

13 The RUC uses its process to develop
14 recommendations for CMS. CMS then reviews those and
15 publishes a notice in the Federal Register before any
16 changes become final.

17 To date the process has been rather lopsided in
18 favor of undervalued services compared to overvalued
19 services. In other words, increasing RVUs instead of
20 decreasing them. In the absence of greater balance in the
21 reviews that have occurred, it seems likely that many
22 services in the fee schedule now have work RVUs that are too

1 high. For the next five-year review it would be good to see
2 a review that is very different from ones that happened
3 previously. Some attention may be necessary on any
4 remaining undervalued services but it seems fair to say that
5 the goal now should be to place most of the emphasis on
6 overvalued services.

7 I'd like now to just start talking about the
8 additional projects we have planned in this area, three of
9 them here. The first one would have to do with the
10 frequency of action on misvalued services. The question
11 here is whether there is a need for action between the five-
12 year reviews. We also would want to look in the estimates
13 of physician time that are used for calculating RVUs in the
14 fee schedule. This would be estimates of time associated
15 with individual services. The question here would be --
16 just try to respond to questions that had been raised about
17 the accuracy of those time estimates.

18 A third topic concerns the fee schedule's
19 definition of physician work. Is it necessary to revisit
20 the definition of intensity or complexity of physician work,
21 and see if some other factors are relevant other than the
22 ones considered now.

1 So what we'll do is move on to that first set of
2 analyses having to do with the frequency of action on
3 misvalued services. You'll see I'll try to follow a pattern
4 here trying to lay out what the issues are in each of these
5 areas. In some cases, we've been able to do a little bit of
6 analysis just to see where the problems are and what we
7 might want to look at, and of course to describe the work we
8 have played in each of these areas.

9 So moving on to this first topic, the five-year
10 review is just that. It happens every five years. One way
11 to look at this is that there is a problem, kind of a lack
12 of balance. We have processes in place to define new
13 services and establish RVUs for them. That happens every
14 year. There is other processes for review of existing
15 services and redefining them and establishing new RVUs for
16 those. That, too, happens every year. But the five-year
17 review, of course, and the opportunities that it presents to
18 look at misvalued services comes around only every five
19 years.

20 The other thing about the five-year review is that
21 it's not really sensitive to what we could describe as the
22 often rapid changes that are occurring in physician services

1 and health care generally. For instance, the Commission
2 itself has looked consistently at growth in the volume of
3 physician services and has found that for some types of
4 services, imaging and tests in particular, volume growth is
5 very rapid, suggesting some changes underway.

6 Credit where credit is due, the RUC itself is
7 doing things that would bring about some action in between
8 five-year reviews. For instance, when recommending RVUs for
9 new technology services the RUC is now flagging certain
10 services and identifying them for rereview. Such reviews
11 are expected to start in 2009. In addition, the RUC has
12 established a five-year review work group that is using
13 criteria, such as changes in site of care and so on to
14 identify potentially misvalued services. Some of the
15 services identified would be candidates for the next five-
16 year review but other services more relevant to what we're
17 talking about here today could be candidates for review
18 before the next five-year review.

19 These are nascent efforts, however. A question is
20 whether there should be a requirement for the Secretary to
21 take action more frequently than every five years. For
22 instance, this Commission's SGR report discussed an option

1 for automatic adjustment of RVUs to occur between five-year
2 reviews. These adjustments would occur for services that
3 are growing at rates above a certain threshold. While these
4 adjustments would then be subject to public comment during
5 CMS's rulemaking process and would then be reviewed during
6 the next five-year review, the expectation is that the
7 adjustments would actually occur.

8 Just to provide some illustration here, we
9 analyzed data for 2002 to 2006 and identified physician
10 services growing most rapidly. While spending for all
11 physician services grew at an average of 29 percent,
12 spending for the top three services ranged from 187 percent
13 to 216 percent. Such services are examples of ones that
14 might be eligible for this automatic adjustment.

15 For the services shown here, we also checked to
16 see when they had been reviewed and noticed that they had
17 not been reviewed in the last 10 years.

18 So that's it for our first topic. We'd now like
19 to move on to the matter of the estimates of physician time.
20 And for this, I would just start off by noting that the
21 definition of physician work in the statute includes time
22 and intensity. So what we'll be talking about here is that

1 first part of the definition, time. To determine RVUs
2 according to the statutory definition, CMS has estimates of
3 the time that physicians spend furnishing each service in
4 the fee schedule. Most of those estimates come from two
5 sources, either research conducted in the 1980s by William
6 Hsiao and his colleagues -- this is a study that led to
7 development of the fee schedules. Other estimates since
8 then have come from the RUC.

9 There are concerns raised in government reports
10 and elsewhere about the validity of the time estimates. In
11 general, the concerns are that the estimates are too high.
12 For instance, one study found that the fee schedule's time
13 estimates for surgical procedures were significantly longer
14 than time recorded in operating room logs.

15 In a somewhat similar comparison, the average
16 length or duration of office visits billed to Medicare were
17 compared to the average duration of office visits by
18 Medicare beneficiaries as reported in the CDC's National
19 Ambulatory Medical Care Survey. Overall, visits billed were
20 longer than the visits reported on the survey.

21 A problem with these analyses, however, is that
22 they're somewhat dated, going back to the late '90s, early

1 2000's. For some of these analyses we can't really
2 generalize to the fee schedule overall. For the most part,
3 they have focused on surgical services and evaluation and
4 management services. And we have questions about the
5 studies themselves. For instance, are they based on actual
6 times for the services performed or just scheduled times?

7 But putting these questions aside for the moment,
8 let's just look for the moment at the work RVUs and notice
9 that they are highly correlated with the estimates of
10 physician time. Analyzing the relationship, we see a
11 correlation coefficient that's very high, of 0.93.

12 I'll also note while we're here that at a given
13 level of time work RVUs for some services are higher than
14 for others. The reason for this is intensity, the second
15 component, the definition of physician work, and we'll get
16 back to this matter of intensity in just a minute.

17 But on time, what we have here is a situation
18 where time is important. The data go back perhaps to the
19 1980s and there are questions that have been raised about at
20 least some of the data.

21 So what can we do? One thing would be to just
22 reviewed the literature on this and see if there are some

1 estimates of time to consider, to compared to the ones that
2 are used for the fee schedule. Another thing to do would be
3 to follow the work of the RUC. It has established -- it's
4 looking at the data and has a work group looking at
5 alternative sources, extant data they're called, for
6 valuing physician services.

7 Another thing we can do is to just investigate for
8 ourselves the availability of time data, such as those that
9 are being collected now as part of an effort by the American
10 College of Surgeons. This would be something called the
11 National Surgical Quality Improvement Program or NSQIP.

12 We're now at our third and last topic, which has
13 to do with the definition of physician work. For this I
14 would just note first that the work RVUs tend to be higher
15 or lower, depending upon the amount of time, but that
16 intensity of effort is also important. Conceptually,
17 intensity is the difficulty or complexity of furnishing one
18 service compared to another. The technical definition for
19 intensity in the fee schedule, one that goes back to that
20 Hsiao study, is that it consists of mental effort and
21 judgment, technical skill and physical effort, and tress.

22 The question here is whether this definition of

1 intensity is incomplete. One reason to look at this would
2 be a recent exchange of letters to the editor that appeared
3 in the Annals of Internal medicine. There it was observed
4 that the Medicare fee for a colonoscopy is more than double
5 the fee for a complex office visit. Despite that, it was
6 argued, the visit has higher complexity. And so you're left
7 with this question of why is there a difference in the fees
8 between these two services?

9 We can also consider the specialty choices of
10 medical students and residents and ask whether they are a
11 sign that perhaps physician work is not valued correctly?
12 One of the details on this.

13 For the Commission this kind of thing is important
14 because the compensation for the intensity of physician work
15 varies widely among services. Here we see how the fee
16 schedule accounts for intensity. We just look at the work
17 RVUs for each service, divide it by the services time
18 effort, and have computed here a measure we call
19 compensation per hour. This is intended to give a kind of
20 intuitive measure of intensity and one that can be used to
21 compare services.

22 If we go back to that question about the office

1 visit versus the colonoscopy, what we can do is compare the
2 two types of services, as you see here on this table. Note
3 that we're talking about broad categories of services and
4 not the specific codes that were identified in those
5 letters. Nonetheless the general point remains which is
6 that part of the reason for the difference in fees is
7 because there's more time for a colonoscopy, more time
8 required, than for office visits on average. But the other
9 factor, and the one that we want to dwell on here a bit, is
10 just this one of intensity. Hour for hour, compensation is
11 higher for the colonoscopy than for office visits,
12 compensation per hour here being \$114 for the colonoscopy
13 versus \$84 for the office visits, a difference of 36
14 percent.

15 Using the compensation per hour measure, we can
16 also compare office visits and other services that the
17 Commission has been considering such as imaging. For
18 instance, when we look at the compensation for CT and MRI
19 services that are growing rapidly, we see that the
20 compensation is 40 to 48 percent higher for these services
21 than it is for office visits. Compensation for these
22 imaging services also, we can see here, is higher than for

1 major surgical procedures.

2 So what could the Commission do on this issue? If
3 there is interest in looking more closely at intensity and
4 how it is considered in determining work RVUs, one option is
5 to consider the literature on specialty choice. When
6 medical students respond to questions about their choice of
7 a specialty they mention economic factors such as income and
8 indebtedness but they also identify other factors. For
9 example, students choosing a subspecialty cite intellectual
10 content, technological innovations, prestige, and control of
11 lifestyle among the reasons for their choice. Reasons for
12 not choosing a career in primary care include perceptions of
13 job dissatisfaction among primary care practitioners, lack
14 of prestige, greater stress, and bureaucracy.

15 So the question is should some of these factors,
16 perhaps lifestyle including variability in length of the
17 workday and on-call duty, being the kind of things that
18 should be considered in the definition of physician work for
19 the fee schedules?

20 Beyond considering just a change in the definition
21 itself, there's a question of just how to implement such a
22 change. One option, of course, would be to just change the

1 definition and go about the process of changing the RVUs.
2 If that option is not feasible just because of the sheer
3 number of services involved and so on, another option may be
4 to make some kind of fee schedule adjustments through the
5 conversion factor or some other mechanism to achieve
6 workforce goals or otherwise improve value.

7 As noted earlier, the Commission may consider such
8 adjustments in the context of addressing specialization of
9 the physician workforce and accounting for the comparative
10 effectiveness of services. These would be the issues that
11 we can address at future meetings.

12 I'll close by just leaving this slide on the
13 screen, which is the one having to do with the different
14 areas where we propose to do analysis for the coming year
15 and hope that that prompts some discussion.

16 Thank you.

17 MR. HACKBARTH: Karen.

18 DR. BORMAN: I think Kevin has done a nice job of
19 laying out where some of the biggest concerns are. And I
20 think before trying to get to nuts and bolts I would try to
21 maybe look from a little higher level of this.

22 We can take the RUC that whole valuation process

1 and get into the nuts and bolts of that. There is some
2 arcanery to that that would take more days than we had to
3 talk about how some things got to where they are, and I
4 don't think we have the time to do that. But I think
5 there's sort of that level.

6 Then there's the level of asking is a national fee
7 schedule and one based ostensibly an RBRVS the way it's been
8 a resource based and relative value schedule, is that an
9 appropriate approach to physician payment? And then there's
10 sort of the bigger issue of really -- how does this fit into
11 the whole scheme of the whole program, not just the
12 physician piece of it.

13 I think there are multiple levels here and I
14 think, to some degree, this Commission has interest
15 potentially in commenting at each of those levels but I
16 think doesn't want to get too hung up in the granularity of
17 the RUC process and end up just tweaking details of a
18 process and lose time on the bigger feature here. So I
19 would just start out by saying that.

20 I would just make a couple of comments about this
21 whole notion of overvalued services. I think you want to be
22 a little bit careful here for a couple of reasons.

1 Number one, as is pointed out in the paper, there
2 have been some work budget neutrality adjusters, so that
3 every service that has not changed -- that the RUC has not
4 voted to change has, in fact, been devalued several times
5 over the period of the analysis because of the work
6 adjusters. And so just because your value wasn't decreased
7 by the RUC, it's been decreased as a result of those
8 adjusters. So there really is nothing in the fee schedule
9 that hasn't gone down some percentage. Now a few things
10 have gained more but a number of things have gone down. So
11 this whole notion of overvalued, you don't want to start
12 with there are some things that have stayed the same and
13 never tweaked at all.

14 And I would point out that there is roughly about
15 4,500 CPT codes between 1992 and 2007 that have not changed
16 in the description of the code. So the ones that you can
17 look at that have been alive through the whole RUC process
18 for 15 years. It's roughly a 60/40 split. About 60 percent
19 of them have had some value increase recommended by the RUC
20 and about 40 percent of them have not. Now those, again,
21 have been devalued by the adjuster thing. So I think you
22 have to be a little bit careful on this overvalued issue

1 because everything, to some degree, has gone down because of
2 the work adjusters.

3 The second thing is that remember, as Kevin showed
4 you in the pie diagram, it's roughly 45/45 or 50/50 practice
5 expense and work values that make up the whole fee. The
6 professional liability is really a pretty small expense
7 piece of this. The distribution of the total payment varies
8 across specialties somewhat and -- within services to some
9 degree but across specialties. So a given specialty may
10 have much more of its revenue tied up in practice expense
11 and, for example, radiology or certain pathology and
12 anesthesia services that are on the CPT system as opposed to
13 their separate fee schedules will have that as opposed to
14 things where the work is a much bigger chunk of it.

15 And so when you take these broad brush strokes
16 like this you can have actions that end up playing out very
17 differently than how you might have intended relative to
18 certain categories of services. So I think you want to be
19 careful about that particular piece.

20 The time piece, I think Kevin has eloquently
21 described, and there clearly are secondary sources of time
22 data. Each of them has their good points and bad points but

1 there are certainly good secondary sources. And multiple
2 recommendations have been made from lots of sources to the
3 RUC process to use those. I think that that certainly bears
4 reiteration.

5 I think, similar to that, is the notion of a level
6 playing field in the things that are brought to the RUC in
7 that it needs to be uniform. You can't just accept new data
8 from one specialty or another and not accept them from all.
9 You'll remember the discussion this morning about the son of
10 SMS survey is, in part, trying to get at that issue.
11 Similarly, there are work value issues in that regard.

12 So what you want to encourage is a process that
13 has defined criteria that everybody participates in. I
14 think the RUC has tried hard to do that but the nature of
15 the process also doesn't necessarily support that all the
16 time.

17 Finally, the definition of physician work, I
18 think, gets to the very strategic level of is this the right
19 system to start with? I think we all understand that you've
20 got to apportion the money in some relative valuation of
21 where the money goes across the program has to exist. But
22 this, remember, is a relative system. It doesn't set the

1 absolutes. The absolutes are a function of how much money
2 is in the pot and the implication from that is the
3 conversion factor.

4 We have to think about we may need some kind of
5 relative process. But maybe there's a bigger view of says
6 to do the total payment. And certainly, we've talked about
7 bundled A and B services and that kind of thing. But just
8 for an example, the cost piece of physician practice,
9 whether they're in small groups or large groups, is probably
10 pretty measurable through some other sources and maybe
11 doesn't even belong in here. The practice expense becomes a
12 place to manipulate a lot of things in the RBRVS. And maybe
13 there's a way to take it out to something more objective in
14 terms of cost reporting like many other elements of the
15 Medicare program do.

16 So then you're left with this piece of what's
17 truly the physician work of it that may need a different
18 formula to address it.

19 I'm going to stop there but just some thoughts
20 about going forward.

21 MR. HACKBARTH: Karen, can I ask about one of your
22 first points on overvalued services? I just want to make

1 sure I understand what you were saying.

2 You emphasized several times the process that we
3 sometimes refer to as passive devaluation. In order to
4 achieve budget neutrality everything needs to be cut by some
5 percentage to offset the increase that would result from new
6 codes and some things being increased in value.

7 To my way of thinking, that process of passive
8 devaluation makes it very, very important that we have a
9 systematic approach for identifying the overvalued services.
10 So long as we have a skewed profile as we have historically
11 where many more things are increased in value than reduced
12 through the RUC process, that means that that passive
13 devaluation factor has to be larger than if we had a more
14 systematic approach for getting at the overvalued stuff.

15 I think a large passive devaluation adjustment is
16 potentially a sign of system failure that is really causing
17 some problems.

18 Am I seeing this differently than you are?

19 DR. BORMAN: I think there's a couple of facets of
20 the issue of overvaluation and I think we have a problem
21 because we think of it in absolute terms and yet we're using
22 a relative scale.

1 I believe it, in part, what you're saying is this
2 passive devaluation says that our ability to have the right
3 relative relationships is not correct. I'm sure Kevin has
4 been to the RUC enough times to know as well, the biggest
5 stumbling block is the cross-specialty comparisons, the so-
6 called multispecialty points of comparison list and all that
7 kind of thing. That certainly is the stumbling block. I
8 think what you raise is a very important thing. It says
9 something about our ability to do the relativity.

10 But some of what the practicing doc looks at is
11 the payment I get at the end of the day for the service, and
12 that's absolute number. In fact, for a lot of things that
13 has gone down over time. And it may or may not reflect the
14 social or political or whatever goals. From the discussion
15 here we would believe that it's not rewarded necessarily
16 efficiency or quality or whatever. And yet, when you look
17 some of the things that have gone down have, indeed, been
18 some things like major procedures that we think we have too
19 much of.

20 So I think you have to be a little bit careful of
21 whether it's overvalued in an absolute sense, what I take
22 home at the end of the day, versus relative to the other

1 existing things.

2 Maybe that's nitpicking, Glenn, but that's how I
3 would rationalize the two.

4 MR. EBELER: Just to build on that exchange, it
5 strikes me that there is an argument to look to see if there
6 are things that are relatively overvalued because the
7 breadth of folks are getting punished by that. And I don't
8 know if you said it here but in the paper, Kevin, you point
9 to sort of automatically looking at the high volume growth
10 procedures and new procedures that are diffusing rapidly.
11 It strikes me that if you had to have some initial screeners
12 for what you might look at to make it more efficient, that
13 struck me as helpful.

14 The final two bullet points here, if you connected
15 this to what we've talked about with sort of aiming towards
16 something like a medical home, it strikes me that there's a
17 connection here and sort of the comparative investment in
18 coming up with an appropriate payment for care management
19 at the medical home strikes me as something that if we're
20 going to invest another dollar in payments, that heads us in
21 a more positive direction long-term than a marginal
22 adjustment in unit fees. So connecting that discussion into

1 this payment discussion strikes me as an interesting way to
2 go.

3 DR. WOLTER: I was going to comment on the budget
4 neutrality adjustment, too, that got put in place after this
5 latest five-year review. And kind of as an aside, I
6 suppose, it's a relative nightmare to administer that in a
7 group practice because all the specialties are quite aware
8 of the RVU changes. What they weren't as aware of was the
9 subsequent 10 percent reduction to create budget neutrality.

10 And then most group practices, like ours,
11 benchmark themselves against data that's compiled by AMJA or
12 MGMA, and none of that data yet reflects the new RVUs or the
13 budget neutrality adjustment of 10 percent.

14 This as further compounded by the fact that the
15 commercial payers have adopted the new RVU system but are
16 not doing the budget neutrality adjustment. And so trying
17 to work this through 225 physicians, all of whom want to be
18 treated fairly, has been -- I'll just tell you -- relatively
19 a nightmare in the way that it has unfolded, absolutely a
20 nightmare.

21 That's sort of an aside. You'd have to deal with
22 these things as you get into changes like this.

1 But I think your summary, Glenn, is accurate in
2 the sense that the system doesn't seem to be rebalancing
3 itself maybe in the way you might like it to, and so we're
4 having to apply budget neutrality factors.

5 I think the issue with that point of view though
6 that others might take is that that's assuming that the pool
7 right now is the right number. And if you did have an
8 objective system to value physician work, you might expect
9 the pool to go up or down in any one year if you really
10 thought you were valuing that work appropriately. But of
11 course, we're stuck with a policy around budget neutrality
12 which means we define everything, relatively speaking, based
13 on some historical number. And that's maybe not entirely
14 objective either.

15 Then the last thing I just wanted to mention,
16 because I'm certainly fine with the direction we're taking
17 here and trying to do this analysis. It makes a lot of
18 sense. I do worry about some of the geographic adjustment
19 issues that we have in the physician payment system. I hear
20 a lot about it from rural providers. Evidently we do so
21 adjustment geographically even on the work RVU, and I think
22 some floor was put in that is expiring or something on that.

1 I hear a lot from rural providers about the
2 practice expense issues and do we have the right
3 occupational mix built into that? And does it end up
4 creating some biases that are fairly unfavorable to rural
5 physicians? I don't know if that's on our work plan.

6 MR. HACKBARTH: Do you want to address that,
7 Kevin?

8 DR. HAYES: I can just confirm what Nick said
9 about the floor on the work geographic adjuster will end at
10 the end of this calendar year. There's some potential for
11 it to be extended, the Congress has considered that, and
12 that is the rule right now.

13 DR. WOLTER: On that, Kevin, maybe you could just
14 help me understand what the rationale is for it because it
15 does seem like abdominal surgery of one kind or another in
16 New York is similar to what it is in Mississippi. I don't
17 know what the original rationale was.

18 DR. HAYES: The rationale for an adjuster is that
19 there are cost of living differences and differences in the
20 availability of amenities in communities. And so the net of
21 those has gone into calculating some kind of a work
22 adjuster.

1 The Congress though, in setting up the fee
2 schedule, said well, there is something to the other
3 argument, the one that you were talking about, about isn't
4 work the same everywhere? And so the decision was to allow
5 for 25 percent of that cost difference among geographic
6 areas to pass through and to form an adjuster for the work
7 RVUs but not to allow all of it. So it was kind of in the
8 spirit of a compromise, I guess we could say.

9 DR. WOLTER: I guess intuitive to most of us is
10 that we would capture that difference in cost of living and
11 the practice expense category.

12 MR. HACKBARTH: Look at it this way: take a lawyer
13 who's writing a simple will. That lawyer will be paid more
14 in New York City than in Billings, Montana. Part of that
15 difference would be attributable to difference in office
16 space expense and staff cost. But even allowing for that,
17 you get higher salaries in New York than in Billings.
18 That's an observable fact.

19 So the original notion was to carry that over into
20 physician payment, as well. But as Kevin described, the
21 decision was made to limit the impact of that to only a
22 fraction.

1 DR. WOLTER: Actually, if you look at the real
2 data quite frequently in higher cost communities physicians
3 earn less than in rural communities because there's a
4 greater supply. They want to stay in Seattle. They want to
5 stay in Palo Alto.

6 And also, the list we just gave of things we might
7 analyze that should go into the work RVU didn't include
8 location. It included stress, it included complexity, it
9 included the kinds of things that go into it. I guess I
10 would argue that the rationale for the geographic work
11 adjuster is really quite flimsy when you really start
12 thinking through it. And in fact, oftentimes it costs more
13 to recruit physicians of a given specialty into rural areas
14 than it does in larger cities.

15 I know that's not the topic for today so I don't
16 want to have it get us off track.

17 MR. HACKBARTH: But the reason I think it's worth
18 pursuing is that can be a part of the scope of what we do if
19 people want to make it so.

20 DR. SCANLON: I was going to bring it back not to
21 this issue of whether the work is different or the same in
22 any place, but to the issue of what does it take to attract

1 someone to perform this task in different locations? I
2 think that partly relates to the cost of living and it
3 partly relates to the adjustment made to not completely
4 change it for cost-of-living but to give, first of all, the
5 25 percent exemption and then, more recently, the 1.0 floor.

6 The idea is that I think unlike the rest of
7 practice expense, physicians may operate more in a national
8 labor market and it's easier for them to relocate. And so
9 therefore, if you are talking about trying to attract people
10 to an area you have to worry about prices and the incomes
11 being paid in New York City or someplace else.

12 That is something that, in some respects, can be
13 empirically driven. What does it take to get the supply
14 that you want everywhere? Because I think if we try to use
15 the argument that the work is the same, and come back to
16 where Glenn is which is well, the work is the same in other
17 occupations as well, but we see these differences in the
18 compensation. And in fact, the geographic adjusters are
19 based upon these differences in compensation in other
20 occupations, not for physicians.

21 DR. MILLER: Just a couple quick things on that,
22 and again I understand this isn't the subject of

1 conversation and we can go down this road. But I want to
2 set some expectations if we go down this road.

3 On the physician work issue, which has been fought
4 out a number of times, there's a bit of philosophy at the
5 end of the day. You can analyze the hell out of it but in
6 the end it sort of is physician work the same in one
7 community or another comes down to kind of a question of
8 judgment. So I just want to set expectations in the end.
9 There won't be any analysis that will just say okay, the
10 answer is... You'll find a bit of a philosophical bent
11 there.

12 And one other thing on what do you have to set to
13 attract a physician. There is a certain amount of empirical
14 evidence that could be brought to bear on that question but
15 that also opens the door to -- think of the MA situation
16 where you set the rates high enough to attract. And that
17 debate can also go off the tracks, depending on -- because
18 implied in, Bill, your comment was you set it to the amount
19 of access you want. And that has also kind of a judgment
20 feel to it.

21 So we can go down these roads but also want to set
22 some expectation that this will involve reaching a judgment

1 in a lot of instances.

2 DR. SCANLON: Let me just say, I think we borrow
3 from economics a lot but we don't necessarily go all the
4 way. If we were looking for efficient prices, what we'd be
5 looking for is the price it takes to get somebody to supply
6 the service. We're not there yet.

7 But as we think about how we're adjusting prices
8 over time, this whole issue of access may become a much more
9 important component in terms of how we're setting these
10 fees. And then we have to start thinking more in economic
11 terms than we've been doing in the past. We're going to
12 have to borrow more from the economics profession than we
13 have up to today.

14 DR. DEAN: I'd like to follow up or pick up on one
15 of the things that Karen said, and I hope I interpret it
16 correctly. But I think there's a real question whether this
17 system can ever do what we want it to do, especially as it
18 relates to what I do in primary care.

19 Because any individual encounter is very hard to
20 define or precisely measure and they vary tremendously in
21 terms of what goes into them both in terms of the stress, in
22 terms of the complexity. And the complexity that I

1 encounter is very different than the proceduralist, where
2 you can define it. I tend to deal with the elderly person
3 who has three or four diseases and limited income and no
4 family. And how do we construct a care plan that will get
5 them the best outcome? And I don't know how you define that
6 in terms of work units.

7 I think the issue of time can be very misleading
8 because, hopefully at least, I can do those things much more
9 efficiently being in one practice for many years and knowing
10 these people much more efficiently than I did 10 years ago
11 or 15 years ago. So I think the value of what I do is
12 probably higher -- I hope -- that's self-serving but I hope
13 it is -- and more valuable than it was then but I'm doing it
14 in less time.

15 I guess the final point I'd make is I think we do
16 have to -- maybe it's what Bill just said. If people are
17 not going into the specialties that we think are necessary,
18 then there's a problem and this system is not working.

19 MR. HACKBARTH: The problems with the system are
20 rife. They're really everywhere you look. And then you
21 come to the question okay, what's the better alternative?
22 And that's where things get hard. I'd be prepared to say

1 let's scrap this baby, this is going to consume way too many
2 hours already. But what do you put in its place? That's a
3 really hard question for me to answer.

4 DR. DEAN: [off microphone] An awful system
5 compared to what?

6 MR. HACKBARTH: Yes, compared to what. The
7 suggestion box is often.

8 DR. REISCHAUER: But this is still a market,
9 remember. Medicare is paying 20 percent, roughly, of total
10 physician fees and 80 percent is being paid by somebody
11 else. And the somebody elses have equally flawed systems of
12 determining individual payments for --

13 MR. HACKBARTH: But they're using this one more
14 and more.

15 DR. REISCHAUER: They are, but then the total
16 package is what the economic incentive is to locate in South
17 Dakota versus New York or to be a radiologist or a primary
18 care physician.

19 And I think you're right, that maybe we should be
20 looking at this and saying looking at the big picture is the
21 supply allocated the right way both geographically and
22 specialty-wise for the best care? And we're one little

1 piece of the answer.

2 And to the extent it isn't, make adjustments that
3 would improve it, which would be relatively crude as opposed
4 to what we're doing here which is like trying to repair a
5 watch or something with big hands.

6 DR. DEAN: [off microphone] I would argue this is
7 pretty crude because it leaves out a whole lot of variables.

8 DR. REISCHAUER: I'm agreeing with you. But I'm
9 saying we're never going to be able to measure every one of
10 those and weight them and add them up to say you're city in
11 South Dakota really should get a 1.2-something or other, as
12 opposed to some rather broad brush adjustments of the sort
13 that Congress would like, a rural adjustment or a nick on
14 radiologists or whatever.

15 MR. BERTKO: The first part is redundant because
16 I'm going to support Tom's comment here that this looks
17 like, as well as Kevin has outlined it in part three, that
18 it is a workforce and future access issue that we've got to
19 deal with. Maybe that calls for the expansion of that part
20 of the debate on the intensity and how it's defined.

21 The other comment I was going to make is just
22 looking at his chart there with the three RUC reviews, as

1 hard as the RUC Committee has worked over the years -- and
2 the presentation we had seemed to say they put a lot of time
3 into it -- it seems like we've pulled up this huge amount of
4 things that might be overvalued -- however defined -- and do
5 we want to think about and maybe support a special interim
6 review to do the catch up on that, leading the RUC kind of
7 go about its own business for the next five-year review?

8 Because it looks that we might want to revisit
9 thousands of those 4,500 procedures to see if they fall into
10 the overvalued category.

11 DR. MILLER: In a sense, when you say something
12 like that, it's sort of like what apparatus and what entity
13 would do that? And then we're talking about 7,000-plus
14 codes to churn through.

15 I think the other way -- because we just got off
16 topic a little bit -- which is not to say that there was
17 anything wrong with the statements. The physician work
18 issue has been a perennial question.

19 But back to what Kevin is kind of proposing here,
20 and it does connect to some of the things you're going to
21 say. The first point he's making is perhaps in between
22 these larger five-year estimates we go after certain

1 services that do seem to have these characteristics that
2 might suggest they're overvalued and something happens.
3 Either they're reviewed immediately or automatically they
4 come down and then they hit the five-year review for the RUC
5 to examine.

6 The second thing is saying maybe the estimates at
7 the beginning weren't right to begin with. Maybe there's
8 another set of data that we could use to get at time
9 estimates, although Kevin tried to say in the presentation
10 some of those things that are suggested we've got to look a
11 little carefully at because there may be some hang ups
12 there.

13 And the last point is this what we've been talking
14 about is maybe when we said the work intensity we didn't
15 take all the intensity into account. And this is not to
16 brush aside the geographic or the physician work stuff.
17 Those are issues.

18 But I also want to bring us back just for a
19 second. I'm not hearing necessarily objections to pushing
20 on these things. What I would say to you is this is our way
21 of, in a sense, a more efficient way of trying to get at a
22 full review of 7,000 things through some apparatus that

1 might not exist. That's kind of the strategy.

2 MR. BERTKO: I would agree with everything you
3 said, Mark. I was just pointing out that we might one time
4 want to get some recognition that there is a ton of work
5 piled up in front of it right here and there may need to be
6 some catch up and then it goes back to a more normal
7 process.

8 DR. CROSSON: I'd just like to get at the topic
9 that we've been discussing here from another slightly
10 different point of view, and it has to do with what do we
11 really mean in this formulation when we're talking about
12 value? Value to whom?

13 So the notion here inherent, I think, in RBRVS as
14 it applies to physician work, that the value is the resource
15 intensity. RB equals value. There could be a different
16 definition; right? I think that's what the third point gets
17 to, which is in an administered pricing system who should
18 determine what the value is? It would seem to me that
19 whoever is paying for it.

20 In a market, as we're going to find out in our
21 housing situation in the next few years, it's worth whatever
22 somebody will pay for it. But in an administered pricing

1 system it seems to me that the value needs to be set by the
2 entity -- in this case Medicare -- who's paying for it.

3 If that's the case, is the only value at play here
4 the input resource costs? Or is, in fact, it time to mature
5 the notion of value by adding some of these other
6 considerations, considerations that have to do with the
7 inherent social value or inherent disease prevention value
8 or other issues with respect to physician manpower?

9 Now you can say you don't want to disturb or
10 distort the marketplace. But I think we've got evidence
11 that the marketplace has been wildly distorted by the
12 payment systems that exists at the moment.

13 I just think if we think about this from the
14 perspective of whose value and long-term versus immediate
15 value, we might get someplace.

16 MR. HACKBARTH: I think that's very well put. So
17 you can say all of the things that Kevin has outlined are
18 important things to do. The question that you're raising is
19 well there, in addition to that, need to be some other
20 adjustment in the system, some other factors in the system
21 that reflect -- Arnie has proposed in the past cost-
22 effectiveness of services, value to the patient and to

1 society in that sense, or potentially supply and assuring
2 appropriate supply both by specialty and perhaps by
3 geography.

4 And all of that conceptually hangs together for
5 me. The challenges would be presumably in starting to
6 quantify some of those things.

7 Part of the original design of the system was
8 let's have an analytic system, where you try to measure
9 things and have formulas to minimize the amount that's
10 determined politically through just raw power and political
11 contributions and chairmanships of committees and whatnot.

12 So long as you're talking about resource inputs,
13 that's mind numbing enough to scare away a lot of people.
14 But if you start talking about adequacy of supply and
15 different geographic areas, you're starting to get closer to
16 home where political intervention is much easier and
17 inviting. But ultimately that may not be a reason not to do
18 it. Just a cautionary note.

19 DR. BORMAN: Having pointed out all of the bad
20 things, or some of the bad things about the RBRVS, I think
21 we should step back and also say what did it get us to?
22 Because there's certainly been some outcomes that presumably

1 have been positive for the Medicare program and potentially
2 for those who utilize the RBRVS.

3 Part of it was that there was really no
4 understandable relationship about what was contained within
5 a service and -- we talk about geographic variation now, but
6 certainly it was exponentially greater pre-Medicare fee
7 schedule and RBRVS; right? Because a global period might
8 have been two days, it might have been 180 days, presumably
9 only for the same service. Some things had just incredible
10 variations. They just were pretty hard to justify. And
11 Medicare was paying all of that across that variety for
12 presumably what was the same service.

13 So I think we have to say it has accomplished some
14 things in terms of legitimizing the notion of a national
15 schedule and trying to popularize or embed the concept that
16 work is work.

17 Of course, one of the things inherent in that was
18 walking away from specialty payment differentials. And so I
19 think if part of what you want to do is build back in some
20 sort of specialty incentive, that's going to have to be a
21 conscious and explicit and stated thing because that
22 certainly is something that was kind of not part of the move

1 to the RBRVS. I'm not saying that's right or wrong, but it
2 has to be a pretty up front, over explicit kind of
3 statement.

4 And just one technical comment on the intensity
5 piece, Kevin, and I don't know whether it's worth learning a
6 bit more about. But as I recall, the two things with which
7 work tracked the most as Hsiao looked at it was time. And
8 Tom has elegantly pointed out the issue of time.

9 But another was site of service and that most
10 people agreed at that point in time -- remember the late
11 '70s, early '80s -- that inpatient care was more
12 professionally demanding than outpatient care. So that
13 there was more intense work, if you will, per minute of
14 inpatient care than there was of outpatient care. And site
15 of service had some differential.

16 I think we all agree there are more acutely ill
17 outpatients now than there used to be. But site of service
18 may still have some predictive power. And as one of the
19 things that's in that, that was a -- it didn't end up in the
20 definition of intensity but it was an independent predictor
21 along with time. And so you might want to tease out just a
22 little bit what is that a proxy for today.

1 So just that last technical piece.

2 MS. HANSEN: I'd like to go back to something you
3 said earlier, Glenn, is part of our goal posing what the
4 future is? This is very specific to the tweaking we have to
5 do.

6 I'd really like to reinforce his whole thing of
7 where do we need to go with the supply side? Which is going
8 to be one of our points about the medical preparation of
9 people to be prepared to do some of the geriatric kind of
10 work.

11 If we look at the demographics side of it, the
12 growing number of people over 85 really is just marching
13 along. And the reflection of that population reflects the
14 chronicity. So the preparation side is real important.

15 While we're noodling with the complexity -- which
16 I don't professed to have any expertise with relative to the
17 work -- the only thing I would comment, as maybe a
18 nonphysician when I'm doing with this population, the
19 ability to value the cognitive complexity that is necessary
20 for people to deal with geriatric complex people, to prevent
21 going to a site of service that's highly acute, highly
22 technical. It seems like the upstream side is something

1 that has to be done.

2 I just want to finish up by, it was just last
3 night that I saw Dr. Bob Butler, who started the first
4 geriatric school, and we saw a picture about England. One
5 of the things we were talking about workforce. And I said
6 how can we think about more people -- besides the
7 reimbursement, which is huge -- but why don't people choose
8 geriatrics?

9 He said one out of three graduating physicians in
10 the UK picked geriatrics or primary care. But every single
11 medical school has geriatrics curriculum built into it. I
12 think there are about 1,200 or 1,400 medical schools. There
13 are only 31 schools of geriatrics here.

14 So it seems like there is some disconnect, that we
15 have this growing population with a lack preparation, that
16 we're focusing on a lot of the acuity issues when we really
17 should be looking at the entire spectrum.

18 I just would like to raise this on that side of it
19 again, speaking as a nonphysician.

20 DR. DEAN: It just occurred to me, I just reread a
21 little while ago the paper that Dr. Wagner and several other
22 people wrote regarding the chronic care model. They used a

1 phrase in there, the tyranny of the urgent.

2 I think that really plays into the development of
3 these models, and it's particularly relevant to geriatrics.
4 Because a lot of times we're not dealing with things that
5 are really urgent but it doesn't make them less important.
6 And yet, the ideas of intensity and complexity and so forth,
7 I think, are tied in to the idea of urgency.

8 And our system is focused on urgency and we've
9 sort of ignored the things that are not urgent. And I think
10 we pay the price for it in the end.

11 MR. HACKBARTH: We're going to have to move ahead.

12 Kevin, as always, you did a terrific job in laying
13 out the issues.

14 What I hear, though, in the discussion is again,
15 and we've gone through this several times now in recent
16 years, a real frustration with the system at a fundamental
17 level. It's not just a matter of tinkering with the
18 existing work adjustments but it's really missing some
19 fundamental considerations, whether they be the value of the
20 services to the patient or supply issues for the future or
21 whatever.

22 So let us think a little bit about how we might

1 tackle those issues and then I will call around before our
2 next meeting, once we've got some thoughts, and get your
3 reaction to those. We'll try to figure out a way to be
4 responsive to the urge to go beyond mere tinkering to
5 introduce some more fundamental changes in the system. It
6 won't be easy but we'll try to do that.

7 DR. KANE: What happened to the recommendation
8 that there be oversight at CMS around what to recommend to
9 the RUC?

10 MR. HACKBARTH: The last I heard, not yet adopted,
11 although a provision along those lines was included in the
12 CHAMP bill, as I recall, to require CMS to do it and to
13 provide funding to support the activities. Is that right,
14 Kevin?

15 DR. HAYES: Yes. I'm not sure about the funding
16 part, but there's a provision in the CHAMP Act about this.

17 MR. HACKBARTH: Thanks a lot, Kevin.

18 Next is hospital construction spending.

19 MR. GLASS: Each year we examine access to capital
20 for hospitals as one of the indicators of payment adequacy.
21 Over the last several years we've noted that one measure of
22 hospitals access to capital, hospital construction spending,

1 has been growing very rapidly. So today, we'll present an
2 overview of the growth in hospital construction. In
3 November, we'll discuss what factors are driving the
4 spending.

5 We would like to thank Hannah Neprash for managing
6 much of the data involved in this project.

7 As you can see, non-federal spending on hospital
8 construction has more than doubled since 2000 and is
9 projected to exceed \$30 billion in 2007. Eventually, these
10 construction costs will find their way into Medicare cost
11 reports in the form of depreciation and interest expense.
12 When they do, they may increase hospital costs and slightly
13 depress hospital margins. Our payment adequacy analysis
14 could then reflect the increased costs and lower margins.

15 More importantly, the increased hospital capacity
16 may lead to an increase in utilization and, hence, Medicare
17 spending. This indirect effect of increased utilization may
18 far exceed the direct cost of the construction.

19 We find that overall health care construction --
20 the yellow triangles there -- slowed as a share of the
21 economy in the 1990s as reduced length of stay in hospitals
22 reduced the need for hospital beds. However, the trend has

1 changed and health care construction has been an increasing
2 share of gross domestic product since 2000 and is now at the
3 highest level in the last 15 years.

4 Hospital construction growth is responsible for a
5 majority of the rapid rise in overall spending on health
6 care facilities, reaching over 0.2 percent of GDP in 2007.
7 The growth in construction spending has coincided with both
8 a decline in interest rates and an increase in hospitals'
9 profit margins on private pay patients and an increase in
10 all payer margins from 2001 to 2005.

11 The green line shows health care construction
12 spending divided by total health care spending. If
13 construction spending grew at the same rate as health care
14 spending, the line would be flat. But it's not.
15 Construction spending as a share of the total health care
16 spending declined in the 1990s but has rebounded to a
17 cynical high in 2007 of roughly 2 percent of health care
18 spending. This is true even though health care spending
19 itself has been increasing rapidly, which is why
20 construction spending has been increasing as a share of GDP.

21 Given health care construction is at a peak level
22 by any measure, the question is is this a cyclical top or a

1 trend to even higher spending?

2 To try to get a handle on that question and where
3 hospital construction is going, we look at another data
4 source. Modern Healthcare does a construction and design
5 survey and they surveyed a group of construction design and
6 architecture firms that specialized in the health care
7 industry. There are a few breaks in the graph where they
8 didn't quite break it down in the same way.

9 But the survey provides some insight in the
10 interest that health care providers have in future
11 construction projects. Reporting construction firms have
12 broken ground on projects with increasing value since 1999 -
13 - that's that orangeish line on the bottom. The green line
14 shows design activity. It has been growing strongly and
15 bounces up to almost \$58 billion worth of design activity in
16 2006. Even though some projects are designed but not built,
17 this could lead to an increase in actual construction over
18 the next couple of years. So we may not have seen the last
19 of the construction boom.

20 Jeff is now going to show us where the boom is
21 occurring.

22 DR. STENSLAND: Where is this construction taking

1 place? This picture breaks the country down into Census
2 regions and provides two pieces of data. The top number is
3 the percentage change in hospital construction from the
4 five-year period ending 2001 to the five-year period ending
5 2006. The number in parentheses is the spending per capita
6 during the most recent five-year period. This data only
7 includes construction cost reported on construction permits.

8 We can see that construction is taking place all
9 across the country. Total spending adjusted for inflation
10 has grown by at least 37 percent in all Census regions since
11 the 1990s. If you look at the map, you'll see the highest
12 growth rate has been on the Pacific coast. However, you
13 have to notice that the Pacific region started from a very
14 low level of construction in the late 1990s and is still has
15 one of the lowest levels of construction per capita in the
16 country, if you look at the number in parentheses.

17 Our next step is to examine construction spending
18 on a county by county basis. We want to know what factors
19 are driving the spending. The Commission may want to know
20 whether the construction projects appear to be driven by
21 need. For example, is construction strongest in areas with
22 population growth and/or aging hospitals? Or does

1 construction appear to be driven by economic opportunity?
2 For example, are construction projects focused in counties
3 with high levels of income? Or is construction focused on
4 product lines that are viewed as profitable?

5 In the end, the data on hospital construction can
6 be used as one factor to evaluate whether payments are
7 adequate. The data may also shed light on whether the
8 current financial incentives in the health care system are
9 leading to a desirable distribution of capital spending or
10 to a distribution of capital spending that is troublesome.

11 Now we want to know if you have any questions
12 about the data or any suggestions regarding our analysis
13 plan? We'd also like to know if there are any capital
14 spending analyses, other than we've talked about, that you
15 would like us to look into?

16 MS. HANSEN: Jeff, this is just a clarifying
17 factor. For the West in terms of the spending, but
18 specifically to California, were there are some factors
19 considered relative to the statutory requirement in our
20 state for earthquake retrofitting?

21 DR. STENSLAND: We haven't made any adjustment to
22 that, so this includes any spending that they have actually

1 done, construction put in place by 2006. However, when we
2 did look at some of the hospital systems that have hospitals
3 in California, a lot of them look like they haven't actually
4 started that construction yet. It may be on the plans but
5 it looks like more in 2008 and 2009 we may see more of that
6 activity.

7 MR. BERTKO: Jeff and David, here's something
8 that's perhaps related to this but only marginally so. I
9 took from your paper that it appears that construction,
10 which we don't know yet is going to advance greater than
11 needed capacity at least in the short run, which if I'm
12 interpreting it right would say we may be moving back to the
13 early 1990s era. Separate from Medicare, that would then
14 hint that commercial payers may then be able to negotiate
15 for lower rates, which would probably also have an effect on
16 overall margins and potentially on Medicare margins.

17 I was wondering if you had any plans to think
18 about that as you finish up this work?

19 DR. STENSLAND: I think that's part of what we
20 talk about on the policy implication of this. If there is
21 rapid growth in spending than, as you say -- or even if the
22 private payers simply stop paying for it by stop having 7

1 percent increases per year in their payment rates, then
2 there could be some excess capacity and is Medicare going to
3 be asked to pay those higher costs?

4 MR. BERTKO: Then there's the open question of
5 should Medicare pay for, and it may be poor planning on
6 behalf of the industry.

7 DR. REISCHAUER: I was wondering if you want to
8 supplement this with some overflying information about net
9 change in beds and occupancy rates as just a way of trying
10 to understand what it is that we're seeing. Are we seeing
11 the GW Hospital being ripped down and a new one being built
12 in its place? With little change in overall capacity or
13 what? And is there -- is this occurring sort of in the
14 "right places?"

15 DR. STENSLAND: The data does come down so we can
16 break it down into new facilities, replacement facilities,
17 versus remodels. So we can do that. And add that data in
18 there about beds and occupancy.

19 DR. KANE: It would be interesting to know if it's
20 greater in areas with less concentration or more
21 concentration. If consolidation has really led to some
22 hospitals not being in a -- it won't help John much or the

1 insurers much if it's just the ones that have become common
2 dominant in their market and they're just expanding without
3 any constraint because they can pass the costs right
4 through. So it would be interesting to see what the market
5 competitive characteristics are.

6 And then just a question. Do you know if the
7 amounts reported include either information technology --
8 information systems related costs? I do know if that's part
9 of what they're asking for and I don't know the data source.

10 And then the other question would be --

11 DR. STENSLAND: No.

12 DR. KANE: It does not. It's just buildings.

13 And then do they take out all research related
14 buildings? Because in my area, research buildings are going
15 up on every corner. And they're built by hospitals.

16 DR. STENSLAND: There is a separate subcategory of
17 research facility and I don't remember if they lump it in
18 with hospitals or not.

19 DR. KANE: If that's the case, you might also want
20 to adjust or take into account the affect of research
21 spending.

22 MR. EBELER: It may be a follow-up to Nancy's. We

1 look at hospital construction as a percentage of GDP and
2 then went look at the labor as then health care construction
3 as a percent of health spending. The implication is that
4 there is non-hospital construction and the difference -- it
5 would just be useful, I think, to know the difference
6 between what the hospital construction number is and the
7 total health care construction.

8 MR. GLASS: We can give you that. The hospital is
9 what's driving it.

10 MR. EBELER: I assume it is, but it's just that
11 the difference is implied but not stated.

12 MR. GLASS: We were just trying to simplify life
13 there, but that's true.

14 DR. REISCHAUER: A lot of the other stuff is
15 rental. The doctors offices are in rental buildings. And
16 so you can get a big increase in construction for medical
17 purposes that wouldn't show up in these data.

18 DR. STENSLAND: In the overall health care
19 construction it would be in there. But in the hospital it
20 wouldn't.

21 MR. GLASS: Some of the data sources track medical
22 office buildings, for example. So if it's a doctor's office

1 in a medical offices --

2 DR. REISCHAUER: There are mixed purposes
3 buildings all over this town.

4 DR. CROSSON: Just two notions from our experience
5 in California the last few years. I think even though
6 specific seismic retrofitting or building of new hospitals
7 or deconstructing hospitals and rebuilding them hasn't
8 started yet. Certainly in the case of our program in the
9 hospitals we've brought online in the last few years, the
10 cost has been increased as a consequence of knowing that the
11 new hospitals have to meet those standards.

12 But I think perhaps the more confounding issue for
13 us has been in terms of protecting capital expenditures has
14 been the cost of steel and concrete. And I wonder, along
15 the same lines that Bob was saying can we look at beds as
16 well as dollars, you might consider normalizing some of
17 these for that extraordinary -- I mean, it's been 30 percent
18 year-over-year increases in the material to build hospitals.
19 And that's been our single most difficult aspect to
20 forecast.

21 DR. STENSLAND: We do have one piece of data that
22 addresses that. If you look at the expenditures on health

1 care construction versus other non-residential construction
2 -- so all the other office buildings, the warehouses and all
3 that. It's kind of the same story, they're back up to a
4 cyclical peak of being about 13 percent of overall
5 construction, health care is, in terms of everything else.

6 DR. CROSSON: I just wonder whether you might need
7 to correct for that or are underestimating that impact.
8 Because as I said, in terms of our budgeting it's been the
9 single most whap up side the head has been what has going on
10 as a consequence of competing with Asian markets for
11 construction material.

12 DR. DEAN: I was just curious, these numbers,
13 these increases, can you correlate that with an increase in
14 number of beds? Because just looking at our own local
15 situation, our hospitals in the midst of a major renovation
16 will end up with fewer beds. But it's because the role of
17 the hospital, at least in a small community, has changed
18 quite dramatically. We do a lot less inpatient care. Even
19 though we'll end up with a bigger facility, a much larger
20 portion of it is going to be devoted to community education,
21 rehab, physical therapy, those kinds of things. And the
22 actual number of acute beds is going to be about half or a

1 third of what we typically had before.

2 MR. GLASS: We'll note how many beds are showing
3 up but some of the surveys show that the hospitals are
4 planning to increase inpatient capacity, as well. And then
5 there's the whole shift from hospitals with semi-private to
6 private rooms. So you can get construction activity and the
7 number of beds stay the same but there are a lot more rooms.
8 There are actually fewer beds but more rooms.

9 DR. WOLTER: I just wanted to underscore a couple
10 of points already made, the inflation issue being one of
11 them. It's really been quite extraordinary the last few
12 years, in terms of the cost per square foot related to that.
13 It might be good to index for that.

14 This is just an anecdotal observation, I also am
15 seeing a fair amount of construction in our state, the
16 minority of it being related to new hospital beds. We have
17 some critical access hospitals that have 50-year-old
18 facilities that are going to be doing some building, in a
19 couple of cases, where they will be the same or fewer beds
20 but some more modern services.

21 In our own case, we were in an emergency room
22 providing services to three times as many patients as it was

1 built for. We have an ICU that no longer would meet code.
2 Many of the rooms are too small now to be considered state-
3 of-the-art. And as you look at where some of the increased
4 need for services is, if you try to predict that
5 objectively, some of the facilities we have aren't really
6 prepared for what we're headed into the next 10 years.

7 So I hope that the age of plant and some of the
8 issues around where there are disease burdens growing can be
9 part of the analysis.

10 There's a certain amount of medical arms race
11 going on, there's no question about it. But there's also a
12 certain amount of need that's being planned for, if we can
13 just try to include that thinking in our analysis.

14 MR. GLASS: We'll look at age of plant and
15 equipment or age of hospital. It's not quite the intuitive
16 thing you think of as my house is 40 years old and my
17 neighbors is 40 years old. It's kind of they look at
18 depreciation and the capital spending to begin with and
19 decide how old it is from that viewpoint.

20 That number has been steady for many years and
21 actually dropped a bit recently, according to one of the --

22 DR. WOLTER: I understand that the accountants and

1 the CFOs look at things like age of plant from a certain
2 perspective. But I can say you that doctors and nurses
3 don't think about it that way. They're just wondering how
4 to take care of this load of patients. And so that is
5 driving some of what's going on, at least in my view.

6 Also if you look at the '90s where there was,
7 relatively speaking, less building I think that's just
8 reflective of we may be into this 30 year cycle of renewal,
9 some of which is going to be appropriate and perhaps not all
10 of it.

11 MR. HACKBARTH: Let me just pick up on that
12 because it's reminiscent of some comments that Ralph Muller
13 made last year when we were talking about the update and
14 looking at capital spending plans and the like. I think
15 Ralph's comment was that there's a confluence of things
16 here. One is that hospital overall margins are at a
17 relatively high level, higher than they've been in recent
18 memory anyhow. Interest rates have been pretty low and so
19 the financing opportunities have been relatively attractive.

20 And as Nick just said, there's some degree of
21 backlog of projects that had been postponed from the '90s
22 when overall margins were much lower. And then finally, I

1 think Ralph said, there's also a little looking ahead to a
2 significant shift in the demographics of the population and
3 a growing demand.

4 When you look in all those factors together, maybe
5 this isn't so surprising. That's not to deny that there
6 isn't, in some places, a medical arms race and all of that
7 going on. But yes, there are some real fundamental trends
8 that are sort of consistent with this not being necessarily
9 a surprising thing or a bad thing.

10 So that's what Ralph would say if he were here.
11 what's your reaction?

12 MR. GLASS: That's some of what we're trying to
13 disentangle by looking at it geographically and trying to
14 see if there are -- if we can figure what factors are
15 driving the construction: age of equipment, new population
16 moving in, or just move to places with lots of highly
17 insured people or what. What is going on?

18 DR. MILLER: When we're doing this specialty
19 hospital stuff and you go out to talk to people, and I think
20 even some Commissioners would say, that there were decisions
21 being made in terms of what hospitals were doing in terms of
22 building that were being driven by some of the payment

1 system signals that we were sending -- we, Medicare and
2 others -- were sending out there. We are going to try to
3 get underneath some of that, looking at new and old, that
4 kind of thing.

5 DR. MILSTEIN: First, I think the earlier comments
6 made are very important and that is to disentangle
7 replacement from expansion.

8 With respect to expansion, one element of this
9 analysis that I think I would find helpful and perhaps other
10 Commissioners would, as well, would it be to -- again vis-à-
11 vis just the expansion question -- would be to model for us
12 implications for preventing the need for capacity expansion
13 if more recently developed methods of optimizing hospital
14 throughput and patient flow were in place.

15 When you look at all of the opportunities to
16 reengineer clinical processes to generate better outcomes
17 and lower cost -- which I think that combination is what
18 we're after -- I think one of the most impressive numbers
19 that pioneering hospitals have come back with is the
20 opportunity to improve throughput with existing physical
21 plant.

22 There are a number of examples around the country.

1 One that comes to mind is the so-called OR of the future at
2 Mass General, where they are going to double the flow
3 through the same number of beds once they began to adopt
4 what I would refer to as engineering throughput concepts
5 101. And they weren't at the higher level, just the
6 primitive level. And there are a number of case studies
7 that were written up.

8 But I think that would -- if where this is headed
9 is towards potentially a recommendation as to what aspects
10 of hospital cost, including capital investment, we want to
11 value and perhaps what elements of investment we don't wish
12 to attach the same value to, I think it would be at least
13 useful for the Commissioners to kind of understand what the
14 implications would be if forecasted increases in patient
15 demand were met with throughput reengineering rather than
16 investment in capital and bed expansion.

17 MR. DURENBERGER: I just love what Arnie just
18 said. I don't think I quite understand it, but it really
19 sounds like streamlining the whole system and getting better
20 use out of -- but I love it and I hope we do it. This whole
21 discussion is fascinating because there's so many causes.

22 We've been doing this medical arms race syndrome

1 study for a long time in Minnesota, probably getting
2 nowhere. But during the course of it, asked some
3 construction companies why, what's the rationale, just to
4 get sort of outside the regular box and ask them.

5 And I think early on in the decade in our
6 community it was largely competition. Not that it still
7 isn't to some degree but -- and competition comes in a
8 couple of forms because in our community the hospitals have
9 pretty well divided territory and that sort of thing. So
10 they compete on the margin or they compete at the high-tech
11 level and now they start to compete with the subspecialties
12 and that sort of thing.

13 But then it kind of morphed into what I think I
14 would call the Porter/Teisberg effect. Now that I know what
15 it costs, thanks to Moveon.org, now that I know what it
16 costs to get a full-page ad in the New York Times --
17 \$144,000 if you pick the date or \$77,000 if you pick a date
18 within a week or something like that -- I've noticed the
19 University of Pittsburgh Medical Center and how much they --
20 and then there's Hackensack and so forth.

21 Speaking of Ralph, I read a really good piece on
22 medical research the other day. And it's all about the

1 University of Pennsylvania and the University of Pittsburgh
2 and how much of the NIH pot the two of them get, what they
3 do with it, how much of it goes into new buildings, how much
4 of it goes into hospitals to compete with everybody else in
5 Philadelphia and western Pennsylvania, and now the world.
6 The world should beat a path to the door of -- but this is
7 happening in all of our communities to some degree. If I
8 say that Porter/Teisberg effect, I think you know what you
9 know what I mean. We have the recognized best blah, blah,
10 blah, fill in the blanks.

11 But the next or the more important issue, and it's
12 the reason why Paul Ginsburg and the Center for Studying
13 Health Systems Change and the Nick Wolters and lots of other
14 people are important is the redefinition of hospital inside
15 a community and what is actually happening as physician
16 groups start to align -- independent clinic groups and so
17 forth -- start to align with big hospital systems inside
18 some of our communities, at least, driven in large part by
19 the expense of going to information technology and
20 particularly if there's a Rio in the community and we're all
21 going to standardize our measures and things like that.

22 But beyond that there are the factors that are

1 simply redefining what is the role of the hospital -- Tom
2 talked about one of them, you talked about another one -- in
3 communities that, in addition to just calling it remodeling
4 or something like that, probably drives the sort of
5 reconstruction agenda only around what do we actually put
6 inside those facilities.

7 So I'm going beyond counting beds to trying to get
8 a different dimension to what is currently being planned for
9 what we still call hospitals. And it's probably beyond your
10 ken, but I think using the Center for Studying Health
11 Systems Change and whatever they might be doing, it might
12 give us some additional clues that we can't prove by
13 research analysis about trends.

14 And then that gets us back to things we studied
15 this morning on bundling and some of these other issues that
16 might give us something out of this effort that gives us a
17 sense of direction.

18 DR. STUART: I'd like to pick up on a point that
19 Glenn raised and turn it into a question. In your paper you
20 make reference to tax exempt municipal bond issuances and
21 suggest that that basically has been pretty flat, which
22 suggests that that's not explaining the increase. Do you

1 have any sense of what is fueling the increase in financings
2 for non-publicly financed construction?

3 MR. GLASS: It's been flat but high for the past
4 couple of years. It reached a new high level and it stayed
5 there.

6 But I think part of the idea is that hospitals can
7 finance this out of the increases in margins they're seeing
8 from private payers.

9 DR. STUART: I mean, the cost of capital has
10 changed over this period of time.

11 MR. GLASS: Clearly the cost of capital has
12 changed. Now what's going to happen in the near future to
13 the cost of capital and that sort of thing, who knows?

14 DR. STUART: I guess I was just struck by the fact
15 that if I look at that chart on page five of your report,
16 the amount of issuances in terms of billions of dollars from
17 2001 to 2006 is just a difference of \$2 billion. There's
18 very little change over that period of time. That suggests
19 other sources of financing are driving this construction.
20 So it would just be interesting to find out what those are.

21 DR. STENSLAND: Maybe a little clarification on
22 our data. In some of the data, like the Census data,

1 they'll include things like ASCs in the hospital bundle when
2 we're talking about the hospital construction.

3 So there could be some entities, say if the
4 hospital sets up a joint venture with the physicians and
5 they set up a new ASC that isn't a tax-exempt organization
6 so they can't issue municipal bonds but maybe have to issue
7 taxable debt. That would hit our construction on our total
8 construction but it wouldn't affect the municipal bond
9 number. So I think that might have some play, in addition
10 to the higher margins on hospitals, is that some of this
11 might be migrating out of just the hospital into some more
12 of these joint ventures with physicians or other entities
13 into taxable joint ventures which wouldn't be financed with
14 municipal bonds.

15 DR. KANE: There's also a lag. So like '98,
16 you've got -- it may just be feeding in later.

17 DR. STUART: But lags don't explain flat lines.

18 DR. KANE: It's not that flat, though, if you go
19 to the --

20 DR. STUART: It just hasn't gone up. It went up
21 in the early '90s and then it went up a little bit between
22 2000 and 2001. And I wouldn't expect those kinds of lags to

1 explain something that we see between 2002 and 2007.

2 DR. REISCHAUER: Are you going to break this down
3 by for-profit and not-for-profit construction?

4 DR. STENSLAND: We can't break down the
5 construction on for-profit/not-for-profit. The only thing
6 we could do would be, in the cost reports, break down
7 capital expenditures up through 2006 on for-profit/not-for-
8 profit. There's two different data sources.

9 DR. REISCHAUER: right. I wouldn't know how you
10 do it. But take the GW Hospital, what was that?

11 MR. GLASS: That's an academic medical center but
12 also a for-profit hospital. No, I don't think we'll be able
13 to do that, certainly not with the data we're using.

14 MR. HACKBARTH: Okay, thank you. Good work.

15 Next is hospital outlier payment reform.

16 MR. PETTENGILL: Good afternoon. We're presenting
17 results today from our examination of potential changes in
18 Medicare's outlier payment policy for high-cost cases in the
19 hospital acute inpatient prospective payment system.

20 The starting point for re-examining the outlier
21 policy follows from CMS's response to the recommendations
22 that we made two years ago in the physician-owned specialty

1 hospital study. In that study, we found that differences in
2 relative profitability among DRGs were creating financial
3 incentives for hospitals to specialize in care for certain
4 kinds of patients, such as cardiac surgery patients, and to
5 select a favorable mix of patients within DRGs.

6 To address the sources of these differences in
7 relative profitability and improved payment accuracy we made
8 the four recommendations that you see on this slide. Last
9 year CMS adopted cost-based weights and this year they are
10 adopting major severity refinements of the DRGs in the form
11 of Medicare severity DRGs or MS-DRGs. Our analyses of the
12 MS-DRGs and the cost-based weights show that they do a
13 significantly better job than the prior DRGs and charge-
14 based weights in capturing differences in severity of costs
15 across patients. As a result, these refinements improve
16 payment adequacy and they also reduce hospitals risks of
17 incurring large losses from high-cost outlier cases.

18 The reason is that many high-cost cases that would
19 have qualified under the prior DRG-based system now no
20 longer qualify for outlier payments because they are grouped
21 in a high severely MS-DRG, the payment rate is higher, and
22 therefore their losses are no longer extraordinary.

1 Other cases still qualify for outlier payments but
2 the amounts that they get are much smaller than they would
3 have been before.

4 Because the case-mix refinements reduce hospitals'
5 outlier risk, we should be able to maintain the same level
6 of outlier insurance protection with a smaller pool of funds
7 set aside for outlier payments. The pool of funds, called
8 the outlier pool, also might be reduced if the marginal cost
9 factor is set too high. The marginal cost factor, currently
10 set at 80 percent, determines the amount of outlier payments
11 for cases that qualify as outliers. If this factor is set
12 too high, then Medicare is covering more than the
13 incremental costs that hospitals actually incur to provide
14 services beyond the outlier threshold. Savings from
15 shrinking the outlier pool would return to the base because
16 the outlier policy is budget neutral. This would raise the
17 base payment rate per discharge and give all hospitals
18 higher DRG payment rates.

19 As we will see later, shrinking the outlier pool
20 also would improve payment accuracy.

21 Now let's turn to the main features of the outlier
22 policy.

1 Hospitals always get the usual PPS payments for
2 each case, including the DRG payment rate and any indirect
3 medical education disproportionate share or new technology
4 payments. The outlier policy is intended to help ensure
5 continued access to care for patients that are predictably
6 more likely than others to become extremely costly.

7 To lessen the incentive to avoid or transfer such
8 patients, Medicare makes extra payments when hospitals incur
9 extremely high costs compared with usual PPS payments. The
10 extra payments help to defray the financial burden for
11 hospitals that attract many outlier cases.

12 Three parameters determine the amount and
13 distribution of these payments. When the cost of a case
14 exceeds the hospital's outlier threshold for the assigned
15 DRG, the hospital qualifies for extra payments. The
16 hospital's cost threshold for the DRG is determined by
17 taking the national fixed loss amount, adjusting it by the
18 hospital's wage index, and then adding it to the hospital's
19 usual payment for the DRG.

20 The extra payment is equal to the marginal cost
21 factor -- 80 percent -- multiplied by the amount of
22 estimated cost above that threshold for the case. CMS sets

1 the national fixed loss amount each year so that the
2 projected total outlier spending will exhaust the funds
3 available in the outlier pool. The outlier pool is required
4 by law to be set between 5 and 6 percent of total DRG
5 payments. CMS currently sets the pool at a 5.1 percent.

6 The pool is funded by a reduction in the base
7 payment amount of the same percentage. As you will see
8 later, the funding method is important because it affects
9 payment accuracy across DRGs.

10 The next slide illustrates how the outlier policy
11 works for a hospital that has two high-cost cases in
12 different MS-DRGs. The first case, in DRG A, has an
13 estimated cost of \$100,000. The cost for the case in DRG B
14 is \$88,000. These cost values are estimated by multiplying
15 the covered charges on the claim by the hospital's overall
16 cost-to-charge ratio from its most recent as submitted cost
17 report.

18 The hospital gets its usual DRG payment rate for
19 each case, which is shown in the green area of the slide at
20 the bottom, so it gets \$8,600 for the case in DRG A and
21 \$3,00 for the case in DRG B. The hospital doesn't qualify
22 for any IME, DSH, or new technology payments in this

1 example. But if it did qualify, that would be included in
2 the green area as well.

3 The national fixed loss amount adjusted by the
4 hospital's wage index is equal to \$25,000. That's shown in
5 red. So the outlier threshold, the sum of the base payment
6 and the fixed loss amount, is \$33,600 for the case in DRG A
7 and \$28,900 for the case in DRG B.

8 The estimated cost above the estimated threshold
9 for the first case, in DRG A, is \$66,400. Medicare pays 80
10 percent of that, or \$53, 120. The Medicare payment above
11 the threshold for the second case would be \$47,280.

12 The gray area in each bar at the top is the 20
13 percent of the cost above the threshold that is considered
14 not to be real here or at least Medicare won't pay. Not
15 included in the marginal cost under the current assumption.

16 This slide illustrates a --

17 DR. MILLER: Maybe if I could just slow you down
18 there for just a second, we're going to actually talk about
19 this more. And so I think what Julian was saying there is
20 once you get above a certain level the costs -- and this is
21 subject to some discussion, and we're going to get to it --
22 the cost that the hospital incurs to continue treating that

1 patient isn't necessarily what it would at the average.
2 That is, I think, what he meant by not necessarily real.

3 And then what that percentage is will be the
4 subject of the end of the talk, and so you'll have a chance
5 to revisit that point. I didn't want that to glide right
6 by.

7 MR. PETTENGILL: This slide illustrates the
8 interaction between the fixed loss amount, the outlier pool,
9 and the marginal cost factor. Setting any two of these
10 parameters determines the third. The first line is our
11 estimate of what the policy would have looked like in 2007,
12 under 2007 policies, if the cost weights had been fully
13 implemented. This is a system based on DRGs prior to the
14 adoption of MS-DRGs.

15 With a marginal cost factor set at 80 percent and
16 the outlier pool at 5.1 percent, the fixed loss amount would
17 have been \$24,995 in our dataset. Using MS-DRGs, in the
18 next line, instead of DRGs improves payment accuracy and
19 reduces outlier risk. So the fixed loss amount falls to
20 \$22,475. The other parameters remain the same.

21 This implies that the amount of outlier insurance
22 protection that is provided is actually increased. In

1 effect, we sort of lowered the deductible for the hospitals.
2 They have to incur less of a loss to get extra payments.

3 As shown in the third line, we could treat that
4 decline in outlier risk in a different way. We could have,
5 with the marginal cost factor still at 80 percent, if we
6 held the fixed loss amount at the same level as for 2007,
7 that is keeping the level of insurance protection
8 approximately constant, the outlier pool would fall to 4.6
9 percent of DRG payments. If we also could reduce the
10 marginal cost factor to 75 percent -- in the last line --
11 the outlier pool would fall to 4.3 percent.

12 All of the results we're reporting today are based
13 on matched claims and cost reports for fiscal years 2004 and
14 2005, analyzed using MedPAC's inpatient prospective payment
15 system payment model. Our methods are similar to those that
16 we used in the specialty hospital study. Because we are
17 interested in long-run effects, we modeled 2007 policy and
18 2008 with 100 percent cost-based weights rather than the
19 blended weights they're using now. For 2008 we also assumed
20 that the MS-DRGs are fully implemented rather than blended.

21 Now Craig will talk about our evaluation of the
22 current marginal cost factor.

1 MR. LISK: Medicare statute requires that outlier
2 payments approximate the marginal cost of care beyond the
3 fixed loss amount that Julian talked about. In effect, we
4 are looking at what economists refer to as short run
5 marginal cost is what we are wanting to cover after
6 hospitals reached the fixed loss amount.

7 Marginal costs are defined as the change in total
8 costs associated with a one unit change in output. By
9 definition therefore, short run marginal cost do not include
10 fixed costs such as administrative overhead and capital
11 costs. Thus, for outlier cases we are looking at the
12 incremental cost for providing the next unit of service once
13 the patient reaches the fixed loss threshold.

14 Now setting the marginal cost factor higher than
15 incremental cost of care weakens incentives to provide care
16 efficiently once patients reach the outlier status as the
17 payments exceed the incremental costs of the services
18 provided.

19 If the marginal cost factor is set lower than the
20 incremental cost of care, then hospitals have stronger
21 incentives to provide care inefficiently as the full
22 incremental cost of care after a patient reaches the outlier

1 threshold is not being fully covered. The hospital, in
2 effect, has to share in these costs.

3 Now we have this situation though hospitals,
4 however, would have a stronger incentive to avoid patients
5 outlier cases or send them somewhere else for care
6 potentially.

7 Under current Medicare policy for inpatient care,
8 the marginal cost factor is set at 80 percent of total costs
9 over the fixed loss amount, as we indicated.

10 So how do we get at this 80 percent factor that we
11 currently have? A little history may help here. First,
12 when the inpatient PPS began back in 1983 there were two
13 types of outlier cases: day and cost outliers. The marginal
14 cost factor for both was set at 60 percent. The 60 percent
15 factor was consistent with literature at that time which
16 indicated that short run marginal cost -- the type of
17 marginal cost we are generally concerned what here -- were
18 less than 58 percent of average cost. They chose a 60
19 percent figure because the inpatient PPS did not include
20 capital costs at that point in time and so they chose a
21 slightly higher factor.

22 In 1989, the marginal cost for cost outlier cases

1 was raised to 75 percent, although CMS initially proposed in
2 their regulations to raise it to 80 percent. Day outlier
3 cases, the marginal cost factor remained at 60 percent.

4 This change was made to help balance cost and day
5 outlier policies and was not made because the marginal costs
6 of the two types of cases were different, two types of
7 outlier cases were different. There was higher payments
8 being made and a higher percentage of cost being covered for
9 day outliers compared to cost and CMS was trying to balance
10 the two policies.

11 In 1995, the marginal cost factor for outlier
12 cases was raised 80 percent as day outlier payments were
13 being phased out over four years. To comply with the
14 appropriate distribution of payments between day and cost
15 outliers, the marginal cost factor for day outliers was
16 successively lowered. During transition period, because
17 this phase out of day outliers was part of legislation the
18 Congress implemented, Congress relaxed the provision that
19 outlier payments reflect the marginal cost of care. So CMS
20 was able to have factors that didn't necessarily reflect the
21 marginal cost of care.

22 There was no analysis at that time to say whether

1 the 80 percent marginal cost factor was an accurate measure
2 of marginal cost.

3 To better understand what marginal cost might be
4 for outlier cases, we examined the relationship between
5 average variable costs and total costs for cases with large
6 losses relative to base PPS payments. Average variable
7 costs likely represent an upper estimate of marginal costs.
8 Total costs are the sum of variable costs plus fixed costs -
9 - the administrative overhead and capital. Fixed costs do
10 not change with increases or decreases in output in the
11 short run. Fixed costs include expenses like I just
12 mentioned.

13 Variable costs reflect inputs that may vary with
14 changes in patient volume and include things like direct
15 patient care labor, tests, supplies, drugs, and food. We
16 find that average variable costs for outlier cases are about
17 75 percent of average total costs as calculated under the
18 outlier policy, which uses a hospital-wide cost-to-charge
19 ratio instead of a departmental level cost-charge ratio to
20 calculate costs.

21 But how does average variable cost relate to
22 marginal costs? Well, we believe that average variable

1 costs likely overstate short run marginal cost of care for
2 outlier cases on average. For example, if we think about
3 routine costs of the patient day, the average routine costs
4 of the patient day includes the average nursing hours for
5 patient day. But the hours required later in a patient's
6 are less nursing hours than earlier in a patient stay. So
7 if the hospital is even replacing the labor, we think that
8 those labor costs are likely a little bit lower later in the
9 patient's stay.

10 But we also need to consider how a hospital
11 adjusts its labor to changes in utilization. And if we
12 think about the radiology department or the lab, do they
13 hire another lab tech or radiologist to provide the extra x-
14 ray that the patient may receive? And that's likely not the
15 case. They likely do it within the current staffing. So
16 the marginal costs would only reflect the supply costs that
17 may be associated with those tests and procedures in those
18 circumstances. So that's why we believe that the marginal
19 cost is likely less than the average variable cost.

20 So for illustrative purposes in our analysis, we
21 have assumed a 60 percent marginal cost factor. Now I want
22 to point out one piece of research we recently found since

1 the mailing materials, a recent article in Medical Care --
2 the Journal of Medical Care, which was an analysis conducted
3 by RAND, which looked at the relationship between short run
4 marginal costs and long run marginal costs. This was an
5 analysis on the ER departments, but part of it looked at
6 inpatient care -- the short run marginal cost versus large
7 run marginal costs.

8 We found that short run marginal costs were 47
9 percent of long run marginal costs. So that, again, is
10 another indicator that the marginal cost factor is less than
11 what we currently have in policy.

12 DR. MILLER: Craig, the 60 percent, we're just
13 saying that we're going to show you ranges from 80 to 60
14 percent to give you a sense of how sensitive this is.

15 MR. LISK: That's correct. Our 60 percent is just
16 for illustrative purposes, for example here as we indicate
17 in this slide. We're not defining what the appropriate
18 factor is because that is difficult to do.

19 This next chart illustrates the interactions
20 between the marginal cost factors and the outlier pools if
21 the fixed loss amount is held at 2007 levels that we had
22 under the DRGs. As Julian discussed earlier, the movement

1 to MS-DRGs reduces the insurance associated with outlier
2 cases and results in a lower fixed loss amount of \$22,475,
3 maintaining a 5.1 percent outlier pool.

4 If, however, in implementing the MS-DRGs, we hold
5 the fixed loss amount at 2007 levels that outlier pool, in
6 turn, can be lowered to 4.6 percent. The lower outlier pool
7 would result in higher base rate for all cases, rising half
8 a percent to \$4,998. Because these payments are budget
9 neutral, total aggregate payments would remain unchanged
10 with more payments distributed through the base rates and
11 fewer payments distributed through outlier payments.

12 If the marginal cost factor were reduced so it
13 reflected average variable costs, the outlier pool could be
14 reduced further to 4.3 percent, if again a fixed loss amount
15 were held at 2007 levels. The base rate would increase by
16 0.8 percent to \$5,011.

17 A 60 percent marginal cost factor would result in
18 an even bigger drop in the outlier pool to 3.4 percent and
19 would result in a 1.6 percent increase in base rate to
20 \$5,051. Under this option, hospitals would receive less
21 outlier payments but more in base payments.

22 Julian will now talk about the impact of these

1 changes on payment accuracy and the distribution on total
2 payments.

3 MR. PETTENGILL: So to assess the impact of these
4 policy alternatives, we estimated their effects on payment
5 accuracy and the distribution of payments among hospitals
6 and hospital groups.

7 We measure payment accuracy by calculating the
8 aggregate average payment-to-cost ratio for the cases in
9 each MS-DRG, simply sum the payment and the costs and divide
10 the two. Because we're interested in relative profitability
11 here, we normalize the payment-to-cost ratios as if total
12 costs and payments in the aggregate were equal. If the
13 payment rates tracked costs difference perfectly across MS-
14 DRG, then all the payment-to-cost ratios would be equal to
15 one.

16 If you look at the middle column here on this
17 table, we see that the percentage of total PPS payments that
18 fall in MS-DRGs is where the payment-to-cost ratio is within
19 plus or minus 5 percent of 1.0. Under 2007 policies before
20 the MS-DRGs were adopted, only 23 percent of payments were
21 in MS-DRGs where costs and payments were that similar.
22 Under 2008 policies, in the second line, with MS-DRGs this

1 figure rises to 58 percent.

2 Each policy alternative that we looked at also
3 improves payment accuracy, in the lower part of the table.
4 The reason reflects the impact of the current method for
5 funding the outlier pool. The pool is funded by a flat 5.1
6 percent offset to the base payment amount, which lowers all
7 DRG payment rates by the same percentage.

8 But the prevalence of outlier cases and payments
9 is very uneven across MS-DRGs. DRGS that have a lower
10 outlier prevalence have relatively lower profitability
11 because their contribution to the outlier pool is larger
12 than the payments they get back. DRGs that have a high
13 outlier prevalence have a relatively higher profitability
14 because their contribution to the outlier pool is smaller
15 than the outlier payments they get back.

16 These policy alternatives result in successively
17 larger reductions in the outlier pool and, therefore, also
18 in the offset to the base payment amount. And as you reduce
19 the offset, the differences in profitability also start to
20 go away and the effect is stronger at the low end. That is,
21 in DRGs that tend to have relatively low weights and low
22 outlier prevalence, the improvement in payment accuracy is

1 greater.

2 MR. HACKBARTH: Just a clarify question, Julian.
3 So in this table, you've not yet introduced the policy
4 change to change the way outliers were funded. This simply
5 reflects the benefit of reducing the marginal cost factor
6 and so on?

7 MR. PETTENGILL: And it's impact on the pool, yes,
8 and the offset. That's what increase payment accuracy.

9 MR. HACKBARTH: And then if you took the
10 additional step, as we've recommended in the past, of
11 changing the funding of the outlier pool to make it variable
12 by MS-DRG, you get still further gains in payment accuracy?
13 Is that right?

14 MR. PETTENGILL: That's correct. There are really
15 two separate issues. One issue is what really is the
16 appropriate size of the outlier pool? How much insurance do
17 you want? The other is the question of how you finance that
18 pool after you've made that decision.

19 This slide shows the average percentage change in
20 payments associated with each policy alternative for
21 hospitals in selected hospital groups. Overall, the effect
22 is always zero because the outlier policy is budget neutral.

1 Whatever you take away, you're giving back.

2 The second column shows that using MS-DRGs with a
3 fixed loss amount at the 2007 value and a marginal cost
4 factor of 80 percent would have only minor effects on the
5 distribution of payments among hospitals.

6 As the marginal cost factor is reduced to 75
7 percent, in the third column, and then 60 percent in the
8 fourth column, the effects become larger rising to an
9 average increase of 0.8 percent for rural hospitals in the
10 last column and an average decrease of minus 0.5 percent for
11 major teaching hospitals.

12 As we saw earlier, reducing the marginal cost
13 factor lowers outlier payments and raises the base payment
14 amount. So payments increase primarily in MS-DRGs with low
15 relative weights where outlier prevalence is low and they
16 decrease primarily in MS-DRGs that have high relative
17 weights and high outlier prevalence.

18 This explains why payments increase for rural
19 hospitals and they fall for major teaching hospitals.

20 Except for major teaching hospitals, the effects
21 are largest for small, urban and rural hospitals.

22 The next three slides show the distributions of

1 payment changes for the first and third policy alternatives
2 within selected hospital groups. This slide shows the
3 distribution of the payment impact among all hospitals and
4 those located in urban and rural areas. The policy
5 alternative that we're looking at here is the first one,
6 that is using MS-DRGs with a fixed loss amount set at the
7 2007 levels and a marginal cost factor of 80 percent. The
8 outlier pool is 4.6 percent of DRG payments. The base
9 policy for this comparison is 2008 policy with the fixed
10 loss amount appropriate for an 80 percent marginal cost
11 factor and an outlier pool of 5.1 percent.

12 As you can see a few mainly urban hospitals would
13 have a decline in payments of between minus 1 and minus 5
14 percent. That's those little tiny bumps that you see on the
15 left there. All other hospitals would have minor changes of
16 between plus and minus 1 percent. So there's really not
17 much going on here at all. But that's because the change in
18 the pool is only 0.5 percent.

19 The next slide shows the distribution for the same
20 groups under the third option. That is, we now have a
21 marginal cost factor of 60 percent rather than 80. And the
22 same base policy, again 2008 policies.

1 As you can see, the changes in payments would be
2 larger. More urban and rural hospitals would experience an
3 increase or a decrease of between 1 and 5 percent. Among
4 rural hospitals, for instances, 72 percent would have an
5 increase between 1 and 5 percent. But only 2 percent would
6 have a decrease that large.

7 For urban hospitals the proportions are more
8 balanced, 24 percent would have an increase between 1 and 5
9 percent and 11 percent would have a comparable decrease. 2
10 percent would have a decrease of more than 5 percent.

11 The next slide shows the distribution of changes
12 for the same policy alternative by teaching status. The
13 distribution of payment impact would differ somewhat between
14 nonteaching and major teaching hospitals, as shown in this
15 slide. Changes in payment for nonteaching hospitals would
16 be skewed to the right, while for major teaching hospitals
17 they would be skewed a bit to the left. 48 percent of
18 nonteaching hospitals would have an increase between 1 and 5
19 percent while only 7 percent would have a comparable
20 decrease. For major teaching hospitals, the figures are 13
21 percent for an increase between 1 and 5 percent but 23
22 percent would have a comparable decrease in payments.

1 We've shown you a range of policy alternatives
2 here for responding to two different issues. One issue is
3 the decline in outlier risk that occurred with the adoption
4 of MS-DRGs. The other is the likelihood that the current
5 marginal cost factor is set too high.

6 We have just a couple of last thoughts for today.
7 Each policy alternative represents a different point along
8 the trade-off between the level of outlier insurance
9 protection that is provided to hospitals and the level of
10 DRG payments for typical patients.

11 The question is what's the appropriate balance for
12 this trade-off? How much insurance is the right amount?
13 One complication is that it's also desirable to maintain
14 hospitals incentives to treat outlier cases efficiently once
15 the outlier threshold is reached. In the private insurance
16 world, insurers and hospitals treat both the level of the
17 threshold and the percentage of payments beyond the
18 threshold as a subject of negotiation and it's conceivable
19 that Medicare could do something similar with some kind of
20 an industry-wide negotiation about what the so-called
21 marginal cost factor would be.

22 A second complication is that the prevalence of

1 outlier cases and payments tends to be concentrated in a
2 minority of hospitals within each hospital group. Large
3 changes in the marginal cost factor then could cause
4 problems for some of these high prevalence hospitals and
5 this may have the potential to threaten the goal of
6 protecting access to care for patients who are likely to
7 become high cost patients. Or it could create financial
8 inequities among hospitals.

9 That ends our presentation and now we would be
10 happy to take your questions and comments.

11 MR. EBELER: One presentation question and one
12 comment. Your last slides and tables five through seven in
13 your paper lay out the distributional winners and losers
14 under the three options. Would it be possible to have a
15 table that shows the distribution of winners and losers
16 under the current policy? As I understand it, the base case
17 is this case where most hospitals that pay the 5.1 percent
18 withhold are not recapturing that money. It seems to me it
19 would just create an accurate description of the base.

20 A variant of your first discussion issues in my
21 mind is whether there are opportunities for net savings
22 here. There's a presumption in this discussion that one

1 takes this money and completely redistributes it. The
2 question is as payments get more accurate, are there
3 opportunities here for this to be a potential Medicare
4 savings issue? Because the world outside is looking for
5 savings.

6 MR. PETTENGILL: Whatever is included in the
7 outlier pool has been taken out of the base payments for
8 hospitals. So I think it would be -- and by law, it's
9 required to be budget neutral.

10 DR. REISCHAUER: Unless you think we're overpaying
11 the whole kit and caboodle, in which case you could just
12 have a small --

13 MR. EBELER: There is a standing presumption that
14 we're spending a lot of money in Medicare and people are
15 trying to save it.

16 MR. PETTENGILL: Again, I think there are two
17 different issues here. One is what do you do about payment
18 accuracy at the relative level? And the other is the
19 question of what's the appropriate level of payment across
20 the board? And they're different questions.

21 MR. HACKBARTH: I think that's the key point. If
22 you believe that we're paying too much, the straightforward

1 way to do it is through the update factor in the base
2 payment amount as opposed to rejiggering the outlier payment
3 policy and then not putting it back in the base. I think
4 just being transparent and straightforward is the way to go
5 if that's what you believe.

6 DR. MILSTEIN: Another perspective or angle on the
7 problem of improving the accuracy, and I guess you could
8 also describe it as validity of our outlier payments, would
9 be to begin to integrate into the formula the frequency with
10 which hospitals are generating outlier cases relative to
11 what might be expected based on case-mix and perhaps other
12 risk adjustment factors. That's not something that has been
13 considered so far, but that's something I think, in terms of
14 generating additional value both to Medicare beneficiaries
15 and to the Medicare program, I would think it might be
16 useful for you to model.

17 I would infer from your earlier comments that
18 associated with each DRG is a certain probability of outlier
19 payments that would then lend itself to calculating on a
20 hospital-specific basis hospitals that appear to be
21 substantially out of line with other hospitals with similar
22 case-mix and perhaps other characteristics on the actual

1 incidence of outlier cases as a percentage of total. And
2 that's something that I would think we would -- might be
3 also be useful to address as part of this review. Is that
4 an opportunity to additionally calibrate the outlier
5 payments?

6 MR. PETTENGILL: We have actually done some things
7 like that, comparing outlier prevalence with what you would
8 expect given the case-mix of the hospital. As I mentioned
9 earlier, outlier cases and payments are highly skewed within
10 groups. So you have maybe -- in many groups -- maybe 25
11 percent of the hospitals within the group actually have an
12 outlier prevalence that is above the average for the group.
13 And perhaps another 40 percent have outlier prevalence that
14 is very low. And that's true of all groups. It doesn't
15 matter whether you're talking about major teaching hospitals
16 or small rural hospitals.

17 And so when you calculate their expected value
18 compared with their actual value you find that there are
19 some hospitals -- this group with high prevalence -- have
20 values way above what you would expect given their case-mix.
21 And that's not any great surprise. The question is why do
22 they have that? And we obviously don't know the answer to

1 that.

2 I kind of suspect that there is an informal
3 network among hospitals. The train wrecks tend to go
4 certain places. And that's not necessarily all of the
5 story, but I think it's a big part of it. The referral
6 network operates, although informally. This is the result
7 you get.

8 DR. MILSTEIN: I accept that. But that said, I
9 don't remember I was trying to find where was in the
10 materials. We also know that there is evidence that
11 hospitals that have instituted various innovations in
12 inpatient care have been able to substantially drive down
13 their frequency of outlier cases. Which suggests to me that
14 in addition to there being an immutable factor, that you're
15 describing, that we ought not to hold hospitals accountable
16 for, there's also a manageable factor that I would like to
17 see at least as to consider policies that would encourage
18 going forward in the future.

19 MR. HACKBARTH: Julian, to the extent that you
20 improve the accuracy of the payment system, as we have with
21 MS-DRGs, you reduce the likelihood that it's the referral
22 network that's what you're picking up, because the payment

1 system -- if they come in very sick and needing lots of care
2 -- the payment system is categorizing them more accurately
3 at the front door. And so to the extent you move towards
4 the optimal accurate payment system, the ones that are
5 losing lots of money on outliers tend to be losing because
6 of performance as opposed to patient mix.

7 MR. PETTENGILL: I think you pick up a piece of
8 that. That's what you're seeing when the pool dropped from
9 5.1 percent to 4.6 percent. But the pool is still 4.6
10 percent. And so this effect is still pretty strong.

11 When we get the data beginning perhaps two years
12 from now, where the claims include the information about
13 which secondary diagnoses were present at admission, then
14 there might be a further opportunity to explore what's going
15 on here, how much of this is complications occurring after
16 admission.

17 DR. MILSTEIN: It seems to me we would not have to
18 wait two years if we began now simply mining the data from
19 the states that have had present at admission codes for
20 several years.

21 MR. PETTENGILL: It's certainly something that we
22 can think about.

1 MR. LISK: The other thing I just wanted to
2 mention, other research has been shown that there is a much
3 higher incidence of outlier among cases that are transferred
4 to another hospital, which is kind of indicative of what
5 Julian was talking about. So I wanted to say that there has
6 been research that shows that a lot of these cases do go to
7 certain hospitals, in terms of let's say transfers, per
8 instance.

9 DR. WOLTER: I was just wondering if it would be
10 possible to tease out the availability of post-acute care,
11 SNF, LTCH, et cetera, resources and does that have any
12 impact on this or not? It might be hard to sort that out.

13 But mostly I wanted to thank you for explaining
14 this. I didn't really understand it when we voted for it
15 last year.

16 [Laughter.]

17 DR. CROSSON: I was going to thank you also for a
18 very clear elucidation of what could have been an intensely
19 confusing set of multiple variables moving. I was amazed
20 when I finished it that I actually understood it. Of
21 course, I did wear my noise canceling earphones while I was
22 reading it.

1 I just had one notion here. As I looked at the
2 winners and losers, if you will, under the more aggressive
3 scenario it seemed like it was sort of the obverse of data
4 we've seen before about profitability in general. I wonder
5 if we could look at that explicitly? I don't mean now, but
6 could we compare the winners -- because as we get later in
7 the year we're going to be dealing with a number of --

8 MR. HACKBARTH: So for example, under one of the
9 last slides the biggest winners were the nonteaching
10 hospitals, which are the institutions as a group that have
11 the lowest average margins.

12 DR. CROSSON: So it seems like perhaps later in
13 the year we'll get into some other issues about hospital
14 payment. If this is going to be part of the mix, it would
15 be useful to see that kind of outlined.

16 DR. MILLER: As long as you're kind of keeping
17 those kinds of things in your mind, there's also different
18 sets of -- different things are happening in terms of the
19 reforms, the cost and charge weights, the severity weights.
20 The trigger for a lot of this discussion is the change in
21 severity. For example, at least in one of those categories
22 of hospitals, the teaching hospitals, they benefit from that

1 change. Although from this change they wouldn't.

2 As you kind of think in your mind, there's
3 existing profitability, other changes going on in the
4 system, you can kind of keep that kind of tab running in
5 your head.

6 DR. KANE: Actually, I was going to ask you to
7 keep the tab running in your head, because that was part of
8 my comment, too, is that there is a lot going on. And then
9 the IME on top of that and other suggestions that we make.

10 Also, aren't there a lot of payment add-ons in the
11 rurals and in the sole communities that sunset and that we
12 talked about? It just seems like there's a lot of little
13 pieces that get kind of dumped into the system on occasion
14 for some period of years and then taken out. And some of
15 them are there to partially offset the fact that the profit
16 margins are differential by classes of hospital.

17 I guess I'm just supporting the notion it would be
18 nice to see them all together and say what's the total
19 impact on all the hospitals?

20 I think I'm very much supportive of making the
21 payment system more accurate so that there's fewer of these
22 little add-ons that we have to then discuss every so often

1 and try to take back, which is really hard to do.

2 My only other comment is that there is an
3 assumption that the fixed cost amount, the fixed loss, is at
4 full cost. In other words, the fixed cost goes to -- in
5 other words, the hospital earns that fixed loss at a full
6 cost amount. And then we say anything beyond that we're
7 going to pay you at a marginal cost.

8 What if we assumed though that they actually had
9 to get -- that all of the fixed cost was also at marginal?
10 I don't know why suddenly you kick in the marginal cost for
11 the amount you pay above the fixed loss amount. It's all
12 marginal.

13 So in thinking about how much an outlier hospital
14 really loses, how much -- once you throw back in the fact
15 that you're actually paying full -- no, you're giving them a
16 full cost and then --

17 DR. REISCHAUER: We've overcharged them. This is
18 a deductible.

19 DR. KANE: This is the deductible but you're
20 allowing them to accrue it at a full cost basis, whereas
21 you're saying --

22 DR. REISCHAUER: But they're eating the

1 deductible. So we're overcharging them.

2 DR. KANE: But they're not eating it, if you
3 believe in marginal cost. They're not eating it in full.
4 They're only eating it on a marginal basis. Their out-of-
5 pocket marginal --

6 MR. PETTENGILL: There's another way to think
7 about --

8 DR. REISCHAUER: But if you reduce that, you end
9 up paying them more.

10 DR. KANE: No, you might want to say to reach that
11 you have to reach it on a marginal cost basis rather than a
12 full cost. I was going the other way.

13 DR. REISCHAUER: Okay, so then you blow it up.

14 DR. KANE: Or alternatively, if in fact their real
15 costs are marginal what are we actually paying them when we
16 give them the payment on top?

17 MR. PETTENGILL: There's another way to think
18 about that. The pool is fixed. You have a fixed pool of
19 money to spend for outlier payments. If you count things at
20 marginal cost, yes, you change the dollar amount of the
21 fixed loss amount but it doesn't change who gets the money
22 or how much they get.

1 DR. KANE: But isn't part of what you're asking us
2 is whether the pool should be fixed at 5.1 percent or
3 whether it shouldn't come down? I thought that was part of
4 what was here.

5 MR. PETTENGILL: It is.

6 DR. KANE: I think it's kind of crazy to have it
7 fixed. Where did 5.1 come from? The same place that the
8 GMA/IME came from?

9 [Laughter.]

10 DR. MILLER: Don't act like you don't know what's
11 going on.

12 MR. PETTENGILL: As we noted in the paper, the
13 Congress decided that the outlier pool should be between 5
14 and 6 percent of DRG payments at the very beginning of the
15 PPS. And they had no idea what it really should be. That
16 was taken out of a hat in the middle of the night somewhere.

17 DR. REISCHAUER: Nobody knows what it should be.
18 It's sort of the amount of insurance you want to provide.

19 MR. PETTENGILL: No, that's true.

20 DR. KANE: But do we want to leave it there,
21 because if it's distorting accurate payment and giving the
22 nonteachings a much lower margin, I think it's worth

1 revisiting whether that's the right and a fair way to do it.
2 As opposed to letting Congress then go fix it on these
3 little piecemeal solutions of a little rural add-on here, a
4 little sole community there, and we'll revisit every five
5 years.

6 DR. REISCHAUER: One question and then two
7 opportunities for you to reeducate me, because these are the
8 same questions that I asked you the last time we did the
9 outliers and I've forgotten the answers.

10 The first observation or question, which is new,
11 is do we have any idea about the relationship between
12 hospitals that have high outlier rates and hospitals that
13 have high rates of hospital-acquired infections or other
14 kinds of things? Is this an insurance policy for bad
15 performance?

16 DR. MILSTEIN: Another way of getting at this very
17 question would be to look at the hospitals relative to their
18 case-mix and predicted frequency of outliers are above and
19 comparing those same hospitals using the AHRQ patient safety
20 indicators database. And if the two seem to bear some
21 relationship it tends to confirm the hypothesis that
22 hospitals with above average frequencies of outliers might

1 be dealing with something that is manageable with better
2 clinical performance.

3 DR. REISCHAUER: My reeducation first question is
4 why do we do a fixed amount as opposed to a percent of the
5 DRG? Because supposedly, the DRG is an average payment and
6 you'll gain money on some and you'll lose money on others.
7 But if the DRG is \$1,100, it's hard to think that you're
8 going to pick up a whole lot that is going to sum to
9 \$25,000.

10 MR. PETTENGILL: There was a study by RAND way
11 back in the late '80s where they analyzed the outlier
12 policy. There was also some work by PropAC on the same
13 issue.

14 The problem is that you have -- again as I said,
15 outlier prevalence and payments is highly concentrated in
16 DRGs and hospitals. So that you have a lot more -- think
17 about it this way: the relative weight goes up. So does the
18 standard deviation of costs. That's just another way of
19 saying the same thing. That's why we have a lot of
20 outliers.

21 If you're going to have a fixed pool of money to
22 spend, the most efficient way to spend it to reduce losses

1 is to take the biggest losses first. That was the
2 conclusion of both pieces of work.

3 That's why we have a fixed loss amount. It's more
4 efficient than using a multiple of the DRG rate and more
5 efficient than using a percentage of the DRG rate.

6 MR. LISK: But the original policy as implemented
7 was as a multiple of DRG rate. So it originally started
8 that way.

9 MR. PETTENGILL: And the reason that people
10 decided that that was a bad idea was because in a low weight
11 DRG what you end up doing is paying a lot of money for
12 losses that are much smaller than the losses that are
13 occurring somewhere else in a high rate DRG.

14 DR. REISCHAUER: The second question had to do
15 with the IME and other extra payments. When I was reading
16 through the chapter here my first reaction to all of this
17 was that the teaching hospitals, in a sense, are
18 disadvantaged because you add the regular DRG and then their
19 IME, which is supposedly for something else, in and so
20 they're less likely to be eligible.

21 And so I was surprised then when they come out as
22 net losers on this, which means that they must have an even

1 more disproportionate share of these outliers than their
2 excess IME payments.

3 MR. PETTENGILL: They do.

4 DR. REISCHAUER: Which is really amazing, if you
5 think about it.

6 MR. PETTENGILL: But again, it's uneven. Some
7 major teaching hospitals have a disproportionate share of
8 outlier cases and payments and others do not. So it's a
9 mixed bag for the group, as it is in every other group.

10 DR. REISCHAUER: But you would think that MS-DRGs
11 would have a bigger impact on them, too, because of the
12 nature of the patient load that they have.

13 MR. PETTENGILL: Yes, I don't know. At some
14 level, to the extent that the IME adjustment is larger than
15 perhaps the impact it has on costs, the thresholds are being
16 kicked up higher in major teaching hospitals. I don't know
17 what the right answer is here.

18 DR. REISCHAUER: I'll ask you the next time we
19 have this discussion.

20 MR. HACKBARTH: So at the end of this I want to
21 make sure that we reiterate our previous recommendation on
22 the funding of the outlier pool. I know we're raising

1 separate additional issues but I still think that that's
2 important to do.

3 On the issues that we've discussed today, you said
4 there's no right answer on the amount of insurance to buy.
5 Arnie and some others indicated though, well, insurance can
6 be counterproductive, if you will if, in fact, the payouts
7 are going disproportionately to people who are performing
8 badly, doing bad things. So if we can document that that is
9 where the money is going disproportionately that might lead
10 you to think well, that's an argument for making the
11 insurance amount as small as possible.

12 If you can't document that it's going
13 disproportionately to bad actors -- pardon the expression --
14 then we're back at well, it's a matter of opinion what the
15 right amount is. What do we do in that case?

16 DR. MILLER: I think that was the starting point
17 of this conversation. I assume when you say insurance
18 amount, you're talking about the fixed loss amount?

19 MR. HACKBARTH: Right. And the marginal cost
20 factor, all the variables that define the insurance policy.

21 DR. MILLER: So this is the way I would think
22 about it, Julian, and you'll want to keep track of this. As

1 a starting point, we're saying the environment changed, MS-
2 DRGs incurred, and there should be an increase in accuracy.
3 If you change nothing, five-tenths of a point come off of
4 the pool, if you keep the same insurance value and the same
5 marginal cost factor.

6 That was sort of the road we went off -- it's like
7 if nothing else, everything else is the same, five-tenths --

8 DR. REISCHAUER: But the law says it has to be at
9 least 5 percent.

10 DR. MILLER: We would make a recommendation and
11 say that's no longer required.

12 MR. HACKBARTH: All of that follows, but that
13 assumes that the 5.1 percent was the right answer to begin
14 with. And if you accept that as a given and then we improve
15 the accuracy of the DRGs, then it follows well, it ought to
16 go from 5.1 to the correspondingly lower number. But in
17 fact, we're calling into question whether the 5.1 was even
18 the right number. That logic then breaks down.

19 DR. MILLER: You asked me the question of what do
20 you do if you don't know what the right size pool was.

21 DR. KANE: Doesn't that interact with the fact
22 that the accuracy -- in other words, we're getting up

1 towards a 58 percent accuracy just going to MS-DRGs. And
2 wouldn't it be nice to get higher and higher accuracy and
3 reduce the need for these little add-on this and that's that
4 people lobby on occasion.

5 So I would think, if you look at page 11 we've
6 gone from a 23 percent accuracy which gendered all kinds of
7 silly little add-ons that were impossible to justify over
8 the long-term, to 58 percent with one change in payment. So
9 now we're heading up towards if we went them to get more and
10 more accurate payment, we're getting up towards 69 percent
11 if we lower the marginal cost.

12 MR. HACKBARTH: But you follow the logic of this
13 line and it says well, if we go maybe to marginal cost
14 factor of maybe 50 percent, will that number go up higher?
15 Yes, it would. Hey, if we go to zero, it will even be
16 higher.

17 DR. KANE: But the literature doesn't support
18 zero. It does support 50 to 60.

19 MR. HACKBARTH: But again, it goes to the question
20 of how much insurance you want to buy. This number will go
21 up but the losses won't be evenly distributed. They're
22 going to be concentrated in certain institutions. And the

1 question is whether they're worthy institutions or not, at
2 some level.

3 DR. KANE: And at some level the hospitals will
4 stop taking those cases and you'll know you've gone too far.

5 MR. HACKBARTH: That's true too.

6 We don't need to belabor the point here but I'm
7 still unsure what our test is of when we've got the right
8 number and so we'll have to grapple with that a little bit.

9 MR. PETTENGILL: I wish I had a magic bullet for
10 you, but I don't.

11 MR. HACKBARTH: I know you don't. That's what
12 scares me.

13 DR. MILLER: So just to be clear where we're
14 leaving this, one angle that we'll look into is the
15 relationship between sort out how good of an actor and the
16 flow of the dollars, which is going to be a fairly imprecise
17 exercise but we'll take a swag at that.

18 And where this would come back and you might see
19 it again is when we get into -- and I spoke out of turn when
20 I said if you're keeping a running tab.

21 One place we will have a running tab is when we
22 come back and do the payment adequacy analysis. Implicitly

1 that's a running tab of all the policies and what the
2 effects are, and we can disaggregate as much as you need.
3 But you can see this conversation come again when you see
4 those distributional differences that Jay spoke to and the
5 issue of accuracy at that point, you may see this issue
6 again, well, does this look more attractive in light of what
7 you see at that point in time? Or is the leap too far,
8 given who it's going to go to, that it doesn't look
9 attractive? That's where I could see this coming up again
10 say in December. Is that fair?

11 DR. REISCHAUER: If we go down below the 4.6 and
12 save money, which is what Jack wants to do, then the average
13 negative margin of Medicare hospitals is going to go up.
14 It's going to be more negative because you're taking money
15 out of the system.

16 DR. MILLER: If you money out of the system, no
17 question. But we were talking in this conversation about
18 moving things to the base. But you're right, Jack did raise
19 that point.

20 MR. HACKBARTH: Just for the record, I do think
21 that the best thing to do is to put it back in the base and
22 we can argue about what the update factor out to be

1 separately from this.

2 Thank you.

3 Next is expanding the unit of payment in the
4 outpatient PPS.

5 DR. ZABINSKI: Medicare spending has been growing
6 rapidly in the outpatient PPS, increasing by an average of
7 about 11 percent per year from 2001 through 2006. This
8 trend in spending in the outpatient PPS is also expected to
9 continue, as its greater spending also adversely affects
10 taxpayers through higher taxes and beneficiaries through
11 higher Part B premiums.

12 Analysis by CMS and MedPAC staff indicate that
13 this rapid increase in spending is due to hospitals
14 furnishing more complex services and providing more services
15 per outpatient visit and is not due to increasing
16 beneficiary enrollment or to higher prices.

17 An important feature of the outpatient PPS is that
18 it's largely a fee schedule and that hospitals typically
19 receive separate payments for individual services rather
20 than a single payment for entire packages of services. This
21 feature likely contributes to the rapid growth in spending
22 because hospitals have little incentive to think about the

1 efficiency of their methods because each service they
2 furnish is reimbursed by Medicare.

3 A possible way to slow the growth in volume and
4 spending is to expand the unit of payment. Today, we will
5 discuss two possibilities. One is packaging, which involves
6 combining an independent service and the associated
7 ancillaries into a single unit of payment. Under packaging,
8 payment for an independent service is the same no matter the
9 number or type of ancillaries furnished. For informational
10 purposes, we define an independent service as a procedure or
11 medical visit that is the main reason for a patient's visit
12 to an OPD. It includes such things as surgical procedures,
13 advanced imaging and clinic and ER visits.

14 In contrast, an ancillary service is something
15 that adds time and cost to a visit but it is secondary to
16 the independent service. An example are plain film x-rays
17 and anthology services. Also, the term ancillary is a bit
18 of a catch all in that it includes drugs as well as actual
19 ancillary services.

20 A second possibility for expanding the unit of
21 payment is bundling, where hospitals receive a single
22 payment for all clinically related independent services in

1 the associated ancillaries furnished during an outpatient
2 visit or over an entire episode of care, which can include
3 multiple visits. A simple example of bundling is low dose
4 rate brachytherapy treatment for prostate cancer, which
5 typically involves two independent services, the preparation
6 of the site and the actual implementation of the
7 brachytherapy seed.

8 Because these two independent services are
9 typically provided in the same visit, CMS has proposed to
10 bundle them into a single unit of payment rather than to
11 continue to pay for them separately beginning in 2008.

12 CMS has also gone ahead and proposed expanded
13 packaging and bundling in the outpatient PPS as ways to help
14 slow volume and spending growth in that sector. CMS used
15 their proposals as a first step, as they are somewhat
16 limited in how far they can actually expand the unit of
17 payment. So CMS has also expressed interest in going beyond
18 the amount of packaging and bundling it has proposed. We
19 are also in the process of exploring ways to further expand
20 packaging and bundling and today we'll discuss the work we
21 plan to do on packaging and our work on bundling will come
22 later.

1 A key feature of packaging is it works off the
2 concept of averaging. That is, hospitals receive a single
3 payment for a package of services comprised of a single
4 independent service and the associated ancillaries. The
5 actual package of services furnished varies from patient to
6 patient so that sometimes the payment exceeds the cost of
7 the package actually furnished and sometimes the payment is
8 less. In particular, the greater packaging increases the
9 likelihood that payments for a package of services will
10 differ from the hospital's costs more so than what you would
11 see under a fee schedule.

12 But despite this greater variation in packaging,
13 on average payments reflect the costs of the packages of
14 services that hospitals provide.

15 So under greater packaging, hospitals face more
16 risk because, as I said, payments are more likely to differ
17 from costs than under a fee schedule. This increased risk
18 faced by hospitals increases their incentive to furnish care
19 in the most efficient way in order to avoid losses. They
20 can accomplish this efficiency by considering whether
21 patients can be effectively treated using fewer ancillaries
22 or lower-cost ancillaries or establishing protocols and

1 working with physicians to make sure hospital resources are
2 efficiently used. This increase in efficiency, in turn, can
3 help slow growth in volume and spending.

4 I note that hospitals have some experience facing
5 a single payment for a package of services under the DRG
6 system that is currently used in the inpatient PPS.

7 Our research on packaging indicates that there are
8 two keys to an effective system of packaging. First,
9 packaging should increase hospitals' exposure to financial
10 risk beyond what they face under a fee schedule in order to
11 increase incentives for efficiency but that additional risk
12 should not be excessive.

13 Secondly, a packaging system should be easy to
14 understand and use, especially among hospitals and their
15 staff to implement it. Over the next few slides I'll
16 discuss these two points in more detail, beginning with the
17 issue of avoiding excessive risk.

18 On the one hand, more risk is needed through
19 greater packaging to increase hospitals' incentive for
20 efficiency but the risk should not be excessive and should
21 be avoided because first, it would give hospitals an
22 incentive to avoid complex patients or to limit necessary

1 care; and secondly, it would disadvantage hospitals that
2 attract a relatively complex mix of patients.

3 To avoid putting hospitals under excessive
4 financial risk, we should package ancillaries that meet one
5 or both of these two thresholds, in particular package
6 ancillaries that either lower in cost in relation to the
7 associated independent service or there are always or
8 usually used with the associated independent service. The
9 problem, though, with these two threshold is that they are
10 somewhat arbitrary and that there is, for example, no
11 definition for what relatively low cost might mean or what
12 usually used with an independent service might mean.

13 So what we plan to do is to explore appropriate
14 thresholds which might include consultations with
15 researchers who have developed packaging methods for other
16 hospital outpatient systems.

17 Before moving on, one final thought on risk is
18 that some may still be concerned that even if a packaging
19 system does not expose hospitals to excessive risk, that
20 hospitals might still have an incentive to limit necessary
21 care or to avoid complex patients. But I'd like you to keep
22 in mind that mechanisms are in place that can offset these

1 incentives to hospitals to limit care. In particular, the
2 Commission has recommended pay for performance in order to
3 improve quality of care in Medicare and also CMS has
4 established a set of quality measures for use in the P4P
5 program and it will begin collecting them this coming year.

6 In addition, the outpatient PPS has an outlier
7 policy to offset losses from costly patients.

8 Now I'd like to turn to the issue of making a
9 packaging system that is both easy to use and understand.
10 Two methods of packaging have been developed, both by
11 researchers at 3M Health Information Systems. One is a
12 clinical option, which relies largely on experts judgment to
13 determine which ancillaries to package. For a particular
14 independent service, only ancillaries that are originally
15 provided with it are packaged with it.

16 The other alternative is the more broadly defined
17 uniform option. This method relies generally on empirical
18 information to determine which ancillaries to package.
19 Examples of information that could be used are the cost of
20 the ancillary in relation to the associated independent
21 service or how frequently the ancillary is used with that
22 independent service. Then once you determine which

1 ancillaries could be packaged, you create a master list of
2 the packaged ancillaries. Then any time an ancillary on
3 that list is used with an independent service, it is
4 packaged with it.

5 Although 3M's method that relies on expert's
6 judgment, as it has the attractive feature that payments are
7 based on a collection of services that are clinically
8 meaningful, experience with it indicates that this approach
9 is confusing for hospitals and their staff because an
10 ancillary can be packaged when coded with some independent
11 services and paid separately when coded with others. This
12 confusion among hospital staff can make it difficult for
13 hospitals to plan their resource use, which is important if
14 you want to improve their efficiency. In contrast, using an
15 approach based on empirical information has been shown to be
16 easier for hospitals and staff to understand and use because
17 there is simply a single list of ancillaries that are always
18 packaged whenever used with an independent service.

19 And finally, something that's true no matter what
20 method of packaging is used, is that the more an ancillary
21 is used with an independent service, the more its costs will
22 be reflected in the payment rate for that independent

1 service. For example, an ancillary that is used 20 percent
2 of the time with an independent service, 20 percent of the
3 cost of that ancillary would be reflected in the payment
4 rate for the independent service that's associated with it.
5 But if an ancillary is used 80 percent of the time with an
6 independent service, about 80 percent of the cost of that
7 ancillary would be reflected in the payment rate.

8 The next step we plan to take in our analysis of
9 packaging is to evaluate alternatives for expanding the
10 amount of packaging in the outpatient PPS. One option we'd
11 like to explore is to package ancillary clinical lab tests
12 and drugs that are currently separately paid or are low cost
13 or frequently used in relation to the associated independent
14 services.

15 A second option we would like to look at is
16 implementing the packaging in the ambulatory patient group,
17 or APG system. This is a system that for classifying
18 outpatient services on the basis of clinical and cost
19 similarity, and it has served as a basis for the
20 classification currently used in the outpatient PPS, the
21 ambulatory patient classification system, or APC. The big
22 difference between these two systems is that the APG system

1 has more packaging though than the currently used APC
2 system.

3 To show how we might identify ancillaries or drugs
4 that could be packaged in the outpatient PPS, we developed a
5 simplified example. We started by comparing the cost of all
6 separately paid ancillaries and lab tests to the cost of
7 their associated independent service or services. We
8 calculated relative cost for each ancillary and lab test as
9 the cost of the ancillary or lab test as a percentage of the
10 associated services. For example, if an ancillary is used
11 with more than one independent service, we calculated the
12 relative cost of the answer is averaged across all
13 independent services with which it is used. Then if an
14 ancillary or lab test has a low relative cost, we can
15 consider packaging it.

16 In this diagram we show the results from our
17 example. We started by dividing the separately paid
18 ancillaries and lab tests into groups based on their costs
19 relative to the associated services. In the first column we
20 illustrate this, where in the first row you have the
21 ancillaries with a relative cost below 10 percent on down to
22 the fifth and bottom row where you have ancillaries and lab

1 tests with a relative cost below 50 percent.

2 In the second column, we show the percent of total
3 ancillary volume that is attributable to each relative cost
4 category in the first column. For example, if you're
5 looking at the first row, the ancillaries and lab tests that
6 have a relative cost below 10 percent, encompass about 25
7 percent of total ancillary volume.

8 In the third column, we illustrate the estimates
9 of actual spending for each category in column one. For
10 example, ancillaries and lab tests that have a relative cost
11 below 10 percent encompass about \$300 million dollars in
12 total spending.

13 I think one point you can take away from this
14 diagram is that opportunities do exist for greater packaging
15 and that packaging could have an effect on slowing spending
16 and volume growth in the outpatient PPS. For example, 76
17 percent of ancillary volume is attributable to ancillaries
18 and lab tests that have a relative cost below 30 percent and
19 packaging those ancillaries and lab tests would redistribute
20 about \$1.2 billion in spending.

21 Moreover, I want to emphasize that this is
22 actually a pretty restrictive example in terms of

1 identifying ancillaries that could be packaged. Because if
2 we added to our analysis drugs and ancillaries that are high
3 cost but frequently used with their associated service, the
4 amount of spending redistributed would be higher than what
5 we see in the final column.

6 To summarize, volume and spending have increased
7 sharply in the outpatient PPS and expanded packaging could
8 help slow that growth. An effective system of packaging
9 would increase hospital's exposure to financial risk in
10 order to increase incentives for efficiency but this
11 additional risk must not be excessive and packaging should
12 be easy for hospitals and staff to understand and use.

13 In the future we plan to consider alternatives for
14 expanding the amount of packaging in the outpatient PPS. We
15 also plan to explore greater bundling, which creates a
16 single payment for all clinically related services furnished
17 over a visit or an entire episode of care.

18 As I turn things over to the Commission for their
19 discussion, particular issues we'd like to get into in
20 particular are, first of all, alternatives that we might
21 explore for expanded packaging, whether empirical
22 information or clinical judgment is the better option for

1 identifying which ancillaries to package, and whether you
2 have a good idea on where thresholds could be set for
3 identifying ancillaries that are relatively low cost or
4 frequently used with their independent service.

5 MR. HACKBARTH: Thanks, Dan. Could I ask a
6 question about the table on page 15? I'm trying to get a
7 sense of the opportunity here.

8 So even if you go to 50 percent, the cost of
9 ancillary relative to services up to 50 percent, so you've
10 got \$1.8 billion in spending on ancillaries that meet that
11 test. But that's the total spending. It's not going to all
12 go away.

13 So even if you were successful in avoiding,
14 because of the new packaging policy, 20 percent of that
15 you're talking \$300 million or \$350 million. Am I thinking
16 about this correctly? The \$1.8 billion is the total
17 spending on ancillaries, not the savings opportunity.

18 DR. ZABINSKI: Right. At the same time, though, I
19 said I tried to be conservative here. I only worked with
20 the answer that have relatively low costs. I didn't
21 consider drugs that might be relatively low cost. I didn't
22 consider ancillaries that are pretty expensive but almost

1 always used with their independent service. So I'm not
2 going to even venture a guess at how high that number could
3 go.

4 But in terms of your takeaway specifically from
5 this slide, that's pretty accurate.

6 DR. REISCHAUER: Are the ancillaries growing at a
7 hugely faster rate than the underlying service?

8 DR. ZABINSKI: Their overall growth rate is higher
9 than the rate for your average service, yes. In a sense,
10 yes.

11 MR. HACKBARTH: That's a sort of a hedged
12 response. Could you just be a little bit more specific?

13 DR. ZABINSKI: Let's see, since 2002 to your
14 average ancillary growth is somewhere around 7 percent.
15 Your average service is somewhere around 5 percent in
16 volume, so it's a couple of percentage points higher.

17 DR. SCANLON: A couple points. I know we want to
18 try and move away from fragmentation, but I think in doing
19 that we still have to remember are we getting what we paid
20 for? I think the issue of risk, we've got to go much more
21 beyond the issue of the risk to the hospital, but it's the
22 risk to the patient.

1 The criteria where an ancillary is provided most
2 of the time is, in some respects, a good one because that
3 suggests that what we're talking about is a more homogeneous
4 package. But we have to know they we're getting the
5 homogeneous package, that we're getting everything that's in
6 it. And I think we're premature if we're putting our faith
7 in pay for performance kind of reporting. I think we need,
8 as we design this, to consider what are the other mechanisms
9 that we're going to know that there isn't stinting, that we
10 talk about in other contexts.

11 The second comment is with the issue of what
12 should our design be? The question comes to the objection
13 that were made about the earlier designs from 3M in the
14 sense that they were going to be confusing to hospital
15 staffs. There's a question of who needs to know what. If
16 I'm the clinician sort of providing the service, what do I
17 need to know about the payment system in terms of making my
18 decision as to what ancillaries I should use? In some
19 respects, you'd like them to not take the payment system
20 into account when they're deciding what ancillaries to use.

21 If I'm the head of the department and I'm ordering
22 the ancillary supplies, what do I need to know about the

1 payment system in order to make those kinds of decisions?

2 It didn't totally ring true that this should be
3 sort of a showstopper in terms of one design versus another.
4 It seems to me that we need to think about what's the best
5 design from our perspective, think about then what would be
6 the real problems that a hospital would have and decide
7 whether or not they're manageable. Because as you move up
8 the chain then the payment system and its features become
9 much more relevant. But those folks are the best and the
10 brightest; right? So they're going to be able to figure
11 this out and they should be able to work with the system
12 that we have, that's working from our perspective.

13 MR. EBELER: I know you had a bullet point that
14 talked about slowing growth in spending so I don't have to
15 make it here.

16 Say a little more about this clinical versus
17 uniform method. In the paper you described it as sort of a
18 clinical method and a uniform method and sort of
19 instinctively it struck me that you want something that's
20 clinically coherent for the future. But in your
21 presentation this afternoon, there was a clinical judgment
22 and an empirical method.

1 Could you say a little more about the problems
2 with the clinical approach?

3 DR. ZABINSKI: I'm going to switch shoes here.
4 Mark, correct me if I'm wrong on this. Usually Mark is
5 asking staff to correct him if he's wrong.

6 In any event, the clinical, my understanding is it
7 uses experts judgment on what ancillaries should be with
8 what primary service. And that's got a nice feature to it.
9 You get this clinically coherent sensible unit that you're
10 paying for.

11 But I guess this idea was sort of thought about in
12 practice, that it was real difficult for the staff to
13 understand at hospitals and they sort of scratched their
14 heads, this ancillary here is packaged in this case and it's
15 not packaged here. It really caused a lot of confusion.
16 And that confusion sort of made it real hard to work with
17 and for hospitals to plan their resource use, which of
18 course then makes it hard to increase your efficiency.

19 MR. EBELER: Thank you.

20 DR. MILLER: I was involved in some of these
21 conversations 10 or 15 years ago. And when the APGs --
22 that's the one that does all of the packaging, Dan? Correct

1 me if I'm wrong, please?

2 DR. ZABINSKI: Right.

3 DR. MILLER: When that was done there were two
4 things that sort of came up in that discussion. There was a
5 set of clinical judgments that stood behind the packaging,
6 which not all clinicians agreed with. So the confusion came
7 in two varieties. There's the charge master billing, that
8 side of the hospital, kind of what? But then there was also
9 I'm not sure I agree with this.

10 I won't take issue with you, Bill, but there were
11 some who also made the argument that you don't necessarily
12 want the clinician -- I mean, one of our concerns right now
13 with the current system is clinicians are completely unaware
14 of what the potential -- and you do want some sense of I use
15 this resource, there's some impact here. And people
16 couldn't look out on the landscape in the outpatient setting
17 and know at each time they were making a decision when
18 something was packaged, what was in and what was out. So
19 the confusion kind of ran in a couple of directions.

20 And what you picked up on precisely, Jack, between
21 the writing of the paper and putting the presentation
22 together, is there is this label. When you say clinical,

1 everybody goes right, better. But it was more of a judgment
2 thing, and the ancillary wasn't consistently in with -- in
3 some cases, it was together with the independent services.
4 In some cases not. And that's sort of the distinction we're
5 trying to imply. There's a judgment and it's not always
6 present. And is that harder or easier to work with?

7 I don't think we're litigating the point, but we
8 are telling you that the history was that there was a bad
9 reaction to this when it was put in the field.

10 DR. SCANLON: The whole issue of being efficient -
11 - and I'm not trying to be counter to that. But there's
12 this issue of management. Medicare is one payer. So if you
13 think about the clinician supposedly being prepped in terms
14 of here's how Medicare pays, think about it in these terms,
15 versus this is how somebody else pays and think about it in
16 those terms.

17 I think that management one of these types of
18 settings would be to make the clinicians aware of resource
19 use and be monitoring it at a much more aggregate level and
20 be giving them feedback at a more aggregate level so that
21 there's efficiency across the board. But to keep track of
22 all of the payment flows and try and say okay, now that

1 Medicare is spending this way, do this differently. I think
2 that's what's inappropriate and that's what doesn't ring
3 true from their perspective because that's not how they're
4 going to implement it either.

5 DR. BORMAN: One of the categories that we've seen
6 data about growing enormously over a relatively recent time
7 frame is so-called minor procedures, many of which now are
8 in this basket of things, in terms of outpatient prospective
9 system procedures. A number of things around those
10 episodes, in terms of lab and radiologic diagnostic stuff,
11 is somewhat regulation driven in terms of JCAHO, or in terms
12 of other things that have to be reported to various entities
13 -- payers, other regulators, whatever.

14 But that does generate a number of relatively
15 fixed packages. And I recognize that a system, in order to
16 be useful, has to be able to be implemented by the people
17 that have to enter the data or regulate the charges or
18 whatever. But certainly hospitals that are doing these
19 things, by and large, have this parsed out finer than on a
20 DRG basis.

21 I could understand that if this somehow was all
22 the things grouped up into one DRG and yet within that

1 there's 10 different procedures or kinds of care and in each
2 one of those the ancillaries are different, then doing it on
3 a DRG basis is confusing and not helpful for the hospital.

4 But if it's parsed out on a finer basis, just for
5 an example, by a CPT procedure code which outpatient
6 hospital now uses, whereas there was a time when it didn't
7 and it was using ICD-9 III procedures, you can get this to a
8 more granular level where the bundles are indeed constant.

9 If somebody's coming in for an angioplasty, just
10 for an example, there's going to be some lab that every
11 single one of those people is going to get, or those
12 patients is going to get. And that patient is going to be
13 attached to a pretty specific code in the system.

14 I don't know if there's been enough change in the
15 reporting system or in the IT systems in institutions that
16 are doing a lot of things that are covered under this. But
17 I do think that there should be a pretty good ability to do
18 this at that level.

19 And I remain puzzled by the inability to do it,
20 unless it's just a factor of what's changed over time in
21 terms of IT and the reporting system.

22 DR. MILLER: I was with you all the way up until

1 the last sentence. I didn't quite get the landing.

2 DR. BORMAN: If I hear what has been said about
3 hospital push back before, was that this was too confusing,
4 that if --

5 DR. MILLER: [off microphone] And you're saying
6 now the system should have evolved to the point where it
7 shouldn't be --

8 DR. BORMAN: Right. What I'm trying to say is I
9 think there may be changes in the way that this is reported
10 by the hospital, because it's using a more granular system.
11 And I also think the sophisticatedness of the systems that
12 hospitals have to track it at that more granular level has
13 increased. And maybe that now does allow it. Maybe there's
14 been enough passage of time.

15 If that's not the answer between then and now,
16 then I am still puzzled as to what the answer is.

17 DR. MILLER: Now I see.

18 DR. CASTELLANOS: I don't think it surprises
19 anybody that we have an increase in volume. I mean, site of
20 service, everything is coming out of the hospital, which is
21 much higher cost, and going into the outpatient arena,
22 whether it's the physicians' office, an ASC, or the

1 hospital. I think the site of service tells us why we have
2 an increased volume.

3 I'm just making a point. You hear the word
4 clinical and you say gosh, the doctor doesn't have the
5 equipment to do the operation. That certainly is not the
6 case. This is a charge issue to the hospital. The
7 equipment is available and he or she has the opportunity to
8 be able to take care of that patient under any
9 circumstances. So you're not holding the doctor up or tying
10 his hands.

11 Again, the point here was that you need to get the
12 physicians involved. You need to get the physicians
13 understanding costs. You need to get the physicians, in my
14 estimate, financially involved. And again, we're not
15 talking about bundling yet. But you can talk all you want
16 about what the hospital needs to do, but it's the physician
17 that has to understand these ramifications. And I think the
18 best way to put that is to put both the hospital and the
19 physician at risk for both cost and quality.

20 MR. HACKBARTH: Okay. Thank you, Dan.

21 And last, but not least, is Jennifer and Medicare
22 Advantage.

1 MS. PODULKA: As Glenn mentioned, I'm here to talk
2 about special needs plans or SNPs. You may recall some
3 presentations on this last year, so this is a bit of an
4 update with some new information.

5 Special needs plans were added as a type of
6 Medicare Advantage plan by the 2003 MMA. SNPs are paid the
7 same as any other MA plan type and are subject to the same
8 requirements. There are only two differences. First, they
9 must provide the Part D drug benefit. And also, they are
10 allowed to limit their enrollment to their targeted
11 population. This authority to limit their enrollment will
12 lapse at the end of 2008 unless the Congress acts to extend
13 it.

14 And SNPs targeted populations include three types
15 of beneficiaries: those who are dually eligible for Medicare
16 and Medicaid, those who reside in institution or in the
17 community but are nursing home certifiable; and third, those
18 who are chronically ill or disabled.

19 There are several aspects of SNPs that raise
20 concerns. First, we are concerned about the lack of
21 Medicare requirements designed to ensure that SNPs provide
22 specialized care to their target populations and SNPs'

1 resulting lack of accountability. This raises questions
2 about the value of these plans to the Medicare program. For
3 example, dual eligible SNPs are not required to coordinate
4 benefits with Medicaid programs and many dual eligible SNPs
5 operate without any state contracts.

6 Third, since they were introduced, SNPs have grown
7 rapidly, both in number and enrollment. I'm sorry, that was
8 second.

9 Third, organizations entering the SNP market
10 include those with experience with Medicaid and special
11 needs populations but also include MA organizations that
12 chose to add SNPs to their menu of plans. This raises
13 questions about whether this represents plans' marketing
14 strategies or a real investment in providing specialized
15 care to their targeted populations. I'm going to talk more
16 about each of these concerns but first about that growth.

17 SNPs have grown rapidly in number since they were
18 introduced. Currently, there are more than 400 SNPs. Just
19 last week we learned that if all applications are approved,
20 next year we're going to see more than 700 SNPs. SNP
21 enrollment has also grown quickly, nearly doubling from last
22 July. We are currently at over one million beneficiaries

1 enrolled in special needs plans. The enrollment in SNPs is
2 roughly proportional -- by type, is roughly proportional to
3 the plans availability.

4 In light of concerns about SNPs being offered by
5 organizations both with and without specialized experience,
6 we examined SNPs available in 2006 and found that only 13
7 percent of them were offered by a parent organization that
8 focused exclusively on operating special needs plans. The
9 rest offered some other type of MA plan. This is an issue
10 because the Congress created SNPs, in part to allow certain
11 demonstrations in specialized types of plans to continue on
12 a more permanent basis. I think it's been a surprise to
13 many just how many other SNPs are being offered by other
14 types of organizations. As I mentioned earlier, this raises
15 the question of whether this represents plans' marketing
16 strategies or a real investment in specialized care.

17 A couple other things I want to make sure you know
18 before we continue with some of the policy options. First
19 is that special needs plans are required to be coordinated
20 care plans under Medicare Advantage. And SNPs, along with
21 employer-sponsored plans, were the only source of enrollment
22 growth in local HMO plans between 2006 and 2007. I'll leave

1 this to your interpretation, but it may be encouraging news
2 given the Commission's concerns about growth in less managed
3 forms of MA plans. Of course, it also means that special
4 needs plans also receive the same additional payments that
5 we're concerned about for all MA plans receiving.

6 Second is that SNPs 2006 benchmark and payments
7 relative to fee-for-service are similar to regular HMOs
8 moreso than some other plan types, which you can see on this
9 table.

10 Now you have somewhat of a picture of special
11 needs plans and one question that frequently comes up as a
12 possible explanation for all this SNP growth is that the
13 risk adjustment system is not working like it should. We
14 recognize that risk adjustment has improved a lot over the
15 past several years, but there are at least two ways that it
16 could be fueling SNP growth.

17 First, the risk adjustment system is based on a
18 list of diagnoses that plans submit. But there are degrees
19 of severity in each of these diagnoses that are not captured
20 by design. For example, a plan could potentially enroll
21 people only with stage I cancer while receiving a risk-
22 adjusted payment that is based on expected costs for the

1 full range of cancer patients.

2 An alternative explanation could be the risk
3 adjustment systems intended goal. It is designed to predict
4 spending for patients in fee-for-service Medicare and a
5 plan, simply by managing care, could spend significantly
6 less than this amount. We very well may need to revisit the
7 risk adjustment system but addressing the first issue will
8 require additional data collection and analysis and
9 addressing the second would require a philosophical shift in
10 what we expect of our risk adjustment.

11 Rather than going into more detail on these now,
12 I'd like to discuss some other aspects of SNPs that I'd like
13 you to keep in mind. This is in preparation for a whole
14 slate of questions.

15 As I mentioned, SNPs, or at least their authority
16 to limit their enrollment, expires at the end of 2008. The
17 question of whether to allow them to continue comes down to
18 whether SNPs need to limit their enrollment to do something
19 special. In other words, can whatever SNPs do be
20 accomplished just as well by regular MA plans?

21 A key motivation for creating SNPs still applies
22 to allowing them to continue and that is providing a big

1 umbrella to cover all special plans and demonstrations. If
2 the SNP authority ceases, then some existing SNPs could
3 change into regular MA plans while other SNPs could revert
4 to or become demonstrations. This would mean that CMS would
5 need to continually reapprove these types of demonstrations
6 and any new projects that hope to build off lessons learned
7 would also need to enter the program as demonstrations.

8 However, if SNP authority is extended, then SNPs
9 should be expected to provide specialized care for their
10 enrollees that regular MA plans cannot provide as well or as
11 efficiently. SNPs may be able to tailor unique benefit
12 packages that allow them to provide efficient high quality
13 care through economies of scale. However, there are SNPs
14 that clearly do not meet this standard right now. Given
15 that the MMA language which created SNPs was broad and vague
16 and CMS has done little to further focus SNP requirements,
17 I'm going to suggest a whole list of policy options for your
18 consideration.

19 The first ones have to do with quality,
20 information and accountability. On the first bullet,
21 currently SNPs must measure and report the same quality
22 measures as other MA plan types. If SNPs need to limit

1 their enrollment to a target population to provide
2 specialized care, then the quality of that specialized care
3 may need to be measured by appropriate measurement sets.
4 CMS has contracted with NCQA to develop new SNP-specific
5 measures, but it could be a year or more before they even
6 began collecting data on those.

7 On the second bullet, based on discussions that
8 we've have with SNPs, states and CMS, we have learned that a
9 lack of clear information is an impediment to beneficiaries
10 learning about and making an informed decision about joining
11 a SNP. Because the CMS website is structured to compare all
12 MA plans in a consistent manner, and CMS has yet to provide
13 sufficient flexibility for SNPs, these plans are not always
14 described accurately.

15 For example, the Medicare Compare website shows
16 cost-sharing requirements for some dual eligible SNPs that
17 charge their enrollees no cost-sharing because it's covered
18 through contracts with state Medicaid agencies.

19 An option for dealing with this would be to
20 require CMS to include comparative SNP information on their
21 website, and even as written information for eligible
22 beneficiaries.

1 The third bullet there, if SNPs are allowed to
2 limit their enrollment, then they should better manage the
3 care of their enrollees than a regular MA plan. Linking
4 enrollees with an individual responsible for coordinating
5 their care would be a minimum step towards managing that
6 care. This would also allow plans and CMS to survey
7 enrollees about their awareness of and satisfaction with
8 this service.

9 Next, there's something I need to bring up before
10 I can proceed to the next policy option, and that's the
11 disproportionate share provision. Under this, SNPs may
12 limit their enrollment to the targeted special needs
13 population. That's a given. Or they may apply to CMS for
14 permission to enroll any other beneficiaries as long as
15 their membership includes a disproportionate share of their
16 targeted population. This means that the percentage of the
17 target population in the plan must be greater than the
18 percentage that occurs nationally in the Medicare
19 population.

20 Until this year most SNPs had chosen to limit
21 their enrollment to their target population, in other words
22 not taking advantage of this provision. However, we are

1 concerned about some notable exceptions.

2 For example, the SCAN social health maintenance
3 organization became an institutional SNP in 2007 under this
4 rule because 26 percent of their enrollees are nursing home
5 certifiable living in community, and that's not even
6 necessarily in institutions. So if you are unsatisfied with
7 this existing provision, a simple option to deal with it
8 would be to require that SNPs predominately enroll
9 beneficiaries from their targeted population.

10 One more thing that I need to set up before we
11 talk about the policy option, and that's dual eligible SNPs.
12 There are two types of dual eligible beneficiaries. Most
13 are full duals in that they qualify to receive full Medicaid
14 benefits. Beneficiaries with somewhat more income and
15 assets are eligible for more limited Medicaid coverage
16 under multiple categories collectively known as the Medicare
17 Savings Program. CMS currently does not allow plans to
18 limit their enrollment to the Medicare Savings Program duals
19 alone because the Agency said it was concerned about
20 selection issues, as these tend to be healthier individuals
21 than their full dual counterparts and the current risk
22 adjustment system does not distinguish between full dual and

1 the MSP duals.

2 Instead, CMS decided that an MA organization can
3 offer two dual eligible SNPs in the same county, one for
4 full duals and one for all duals. This has the benefit that
5 it may facilitate state contracting with the plans because
6 the states might not be willing to contract with plans where
7 they had exposure for more cost-sharing than they currently
8 are required to cover. However, in practice it runs the
9 risk that organizations that choose to do the two dual
10 eligible SNP options may attract the MSP duals into the all
11 dual plan, thus getting around CMS's original prohibition.

12 If you tracked on that, we have a couple of
13 options for dual eligible SNPs. First, all dual eligible
14 SNPs could have a contract with states to cover Medicaid
15 benefits because without one it is unclear that a dual
16 eligible SNP would behave any differently than a regular MA
17 plan. We feel that it might be reasonable to give plans a
18 few years to get ready for this because based on our
19 discussions with SNPs that do have a contract, it may take
20 that long to set one up. Ideally, these contracts would
21 cover long-term care but we recognize that this may be more
22 complicated than covering other more acute care services

1 under Medicaid.

2 On the second bullet there, in the meantime you
3 might want to require dual eligible SNPs without a current
4 state contract to limit their cost-sharing for their
5 enrollees to no more than those enrollees would be charged
6 under their state's Medicaid program.

7 And third, to address the issue of attracting the
8 Medicare Savings Plan only duals, which we discussed on the
9 previous slide, you might want to limit MA organizations to
10 offering only one dual plan in each area. They could decide
11 for themselves whether they wanted to offer it to all duals
12 or just the full duals, but they couldn't do both in the
13 same county.

14 The next policy option is on the chronic condition
15 SNPs. CMS decided to leave the definition of chronic
16 condition SNPs abroad because they didn't want to limit
17 innovation. As a result, not all chronic condition SNPs may
18 be sufficiently specialized to warrant formation of delivery
19 systems and disease management strategies. For example,
20 there is a chronic condition SNP for beneficiaries with high
21 cholesterol, a condition that affects so many beneficiaries
22 one would hope that any MA organization could effectively

1 treat it.

2 If you would like to see a more focused definition
3 of chronic conditions SNPs, it would be possible for CMS to
4 convene of clinicians and other experts to create a list of
5 eligible chronic conditions for SNPs to focus on. In the
6 meantime, a more focused definition than occurs right now
7 could be used, such as requiring chronic condition SNPs to
8 serve beneficiaries with medically complex or advanced late
9 stage chronic conditions that influence many other aspects
10 of health, have a high risk of hospitalization, or other
11 adverse health outcomes, and require specialized delivery
12 systems.

13 So this is it, the final policy option. It's the
14 inherent question of whether to extend the SNP authority
15 pass the 2008 deadline, which I mentioned. We find that
16 there may be sufficient reason to make some types of SNPs
17 permanent after making the changes discussed earlier, such
18 as requiring state contracts for dual SNPs. However, there
19 are two exceptions that may require a temporary extension to
20 allow further study.

21 The first is the chronic condition SNPs. These
22 may be able to better care for beneficiaries with certain

1 conditions and even improve their health outcomes. However,
2 it is not entirely clear why these disease management
3 functions could not be carried out as well by regular MA
4 plans. That said, on the other hand, there is probably some
5 potential benefit to organizing care around significant
6 chronic illnesses and thus, they should be further studied.

7 The second one are a specific kind of
8 institutional SNP. Institutional SNPs are permitted to
9 serve both beneficiaries in nursing homes as well as those
10 who are nursing home certifiable but living in the
11 community. There are fewer existing in the program right
12 now of that latter type.

13 These plans, like their brethren, may have the
14 similar potential benefit of avoiding hospitalizations and
15 improving care for the enrollees. However, they have less
16 experience and have been less evaluated. So it might be
17 reasonable to extend them on a temporary basis to allow
18 further study.

19 That's it. I look forward to your discussion, and
20 especially if you have any questions or information that I
21 didn't share that you'd like to see.

22 MS. DePARLE: Good work. And I'm glad that we're

1 taking this issue up. I think it's an important one.

2 I had two or three points. I guess I'll start
3 with the last one, which is I'm glad we're thinking about
4 making recommendations here. And I would say that if we're
5 going to make recommendations, it would be great if we could
6 do it now, as opposed to -- is this on a track to come out
7 in January? March?

8 This is a topic, as everyone knows, that's being
9 discussed right now in Congress. I think if we have a view
10 of it, it would be good to have it out there now. I, at
11 least, would be prepared to do that.

12 MR. HACKBARTH: Of course, the formal publication
13 would occur, I assume, in March or June.

14 MS. PODULKA: I hope no sooner than March for
15 publication, but I think, in part, that's why we're here
16 right now in October talking about this.

17 MR. HACKBARTH: Just for the sake of argument,
18 let's assume that we're talking about March publication. We
19 would have draft recommendations in December. And that
20 would be sort of the earliest, which may or may not be
21 timely for congressional deliberations on a Medicare bill
22 this year.

1 I would bet that it would be timely, given their
2 Christmas Eve resolution of these issues in recent years.
3 But under the best of circumstances it's going to be pretty
4 difficult to be timely for this year.

5 MS. DePARLE: I'm only one voice here, but I would
6 urge you to consider whether or not that makes sense in this
7 particular context because --

8 MR. HACKBARTH: We'll look at what we can do.

9 MS. DePARLE: It might not need to be in the form
10 of our formal report, but you might be asked to testify
11 about this or to say what our view is. And I don't know
12 that we do have a view. I haven't heard from my fellow
13 commissioners. But if we did have a view, for example, that
14 chronic care SNPs should be extended or extended for three
15 years, as this recommendation kind of contemplates, I think
16 it would be good to put that out there.

17 I was a little bit lost in the section about dual
18 eligibles. I guess I honestly don't see that as being a
19 SNP. So you almost have to go back to first principles for
20 me to understand why -- to me, that -- while there is
21 certainly a crying need for attention to the people who fall
22 into that category of being dually eligible for Medicare and

1 Medicaid, to me their primary needs are around their
2 conditions and diseases. As opposed to what I think this
3 SNP has become, and as I understand it it's the one that has
4 grown the most and has been the biggest from the beginning,
5 it's more of a financing mechanism to me. It describes
6 where their financing comes from rather than describing
7 their condition.

8 So if I were looking at it, I would prefer that a
9 person who is a dual eligible who has diabetes be treated in
10 a SNP that meets the definition you just described for
11 chronic care SNP, that truly does something about diabetes.
12 As opposed to just signing up for a dual eligible SNP, which
13 I'm not sure that tells me anything about what they're
14 actually going to get. So I would make that point.

15 And on the chronic care SNPs, too, one more point
16 that I think is not mentioned in the paper, I have become
17 convinced that there needs to be a separate special needs
18 plan for chronic care. Some have argued well, it's the same
19 thing that Medicare Advantage plans were supposed to be
20 already. They were supposed to be able to treat chronic
21 conditions. And I see that point.

22 But if you understand the way Medicare Advantage

1 plans have to provide benefits to beneficiaries, it is very
2 hard for them to say if a person with diabetes needs the
3 special shoes that are very expensive, it's very hard for
4 them to say we're going to provide those without basically
5 providing them to the entire population that they serve.
6 And this is a way of focusing in.

7 Now granted, we need lots better definitions of
8 what it means. I don't think high cholesterol should define
9 a SNP category. So we need better definitions of what it
10 means to be a SNP. And we need better metrics and
11 requirements for what they're going to achieve. But I do
12 think there's a basis for that and so I would hope we would
13 take a position about that.

14 I don't know if you have any thoughts about my
15 reaction to the dual eligibles SNPs, but I have to confess I
16 just don't get it.

17 MS. PODULKA: I, at least, have gone back and
18 forth a lot on this, all three SNPs. It's true, we've done
19 some work previously on the Commission on dual eligibles.
20 As a group they tend to be somewhat less healthy, to have
21 somewhat more rates of chronic conditions. But the current
22 definition of a dual eligible SNP requires nothing other

1 than you be dual knowledgeable. They could be healthy.

2 Just as I said in the presentation, if there isn't
3 that state contract where they're at least promising to
4 coordinate the two financing streams and do some sort of
5 benefit coordination, it is really unclear what they're
6 doing that's different. Just my thought on that.

7 MS. DePARLE: Again, I'd rather see them
8 evaluated. We do need to be doing more with and for that
9 population. But have them evaluated and then maybe they
10 need to be in, maybe they don't need to be in any special
11 plan. But maybe they need to be in a plan that focuses on
12 their particular disease.

13 DR. CROSSON: On this point, just talking about
14 our own organization, the only SNPs we have our dual
15 eligible SNPs. And they're not established because we're
16 going to give different care to the members of this SNP than
17 we give in our regular MA plan. They're established simply
18 because if we don't do that we have no other way to
19 essentially lower the premium and copayments to the dual
20 eligibles, to pass through in fact to them the benefit of
21 the coordination of the financing with the state. Because
22 if we give them differential premiums or copayments, then we

1 violate the strictures of MMA that say that we're inducing
2 these individuals to join our regular MA plan.

3 So whether that's what you said is basically a
4 financing purpose or not, it is. But from our perspective,
5 it's a legitimate one and one that we shouldn't lose I
6 think.

7 DR. KANE: I'm on the board of a group that has a
8 dual eligible scope, but I guess we're calling its SNP
9 because Medicare kind of came in with that terminology. A
10 couple of things.

11 One is it takes a long time to get all the pieces
12 in place for the really frail people. I'm just looking at
13 the time frame and saying wow, you're expecting a lot awful
14 fast.

15 For instance, we just got caught because our
16 coding hasn't -- we're probably risk-adjusted much more
17 expensive than we look right now because we haven't even
18 learned to code for the new risk-adjusted methods. We just
19 got caught not knowing how to tell people to code properly.
20 So I'm just thinking it takes -- it took us five years to
21 get a Medicaid contract in place. So they don't happen
22 overnight.

1 The other thing about the dual eligibles that we
2 serve is there is no one chronic disease. They have lots of
3 problems. They are really sick. We also have the
4 institutional SNP with Evercare. A lot of those people
5 could be in either place. So they have a lot of problems.
6 We have the house calls.

7 There's a lot of things that they need a lot of
8 care around multiple conditions. So I don't know that you
9 could pick any one chronic disease, if they wouldn't be
10 jumping across different plans to treat their different
11 diseases. So they're a very expensive group to take care
12 of.

13 I guess my last comment is if you're going to look
14 at their payments relative to fee-for-service, for the dual
15 eligibles to be fair you have to put in their Medicaid fee-
16 for-service equivalent. You're really managing the bundle
17 and you want to see how you do relative to the bundle of
18 Medicare and Medicaid fee-for-service, not just one of the
19 two parties. Because you may be playing off -- you may be
20 using one funding source more heavily than the other to
21 avoid spending more on the other.

22 So I don't think you can evaluate them in the same

1 way that you do -- I think you have to put the Medicaid
2 expenditure for fee-for-service in there, too. And I know
3 how hard that is, so it may be really hard to evaluate them.
4 But those two bundles go together and get managed in a very
5 different way in a dual plan.

6 DR. MILLER: I don't dispute any of that, and
7 actually I think our -- I'm looking at a couple of people
8 over there, Carlos and Scott and Sarah. I don't know
9 technically whether we would be capable of building that in
10 in our lifetime in any case.

11 But I think the point of why we brought it up
12 here, which I just want to reinforce this point. If I get
13 this one, don't tell anyone.

14 But I think the reason we brought this up here is
15 we were saying actually, given all the questions about SNPs
16 that we were raising and what are they actually doing and
17 should we be setting these requirements, we're also saying
18 this is kind of an organized network of care which a lot of
19 growth in MA plans right now isn't.

20 And incidentally, they look sort of like the HMOs,
21 if I recall the table correctly. Do I have that correct?

22 So I realize part of that equation isn't there but

1 we were sort of saying hmm, they do kind of have organize
2 systems which, when you talk among the Commissioners, the
3 Commissioners kind of like that idea for managed care plans.
4 I think that was really the point.

5 Now this is not to dismiss your point, but
6 analytically I don't think we could get to your point in any
7 real way.

8 DR. KANE: Probably not but it makes it a lot
9 harder to judge them that way because you're not looking at
10 the total.

11 I guess my point is there probably does need to be
12 greater definition around who's going in and what they're
13 doing and I don't disagree with that. I'm just saying it
14 takes a long time to get these pieces together and the
15 provider groups that do it aren't the most sophisticated at
16 doing all of the risk-adjusted -- the recordkeeping for all
17 these new risk-adjustment systems.

18 So it may just take a while to be able to fully
19 evaluate what their real risk-adjusted expected costs would
20 have been.

21 DR. DEAN: What little exposure I've had to these
22 plans, I've been thoroughly confused, especially by this

1 table. The only one that's really been pushed in our area
2 is a cardiovascular plan. And they aggressively marketed
3 that to people that I would consider basically pretty high
4 risk. And I assumed it was because they were getting some
5 fairly rich subsidies to do that. But at least according to
6 the payments you've got up there, they're really not that
7 rich. Is that true or what am I missing?

8 MS. PODULKA: It's a ratio and so it's
9 standardized. It either does or doesn't include risk-
10 adjustment. Risk adjustment is the same on both the
11 denominator and the numerator. So they do get additional
12 payments for the risk adjustment.

13 DR. DEAN: Okay.

14 DR. MILLER: Don't forget the situation in MA
15 right now. They're being paid on average, by our analysis,
16 12 percent above fee-for-service.

17 DR. DEAN: I assumed that these plans were getting
18 something in addition to that.

19 DR. MILLER: You assume correctly there, as well.

20 DR. DEAN: This plan, at least, certainly didn't -
21 - all they needed was a note from your doctor saying you've
22 got a heart problem and you could get into the plan.

1 They're getting some pretty good benefits, for sure. It
2 never made sense. Even when the representative came and
3 spent a half hour explaining it to me, I still didn't
4 understand it.

5 MR. DURENBERGER: He didn't want you to.

6 DR. DEAN: That's what I figured, that he really
7 wasn't telling me what I wanted to know.

8 MR. EBELER: I just want to build on Mark's
9 comment a little bit. We talked earlier about frustrations
10 with transactional fee-for-service and which direction we
11 want to go. I think one of the reasons it's important to
12 look at these recommendations -- and I like the direction of
13 these recommendations, is that when you look at the other
14 end of that spectrum, you need to make sure that those
15 entities are doing the things that we expect to happen when
16 we go that way. So it strikes me that this is a very
17 positive set of directions. I agree with Nancy-Ann, the
18 sooner we can get them out, the better.

19 I guess the one question I would ask is at some
20 point maybe screen these recommendations and see -- some of
21 them are special need plan specific. But some of them may
22 well be equally relevant and may program more broadly. So

1 again, in the context of looking at the organized capitated
2 end of the spectrum and make sure it's delivering what we're
3 hoping for, it might be worthwhile just doing that policy
4 screen.

5 MR. HACKBARTH: Let me be the devil's advocate for
6 a second, Jack. And I'm focused now on the chronic
7 condition SNPs.

8 Let us set aside for a second the issue of
9 skimming. Clearly, if they're getting paid, overpaid for
10 the actual risk they're assuming because they've figure out
11 some way to beat the system, that's bad and we want to deal
12 with it. I'd like to know exactly how they're doing that or
13 how we think they're doing that before we assume it.

14 But let's set aside skimming for a second, and say
15 the only issue is whether these plans are really offering
16 anything different than is available through a regular MA
17 plan. So take a heart condition SNP. They're saying we
18 want to focus on this population. They're getting
19 appropriately risk-adjusted payments for the patients who
20 enroll. And let's say they're no better than Kaiser
21 Permanente in the same market. Why is that a problem?

22 They're just doing the same thing as a general

1 Medicare Advantage plan but they've just chosen to market
2 themselves to a particular population. They're not offering
3 poor quality care, it's just no better than Kaiser
4 Permanente offers heart patients. Why is that a problem?

5 DR. MILLER: Can I take a shot at this, and I
6 really need some close air support here.

7 I think when we went through this, because I've
8 got to tell you, we spent a lot of time banging our heads
9 against the table and exactly what we were trying to get out
10 of this. And in a sense the answer to your questions I
11 think it begins to get to what you demand in terms of
12 disproportionate share. So you guys see where I'm going?

13 What you're saying with a SNP is you can select
14 people. So you can say I'm looking at two people and I'm
15 going to take you and I'm not going to take you, on some
16 basis. And to the extent that, for example if your
17 disproportionate share requirement is relatively low, I can
18 continue to select across a regular population which is not
19 something that's open to other MA plans.

20 Did I say that right? And it may be if somebody
21 else said it it might help. You know if you hear the same
22 thing twice.

1 DR. REISCHAUER: If risk adjustment were perfect,
2 why have you been advantaged by doing that? I'm going to
3 argue that you shouldn't be allowed to do that for other
4 reasons. But this is a problem with imperfect risk
5 adjustment.

6 DR. MILLER: I think that's it. And what we're
7 saying to the regular MA plan is you have to take all
8 comers. We're saying to this plan you do not have to take
9 all comers. And to the extent there is any imprecision in
10 there, we're creating an opportunity for them. Unless we
11 say disproportionately you have to make 90 percent of your
12 population --

13 DR. REISCHAUER: I'm going to make an argument on
14 why you should.

15 MR. HACKBARTH: You're not allowing them to skim
16 within the heart category. You're saying you have to take
17 all comers within that category.

18 DR. REISCHAUER: I want to answer her questions,
19 and in a way get back to this. Because I'm a believer that
20 in theory the SNP concept is right, a good one, and it
21 hasn't reached its potential. and we should pursue a set of
22 recommendations that nudges it along in the direction of its

1 potential. And those recommendations would be let's extend
2 it permanently, let's say. Let's say you have to have a
3 mission statement that lays out the special things you're
4 going to do. Let's say you have to focus. You don't have
5 to be 100 percent, but my view is it shouldn't be much below
6 90 percent of whatever you're aiming at because I don't want
7 to be -- this is a little like hospice. A few people are
8 going to live a long time but let's not get too excited
9 about it as long as it's a very small group.

10 And what is the theory behind this? It is that if
11 you focus on one particular group, you can design delivery
12 systems that provide better quality care more efficiently.

13 Well, let's have a requirement that you have
14 special quality measures and report those out. And if you
15 are no better than Kaiser for those special ones for heart
16 folks, then that's sort of the floor. But if you're below
17 Kaiser on those special heart related ones, then we're
18 concerned about you. You really aren't fulfilling your
19 mission.

20 Now I'm a SNP and I'm coming along and I'm saying,
21 wait, you're asking me to do a whole lot of extra stuff that
22 these other guys don't and you're only going to pay me the

1 same. There will be risk adjustment but he gets the risk
2 adjustment, too. That doesn't seem fair.

3 So the theory behind this that makes it work
4 supposedly is by focusing on a specialized group like this
5 you have to be more efficient. There has to be economies of
6 doing this. And that's an untested hypothesis. I believe
7 that it should be true. And if we ever get pay for
8 performance, you should be getting an extra bonus because of
9 quality factors, as well.

10 DR. MILLER: So what are we disagreeing on?

11 DR. REISCHAUER: No, I was just articulating in a
12 comprehensive way what you were stumbling around trying to
13 say.

14 [Laughter.]

15 DR. REISCHAUER: I was answering her question.
16 She wanted to know where we'll sit and I sit with Jennifer's
17 -- they aren't recommendations because you're giving them
18 options but I'm down at the bottom on all of those.

19 MR. HACKBARTH: And I agree with everything you
20 said, and I'm not sure if this is a difference or not. Like
21 Nancy, I think that these things take time to organize and
22 develop. And I just caution being careful about too early

1 being too prescriptive and preventing the natural
2 development of it.

3 DR. REISCHAUER: We haven't even asked them to do
4 this at this point. We haven't asked them to say they're
5 going to do something special, set up some measures, things
6 like that.

7 MR. HACKBARTH: Again, I'm saying I agree with
8 that. I just think you need to be careful at the front end
9 about trying to draw it too tight and make it too demanding
10 or the entrance requirements too great if you think that
11 they're not doing harm relative to the generally unavailable
12 MA plans. If you think they're doing harm, then you club
13 them right at the beginning. But if you think they're as
14 good as but not achieving what we aspire to, be expansive
15 early, say this is what we want you to become, set targets
16 for it. But just don't close the gate too quickly too
17 early.

18 MS. THOMAS: We were talking about this internally
19 and specifically around the requirement to have a contract
20 with the state, which we think is kind of the hardest thing
21 from what we've learned.

22 And we said, you know, just because you can't be a

1 SNP right away doesn't mean you can't be an MA plan right
2 away and be getting all your ducks in line to go to SNP. I
3 mean, you can't choose your target population but you could
4 start negotiating with the state --

5 MR. BERTKO: But Jay's point is one of the
6 overriding -- I mean, there are really two populations here.
7 There are the duals, for which you need to have the special
8 benefits and the contract with the state and everything
9 organized. And then you have the chronic condition ones.

10 And you maybe offset a little bit one of the
11 things Mark said here, these people are first sick, I mean
12 poor, and then sicker. So they're somewhat sicker.

13 Rick adjustment generally works that the sicker
14 you are, the less close you are. that is you may be a
15 little underpaid to a lot underpaid, depending on how sick
16 you are. So if anything, in the sicker population you're
17 less likely to be selecting against in that direction.

18 The other point I wanted to make here is on the
19 chronic conditions one. Here's the one I think we need to
20 give a little more scrutiny. I think if they're going to be
21 chronic condition ones, they ought to be ones to which
22 clinical help could actually come to play. And they ought

1 to be scrutinized. I think Jennifer made exactly that
2 recommendation. And we ought to follow up with that.

3 MS. HANSEN: I appreciated the dialogue and I
4 really appreciated the paper, Jennifer, teeing this up. I
5 think this is probably the one area I do some background in
6 relative to some of the complexities.

7 Just by way of the context, but I do have three
8 points out of this context, is that the PACE program does
9 represent probably that example of the dual eligible most
10 frail. We are part of the whole rate setting and risk
11 adjusting that the MA system is there. So it's mainstream.
12 What is different is the frailty factor that is a multiplier
13 on top of that for this particular population.

14 And so it's actually based on two things. It's a
15 financing mechanism, but it's also a delivery system model.

16 And so the concern I have, and we have actually
17 probably negotiated with the equivalent of I think about 25
18 states now. So we have state work developed to deal with
19 the Medicare and the Medicaid relationship.

20 A little footnote as I think, Bill, I don't know
21 whether you were at GAO at the time. But I remember when
22 PACE first came to the table it was the first time, at that

1 point HCFA, Jack, that both Medicaid people and Medicare
2 people sat in the same room. So that difficulty of doing
3 that, but that's been a 15 year effort for us. But we have
4 about 25 states.

5 So the dual eligible is the section that I want to
6 speak to. And that is the ability to have a state contract,
7 as difficult as it is -- and I know because it oftentimes
8 takes five years to develop a state relationship and
9 contract.

10 But unless that piece is done for this most
11 vulnerable population, there's a lot of tossing back and
12 forth that occurs. And I know that, as part of the
13 Commission, I've raised it before and the idea of the
14 Medicaid population is always the -- that's when the curtain
15 kind of comes down. But the reality is these are people who
16 happen to just fit two categories, but they're Medicare
17 beneficiaries.

18 So somehow I think that kind of -- and I hope it's
19 within our lifetime that we can get to some of the issues
20 that Nancy brought up, but you still have to look at the
21 totality of this, that ultimately some of the care
22 coordination systems -- my one point here, when I first

1 looked at this, that some of the SNPs on the surface of just
2 the report and the way they've evolved, they've taken the
3 financing mechanism part.

4 It looks like the early stages of the physician
5 hospital organizations, there's a funding opportunity and
6 you get there. But it's not as simple to say we have a home
7 health agency, we have all these services. And on the
8 surface of it, it looks really good. But it's the same kind
9 of issue about culture change, of making sure that you
10 really are there for the beneficiary.

11 I think one of the examples was transportation.
12 It's great that an MA program may say that we have a service
13 there. But if you don't connect the Medicaid part and
14 coordinate it, then the beneficiary can't get to that
15 provider who's far away.

16 So I think that issue, number one, of just making
17 sure that -- the bottom line is I support the direction that
18 we're going. This is definitely really good. But I do want
19 the conditions that were specified to make sure that the
20 quality measures are appropriate. And I know that NCQA is
21 doing some of the added measures that may look at this.
22 NCQA has not typically focused on this kind of population.

1 The metrics that they've had for measures for Medicare are
2 broader level. They do not address this population. The
3 University of Colorado was given a contract by HCFA at that
4 time to really look at kind of the complexity of frail
5 populations. And that might be something to take a look at,
6 as to how far that has gone.

7 And then the Medicaid contracting, I guess is my
8 final point, is that it's just for that particular area. I
9 think it's something that still has to be looked at because
10 otherwise the beneficiary does get bounced between the two
11 systems. If the savings happens on the Medicaid side will
12 be done in a way that you dump it back onto the Medicare
13 side. So with the duals, especially for the medically
14 chronically complex, I do think that has to be really looked
15 at much more carefully.

16 And just the caveat that I support the direction
17 but I do want some of these quality benchmarks and the
18 Medicaid contracting to still be looked at.

19 DR. CASTELLANOS: My comments are pretty much like
20 Jennie just said. This vulnerable set of Medicare
21 population is really undermanaged. And to my opinion,
22 they're probably undertreated. And here we have an

1 opportunity perhaps to get some coordination of care and
2 setting up maybe a medical home as a definition for this
3 segment of the population. I would certainly set up some
4 quality measures so we know what we're getting and hopefully
5 get it.

6 Everybody said it, but it's not been put. I
7 definitely would get an expert panel for the chronic
8 illnesses.

9 The question I have is that some of these are not
10 required to contract with the states to provide Medicaid
11 benefits, Jennifer?

12 MS. PODULKA: That's correct.

13 DR. CASTELLANOS: Why?

14 MS. PODULKA: The why I can't answer. It seems
15 that the original enabling legislation -- it was very short
16 so it's broad and vague. And it seems as if at many
17 instances CMS has chosen not to further focus it. So a dual
18 eligible SNP means that you can enroll dual eligible
19 beneficiaries. And it doesn't really require anything past
20 that.

21 DR. CASTELLANOS: Do you think we should address
22 that issue?

1 DR. MILLER: That's one of the recommendations, is
2 that it would require it.

3 DR. CASTELLANOS: [off microphone] I hadn't heard
4 anybody say that.

5 DR. MILSTEIN: I am, I think along with others,
6 inherently worried about participation in what I think is a
7 program that offers a lot of opportunity for Medicare that
8 would be geared purely to structural characteristics. I
9 think I heard implicit in some of the prior comments this
10 notion that since this is an area of potentially a big
11 opportunity for Medicare, that is better management of this
12 population, that our hurdles for entry at some point in the
13 future would not only be structural, including reporting,
14 but also distinguish performance both on quality and
15 efficiency.

16 I think among other things it might mobilize
17 current deliverers to realize that their ability to continue
18 to be the Medicare Advantage type plan for these patients
19 would depend on actual results in reduced total spending and
20 improved quality.

21 One question, Jennifer. One of the existing
22 quality measures that Medicare Advantage plans are asked to

1 report is just beautifully tailored to this population but
2 it's not one I think that's currently routinely publicly
3 reported. It's the so-called HOS, Health of Seniors --
4 maybe it's called Health Outcomes Survey. But it's really a
5 focus on the degree to which health status changes in an
6 enrolled population over a 24 month period. It's sort of
7 the ultimate measure of impact of all of these process
8 measures on patients' ability to function in life, which is
9 the purpose of health care, is to raise that.

10 I wonder if we might, the next time we meet, be
11 able to see some results from the HOS survey that perhaps if
12 there's sensitivity about it being health plan specific
13 might at least show us that those numbers are moving more
14 favorably for SNP plans than for the equivalently high risk
15 enrollees in regular Medicare Advantage plans. It's an
16 early window on whether or not meaningful change in
17 improving patients' health is actually occurring as a result
18 of SNP plan enrollment.

19 MS. PODULKA: That's actually a very good
20 suggestion, and I can say that because we've started trying
21 to explore that. We're facing a data limitation with the
22 HOS survey. I need to clarify this, but I think there's an

1 issue where the current data are available at the contract
2 level but don't necessarily -- and I need to confirm this --
3 distinguish at the plan ID level.

4 So in instances where a parent organization, which
5 is the majority of them, offer SNPs along with regular MA,
6 we're not going be able to distinguish -- and this is just
7 preliminary. We're trying to see if we can get around this
8 if there's something to do. But we're definitely interested
9 in the HOS.

10 DR. MILSTEIN: Maybe at least we could focus in on
11 the SNP-only plans, so we don't run into that problem.

12 And also, it seems to me if we have information on
13 the ratio of SNP enrollment in plans, which it sounds like
14 we did based on the statistics, we could show comparative
15 results for plans that only enrolled SNPs and/or SNP
16 enrollment was over a certain percentage, as an early
17 indicator of whether or not the needle is being meaningfully
18 moved with respect to patients' ability to function in life.

19 MR. HACKBARTH: Any others?

20 MS. DePARLE: I really liked Ron's idea, when he
21 brought up the medical home. I just wondered if there's any
22 way to import that into this in some way?

1 MR. HACKBARTH: As a requirement?

2 MS. DePARLE: Yes.

3 MS. PODULKA: Actually, there was -- on the first
4 set of policy options that applied to all plans -- I didn't
5 express it as eloquently -- but there was a recommendation
6 that there be a mechanism to link enrollees to a health care
7 advisor or health advisor coordinator. But perhaps that's
8 sufficiently close to medical home and we could move towards
9 the medical home idea.

10 MS. DePARLE: I don't know if others like it, but
11 we've been struggling with that idea and we all think it has
12 merit and struggling with how we would do it in fee-for-
13 service. It seems to me if we can't do it here, then we
14 know it's going to be really hard to do it in fee-for-
15 service. It seems like a natural fit to me.

16 DR. CASTELLANOS: I'm going to tell you that in
17 clinical practice that this population, nobody else is going
18 to look at. This is an underserved, undermanaged
19 population. And most people try to avoid the Medicaid
20 patient.

21 DR. DEAN: I was just going to say, I don't know
22 any of the details but apparently North Carolina has

1 structured their Medicaid services around the medical home
2 concept and, what little bit I've heard, were very
3 enthusiastic that it really did make a difference. But I
4 only know the most preliminary --

5 MS. DePARLE: They came and presented here.

6 DR. DEAN: There apparently is some benefit.

7 MR. HACKBARTH: Thank you, Jennifer.

8 We'll now have a public comment period with our
9 usual ground rules, which are number one, identify yourself
10 and your organization; and number two, keep your comments to
11 no more than a minute or two. And number three, don't
12 repeat one another.

13 MS. SMITH: Hi, I'm Sherry Smith with the American
14 Medical Association. I staff the RUC.

15 Just a few things in defense of the RUC, first of
16 all, that the slide about the five-year review and the codes
17 that had been reduced is a little not representative of the
18 RUC in terms of its overall work through reviewing new and
19 revised codes, et cetera. Over 400 codes have been reviewed
20 through that process for overvaluation.

21 As Kevin mentioned, the RUC Iraq developed a new
22 technology flagging system in '05, and those codes are going

1 to start coming up for review as claims data is available.

2 Having said all that, the RUC agrees with the
3 Commission that the next five-year review does indeed need
4 to be different than the previous five-year review and has
5 therefore created a five-year review work group. They have
6 already been developing codes for immediate review. A
7 letter is going to CMS tomorrow that 100 codes should be
8 reviewed for site of service anomalies. So the RUC really
9 is making some significant progress since the last time you
10 met and spoke about this activity.

11 There was a number of other screens on the RUC's
12 agenda that they will be working through in coming meetings
13 to identify codes.

14 Having said that, the expectations about how much
15 money is really in the work RVUs for redistribution is
16 something that the Commission really needs to consider.
17 There are 6,500 codes with work RVUs, 3,000 have been
18 reviewed by the RUC. Of the remaining 3,500 codes, 2,400
19 are only performed or performed less than 1,000 times per
20 year on a national basis.

21 So another little factoid that we like to put out
22 is that even if Medicare were to cease payment for all

1 advanced imaging and redistribute that money back through
2 the system, there would only be a 6 percent increase in E&M
3 payment. So the expectations about how much overvaluation
4 is really in the work component of the RBRVS needs to be
5 considered.

6 MS. GORENC: Hi, my name is Theresa Gorenc. I'm
7 Director of Health Policy at the Medical Imaging and
8 Technology Alliance.

9 I wanted to comment on Mr. Winter and Mr.
10 Stensland's presentation from earlier this morning.
11 Unfortunately, just because of the brevity, did not have an
12 opportunity to get up here and speak about it.

13 MITA commissioned a study on the Medicare 2005
14 claims data specifically looking at the incidence of
15 physician self-referral. That was done by Direct Research
16 LLC.

17 The analysis that came out of that -- and I'd be
18 more than happy to share, we have hard copies available as
19 well -- was that the 2005 Medicare data suggested that there
20 is not widespread practice of self-referral in Medicare. In
21 fact, specifically looking at referrals for CT, MR, PET, and
22 SPECT, it was an average of 94 percent of the time the

1 physician that was performing that test was not the ordering
2 physician.

3 A couple of other things that we found in that was
4 that the majority of referrals for imaging services are made
5 by physicians who do not stand to realize a gain from that
6 referral.

7 And then lastly, looked at most imaging for
8 Medicare patients was actually done in hospitals, most of
9 the time in the outpatient arena, but was not done in the
10 physician offices.

11 So wanted to provide this data to you today, would
12 welcome the opportunity to discuss it further with Mr.
13 Winter and Mr. Stensland and the rest of the Commission, but
14 wanted to make sure that you had that available as you're
15 moving forward in your analysis of the Medicare claims data.

16 MS. BAJNRAUH: This is part two. I'm Heide
17 Bajnrauh with Arnold & Porter, but I'm here on behalf of
18 MITA, just on the packaging and bundling issues.

19 I wanted to point out that MITA commissioned an
20 analysis by an external research organization which
21 conducted a review of selected services that were proposed
22 by CMS for packaging. The analysis was conducted using

1 solely without HOPS limited dataset released by CMS and
2 derived from 2006 outpatient claims data up through December
3 2006.

4 The data showed a very large range in how often a
5 dependent HCPCS code is actually billed with one of the
6 independent HCPCS codes and vice versa. Our analysis
7 illustrate the percentage of independent codes that have a
8 dependent service billed with it.

9 It is important to note that although numerous
10 independent codes were billed with dependent services, the
11 dependent services were not necessarily the same HCPCS code.
12 The extreme variability we uncovered in the pairings of
13 dependent services with independent services demonstrates
14 the need for great caution in proceeding with any further
15 packaging until the large number of services and underlying
16 HCPCS codes can be examined to ensure that payment rules do
17 not disrupt appropriate provision of clinical services, they
18 maintain integrity of the payment structure, and ensure that
19 patients and providers can have confidence that Medicare
20 payment policies are equitable.

21 I have copies of the actual report, if anybody
22 would like to see them.

1 Thanks.

2 MS. WILBUR: Hi, I'm Valerie Wilbur with the
3 National Health Policy Group, and my organization represents
4 the SNP Alliance, which has about 30 special needs plans
5 organizations affiliated with it, including all three kinds
6 of SNPs across the country and the demonstrations that were
7 the predecessors of SNPs.

8 I promise I'll try to keep my comments brief and
9 submit some comments in writing.

10 But one of the first issues I wanted to raise is
11 about payment. When you look at the benchmarks and the
12 payments going to SNPs across the board, the question I have
13 to raise is isn't the payment structure as it's currently
14 set up providing an incentive to have SNPs not target
15 specifically the sickest population?

16 Two examples I'd like to give us we have a member
17 that wanted to set up a chronic condition SNP, and they
18 wanted to target three particular -- people that have three
19 or more chronic conditions out of a list of 130 that Hopkins
20 came up with. But based on the research done by their
21 actuaries, it indicated that if they focused on the people
22 in the top third of the highest risk category, they wouldn't

1 be financially viable. In fact, they'd lose about \$700 per
2 member per month after they reduced hospitalization by 40
3 percent and nursing home placement by 20 percent.

4 So actuaries that we've spoken with would tell you
5 they advise their clients not to target all the people at
6 the highest end because the current payment methodology
7 doesn't sustain it.

8 What we've been asking CMS for for a long time and
9 what we'd ask you look at, as well, is instead of looking at
10 SNPs across the board, if you could focus in on some of the
11 programs like the demonstrations that have risk scores
12 anywhere from 1.5 to 2.6, and look at how the current MA
13 risk adjustment system works for them, I think you'd see the
14 reason why there are a lot of SNPs out there that aren't
15 really targeting the high-risk population. So that's one
16 issue I wanted to raise.

17 The second issue I wanted to talk about is quality
18 measures. By the way, I think a lot of the recommendations
19 are excellent and my SNP organization would be very
20 supportive of them, including the quality measures. We
21 think it's really important that CMS and NCQA is doing this
22 work to identify some different kinds of measures that

1 really are going to look at chronic illness care needs and
2 how well SNPs are doing to really focus in on this special
3 things. And if we don't have good quality measures that are
4 SNP specific, we're not going to really be able to show
5 whether they're doing what they're supposed to be doing,
6 when Congress expects. So we're really glad to see those
7 recommendations.

8 On the dual contracts, one of the gentlemen asked
9 why doesn't CMS require Medicaid contracts for the dual
10 SNPs? What CMS has told us is it's straightforward. It's a
11 Medicare Advantage product. Congress didn't require them to
12 have a contract. And as Jenny and some others around the
13 table pointed out, it's very challenging. There's a number
14 of demonstrations, three in particular, that have focused on
15 integrating Medicare and Medicaid for the duals that, as has
16 been pointed out, has taken five years or more to get good
17 contracts.

18 We support contracts for dual SNPs. We think they
19 should be doing coordination. Some of the challenges that
20 have been mentioned could be addressed by, in the short-
21 term, allowing Medicare only SNPs until states get up to
22 speed. But we also think that there should be some

1 incentives for states, like sharing some of the CMS savings
2 from the Medicare rebates with the states to help them set
3 up that infrastructure.

4 And also, we think CMS should be doing more to
5 support states and SNPs that want to develop integrated
6 products.

7 One of the discussion points that was made is are
8 dual SNPs really that important? Are they special? Should
9 we continue them? And I think the integration function is
10 critical. Beneficiaries that are dually eligible have
11 tremendous administrative challenges in terms of having two
12 different enrollment processes, different marketing
13 materials coming at them. It's very confusing. And we've
14 seen some good progress on the integration side with these
15 three demos, but they're starting to slip.

16 Somebody mentioned about the duals being a
17 financing vehicle for integrating Medicare and Medicaid.
18 But because Medicare requires this new bid process, it's not
19 as easy to combine those financing mechanisms and use those
20 pool of dollars, so to speak, for whatever the
21 beneficiaries' needs are because you have to account for
22 those two different products separately. So it's not as

1 easy to do that as it used to be before the bidding process
2 came along.

3 The last point I'll make, and excuse me for taking
4 so much time, is on the chronic condition SNPs, we've had,
5 among the Alliance, so much conversation about how do you
6 define a chronic condition SNP. We finally came down to the
7 idea that we don't support the idea of a list because it's
8 too limiting if somebody -- you'd have to go back to
9 Congress every time you wanted to have different kind of a
10 chronic condition SNP.

11 The other thing is we like the second idea that
12 Jennifer talked about, where you have complex care
13 management criteria to define what is a chronic condition
14 SNP. In fact, we recommended, along with what the House
15 said, either a risk score of 1.35 or that somebody would
16 have a chronic condition plus comorbidities as an indication
17 of complexity. Or that somebody is eligible for Medicare
18 because they meet the ESRD or the disability criteria. So
19 we would be supportive of that.

20 And with that, thank you very much for your time.

21 MS. SUPER: Hi, I'm Nora Super with AARP.

22 I just wanted to follow up on the SNP discussion

1 and agree with what Jack Ebeler and Nancy-Ann DeParle said.
2 If you all can come out with recommendations before March,
3 that would be very helpful. We don't have an opinion or an
4 official position as an organization yet on SNPs, although
5 we've been asked to do so.

6 The legislation, as you know, has been passed in
7 the House and has very strong provisions on SNPs. The
8 Senate is moving through quickly to come up with their own.
9 And they may be finished before December, maybe not, but
10 they probably will decide whether to reauthorize them before
11 the end of the year.

12 So if you want to have an impact, there are many
13 organizations that look to MedPAC, including ours, for
14 recommendations on these types of policy questions. So we
15 would encourage you to please make some sort of statement
16 before March.

17 MS. FISHER: Hi, I'm Karen Fisher with the
18 Association of American Medical Colleges.

19 For those of you who are newer to the Commission
20 and aren't familiar with my organization, we represent all
21 of the allopathic medical schools in the country but also of
22 the major academic medical centers, the major teaching

1 hospitals. Hence, why I'm at the podium today.

2 I wanted to talk a little bit about outliers and
3 very theory because I think what we'll do is do some follow
4 up discussion with the staff.

5 First, let me say that I think it's an appropriate
6 time to talk about outliers, given the implementation of new
7 Medicare severity DRGs. It's an important discussion to
8 have and we welcome that.

9 We'd like it to be a little bit broader than
10 quickly moving to what the marginal cost threshold should
11 be. I think everyone would agree how important outlier
12 payments are to any payment system. You do not want to have
13 a payment system that has incentives for hospitals to avoid
14 very costly patients. And you also want to have a system, I
15 think, that helps compensate those hospitals who are going
16 to treat the patients regardless. So we welcome that
17 discussion.

18 I did want to emphasize what Dr. Reischauer
19 pointed out, that at least for teaching hospitals that treat
20 a lot of cases that end up being outliers, what we hear
21 anecdotally is they can tell them coming in the door, that
22 they are train wrecks coming in the door and they know they

1 are going to be an outlier case. And it's worth emphasizing
2 that a teaching hospital does not receive an outlier payment
3 for a case they treat until they receive the DRG payment,
4 plus the IME, plus the DSH, plus incur \$25,000 in net
5 losses.

6 So while people may think that DSH payments are
7 being used for uncompensated care, one needs to remember
8 that for many teaching hospitals DSH payments are actually
9 going to treat complex patients in these scenarios.

10 We would suggest that as you continue to think
11 about this, that you look at the fixed loss threshold. Is
12 \$25,000 reasonable? Maybe the pool should stay the same and
13 the fixed loss threshold should be lowered. I don't know
14 the answer to that but I think it's a discussion worth
15 having.

16 And some additional datapoints, such as CMIs
17 associated with outlier case, what is the average loss
18 associated with an outlier case? We know it's at least
19 \$25,000 plus 20 percent. But it may be much more than that.

20 What about transfer cases? How many transfer
21 cases turn out to be outlier cases? That type of
22 information we think might help your discussion as you

1 continue to think about this issue.

2 Thank you.

3 MR. HACKBARTH: Okay, we reconvene tomorrow at
4 9:30.

5 [Whereupon, at 5:44 p.m., the meeting was
6 recessed, to reconvene on Thursday, October 4th, 2007 at
7 9:30 a.m.]

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22

PUBLIC MEETING

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

Thursday, October 4, 2007

9:35 a.m.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21

COMMISSIONERS PRESENT:

- GLENN M. HACKBARTH, J.D., Chair
- ROBERT D. REISCHAUER, Ph.D., Vice Chair
- MITRA BEHROOZI, J.D.
- JOHN M. BERTKO, F.S.A., M.A.A.A.
- KAREN R. BORMAN, M.D.
- RONALD D. CASTELLANOS, M.D.
- FRANCIS J. CROSSON, M.D.
- THOMAS M. DEAN, M.D.
- NANCY-ANN DePARLE, J.D.
- DAVID F. DURENBERGER, J.D.
- JACK M. EBELER, M.P.A.
- JENNIE CHIN HANSEN, R.N., M.S.N., F.A.A.N
- NANCY M. KANE, D.B.A.
- ARNOLD MILSTEIN, M.D., M.P.H.
- WILLIAM J. SCANLON, Ph.D.
- BRUCE STUART, PH.D.
- NICHOLAS J. WOLTER, M.D.

1 AGENDA

PAGE

2

3 Hospice payment issues

3

4 -- Jim Mathews

5

6 Expert panel on value-based insurance design

7

8 -- A. Mark Fendrick, M.D., Co-Director of the

52

9 University of Michigan's Center for Value-Based

10 Insurance Design, and Professor in the University

11 of Michigan's Departments of Internal Medicine

12 And Health Management and Policy

13

14 -- Jill A. Berger, Vice President, Health and

73

15 Welfare Plan Management and design for

16 Marriott International, Inc.

17

18 -- Michael Chernew, Ph.D., Professor in the

85

19 Department of Health Care Policy at Harvard

20 Medical School

21

22 Public Comment

133

1

P R O C E E D I N G S

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22

MR. HACKBARTH: The first topic for today is hospice.

DR. MATHEWS: Good morning. It's been awhile since I've been up here.

My discussion this morning will be the first in a series of presentations that we'll cover through the fall on Medicare's payment system for hospice. These presentations will look at a number of issues, including payment adequacy, definition of the hospice benefit, changing demographics of hospice patients, and the effects of the aggregate average per beneficiary payment limit which is better known as the hospice cap. The cap, as you know, has been considering a greater amount of attention as greater numbers of hospices are reaching it.

This morning we will look at the cap in some detail. I will describe which hospices are reaching the cap, offer an explanation as to why they're reaching it, and lay out a couple of different analysis that we plan to pursue throughout the fall. I'll also try and put this information in the context of the larger hospice payment system.

1 Before I begin discussing the analyses specific to
2 the cap, I wanted to take a minute and review some of the
3 basics of the Medicare hospice payment system. Hospice is
4 an end-of-life benefit available to beneficiaries with
5 terminal illness and a prognosis of likely death within six
6 months.

7 In electing hospice, beneficiaries can receive a
8 wide range of palliative care and other services both for
9 themselves and their families. In exchange, beneficiaries
10 electing hospice relinquish further curative treatments for
11 their terminal condition. Beneficiaries elect hospice for
12 defined periods, each of which requires physician
13 certification of the patient's prognosis. Medicare pays per
14 diem amounts for each of four types of hospice care, which
15 you see on this line here, and the program makes these
16 payments for as long as the patient is covered by hospice,
17 regardless of whether a visit is actually provided on a
18 given day.

19 There is minimal Medicare cost-sharing under
20 hospice.

21 Medicare spending for hospice grew at on average
22 annual rate of about 23 percent between 2000 and 2005,

1 reaching \$8.1 billion in that year. Spending is projected
2 to exceed \$10 billion in fiscal year 2008. Spending is
3 driven by greater numbers of beneficiaries electing hospice
4 and by more spending per hospice patient. Both of these
5 metrics increased by about 11 percent per year on average
6 between 2000 and 2005.

7 Since Medicare pays for hospice on a per diem
8 basis, spending per enrollee is largely, albeit not
9 entirely, a function of the length of time a patient is
10 enrolled in hospice. We have previously pointed out that
11 there is a lot of variation in hospice length of stay for
12 patients who died in any given year and that longer stays
13 are increasing, both in length and as a percent of total
14 stays. Between 2000 and 2004, hospice lengths of stay at or
15 below the national median were flat or had declined very
16 slightly. Stays above the median increased in length,
17 especially very long stays.

18 Our preliminary estimates for 2005, which you do
19 not see on this slide, reflect a continuation of these
20 trends. Length of stay at or below the median were
21 virtually unchanged from 2004, while stays above the median
22 continued to grow rapidly. Length of stay for decedents at

1 the 90th percentile of the distribution now appears to
2 exceed 200 days.

3 As a point of reference at the very extreme end of
4 the curve, at the 99th percentile length of stay is about
5 three years for both 2000 and 2005.

6 As I just mentioned, length of stay is a primary
7 driver in the increase in spending for beneficiaries.
8 Spending -- or from the hospice's perspective payments per
9 beneficiary -- is important because it can trigger one of
10 two Medicare hospice payment limits. The first of these
11 limits the share of Medicare inpatient days to 20 percent of
12 a hospice's total Medicare days. Beyond this threshold, the
13 program pays for all days of care at the routine home care
14 rate. This payment limit was implemented to ensure that
15 hospice did not become a substitute for inpatient care. I'm
16 not going to spend any more time talking about it this
17 morning, since this limit is rarely if ever triggered.

18 The second one is going to be the subject of the
19 rest of my discussion this morning. This is the aggregate
20 average per beneficiary payment limit, and I'll refer to
21 this as the hospice cap for the rest of the presentation.

22 Medicare limits the average payment per

1 beneficiary fungible across all of the hospice's patients.
2 The limit is \$21,410 in the current cap year. For example,
3 if the hospice had 250 Medicare patients in a given cap year
4 it's Medicare payments would be limited to just over \$5.3
5 million. The hospice would have to return payments in
6 excess of this amount to the Medicare program.

7 A small but growing number of hospices reach the
8 cap each year. Last year the fiscal intermediaries that
9 process Medicare hospice claims reported that about 5
10 percent of hospices reached the cap in 2004. To investigate
11 the characteristics of these hospices so that we can better
12 understand why they reached the cap, we created a payment
13 and utilization model using Medicare claims and provider of
14 services data and Medicare hospice cost reports. This model
15 allows us to go beyond the aggregate FI numbers and describe
16 these hospices in more detail. I want to state that these
17 and the following numbers are preliminary and subject to
18 revision as we refine these analyses in the months ahead.

19 On this slide you see first order results of our
20 model. The number of hospices reaching the cap increased
21 from roughly 2 percent of all hospices in 2002 to about 6
22 percent in 2005. Hospices reaching the cap represent a

1 smaller share of overall payments for hospice, however, only
2 about 1.5 percent in 2005, indicating that these hospices
3 are generally smaller on averages than those hospices that
4 did not reach the cap.

5 We also compared cap hospices and non-cap hospices
6 by several other characteristics. This is a very busy
7 slide, and I apologize, it's sort of information dense.
8 I'll try and tease out the salient points as best I can but
9 please bear with me if it bogs down.

10 The top row of this table shows the number of
11 hospices reaching and not reaching the cap in 2002 and 2005.
12 Again, about 2 percent of hospices reached the cap in 2002
13 and just over 6 percent in 2005.

14 Urban/rural status does not appear to have much
15 effect on whether a hospice is likely to reach the cap.
16 Ownership does seem to be a major factor, however. In all
17 years from 2002 to 2000 nearly all hospices that reached the
18 cap were proprietary, making up about 1.7 percent of all
19 hospices in 2002 compared to cap hospices compose a 1.9
20 percent of the total. You can see those numbers highlighted
21 in yellow in the leftmost column.

22 In 2005, proprietary hospices reaching the cap

1 made up about 5.3 percent of hospices. That's the number in
2 green about halfway down that chart. Again, a large share
3 of the 6.1 percent of cap hospices overall.

4 These trends are similar for freestanding
5 providers and here what we'll consider in the future
6 analysis is the role of the parent provider in discharging
7 payments to hospices. It might be skewing the freestanding
8 versus provider-based representation in the cap hospice
9 population.

10 Lastly, these data show average annual caseload
11 and, for freestanding facilities, average length of stay for
12 cap hospices compared to hospices that did not reach the
13 cap. Hospices reaching the cap tended to be smaller in
14 terms of their average patient count, 190 patients on
15 average in 2002 compared to 308 for non-cap providers. And
16 for 2005 about 220 patients on average compared to 339 for
17 non-cap hospices. They also had lengths of stay that were
18 about 54 percent greater than non-cap hospices in 2002 and
19 107 percent greater in 2005.

20 So again, a very dense slide, but there are three
21 take away points that I'd like to bring home. One, the
22 hospices that reach the cap are disproportionately

1 proprietary and freestanding. Two, they generally have a
2 smaller patient load. And three, they have a longer length
3 of stay, on average.

4 We closely examined cap versus non-cap hospices
5 length of stay, given the impact of this metric on hospices'
6 likelihood of reaching the cap. Here we used claims data,
7 which permitted us to calculate length of stay for all
8 hospices, not just the freestanding providers that we
9 displayed on the previous slide. The different data source
10 is also why the numbers are somewhat different between the
11 two slides. If you want, we can have a conversation about
12 the specific elements of each of the data sources that we've
13 used here and their strengths and limitations.

14 Here we compare several measures of length of stay
15 for hospice patients, cap hospices compared to others in
16 2005. Patients at cap hospices had median lengths of stay
17 over three times that of patients at non-cap hospices, 71
18 days compared to 19 days; and twice that average length of
19 state -- 111 versus 55 -- relative to non-cap hospices.
20 Further, stays of more than 180 days -- and this is the
21 presumptive eligibility period, a six-month prognosis of
22 likely death -- represented about 40 percent of episodes at

1 cap hospices compared to less than 15 percent of episodes at
2 non-cap providers.

3 Given these fairly striking differences, in length
4 of stay by cap status we investigated further as to why this
5 might be the case. Again, another dense slide here. My
6 apologies.

7 As I mentioned earlier, a major factor that drives
8 hospices to reach the cap is patient length of stay. Length
9 of stay is highly correlated with the diagnosis that is the
10 primary cause of admission to hospice. Some diagnoses as
11 you see here, such as Alzheimer's disease and chronic
12 ischemic heart disease, have relatively long lengths of
13 stay. Further prognosticating the likely remaining life
14 span of patients with terminal stages of these diseases is
15 something of an inexact science.

16 By contrast, patients presenting with diagnoses of
17 renal failure or sepsis, down at the bottom of the screen
18 here, have much shorter lengths of stay on average.

19 Because of the association between diagnosis and
20 length of stay, we hypothesized that cap hospices may be
21 treating a disproportionate number of patients with
22 conditions that typically have longer lengths of stay. If

1 so, the caps may be unduly impeding access to hospice for
2 these patients and adversely financially affecting the
3 hospices that treat them.

4 When we compared the patient mix of hospices that
5 did not reach the cap to those that did, we made two
6 significant findings. Again, this slide and the next slide
7 are going to have a lot of numbers here but I do need to
8 spend a minute or two with them, so again please bear with
9 me.

10 Going back to the two findings, first we found
11 that the eight highest volume admitting diagnoses for cap
12 hospices were the same as for non-cap hospices in 2005,
13 albeit in a slightly different order. These eight diagnoses
14 represented 46 percent of Medicare admissions to non-cap
15 hospices and 53 percent of admissions to cap hospices. So
16 mix of services alone doesn't appear to account for hospices
17 hitting the cap although again, as I mentioned previously,
18 the cap hospices are on average smaller and so even subtle
19 changes in the proportional representation of these
20 diagnoses could have a disproportionate effects relative to
21 hospices with larger caseloads. We're going to pursue this
22 further.

1 The second significant finding is that despite the
2 similarity of service mix across the two groups of hospices,
3 cap hospices had significantly longer lengths of stay across
4 all eight of these diagnoses, ranging from 29 percent longer
5 for lung cancer to 162 percent longer for patients with
6 general cerebrovascular disease. In fact, of the 50 highest
7 volume diagnoses that made up 85 percent of hospice volume
8 in 2005, cap hospices had length of stay that exceeded those
9 of non-cap hospices for 47 of these diagnoses.

10 We do not yet fully understand what accounts for
11 these different patterns of care, but again it does not seem
12 to be patient mix per se. Other factors that could push a
13 hospice to reach the cap include the mix of visits hat it
14 provides. A hospice for which patient care composes 10
15 percent of its patient days has a greater risk of reaching
16 the cap than one for which inpatient visits represent 2
17 percent of its total days.

18 Patients who use more than one hospice may also
19 affect a hospice's likelihood of reaching the cap. The cap
20 is proportionally allocated by the number of days of hospice
21 care a patient receives, so the hospice treating a patient
22 who, either previously or subsequently, has a very long

1 length of stay at another hospice may be pushed towards the
2 cap for reasons above the short stay hospice's ability to
3 control. Again, I can talk about this in a little bit more
4 detail under the context of technical fixes to the cap.

5 Hospices may also reach the cap because they are
6 unable to admit a mix of short and long stay patients.
7 Alternatively, hospices may seek out and promote long stay
8 patients out of belief in the value of hospice care at the
9 end of life or as part of an explicit business strategy.

10 We've heard anecdotal evidence that the length of
11 time that a hospice has been a Medicare participating
12 provider in a specific market may also factor in to whether
13 it reaches the cap as well as the saturation of individual
14 hospice markets. We plan on analyzing the patient mix of
15 all hospices in markets where there are significant numbers
16 of providers reaching the cap to further assess these
17 questions. There may be other factors, as well, and I would
18 be happy to entertain ideas you have about directions we
19 should pursue over the course of the next couple months.

20 We also modeled how constrictive the cap is in
21 terms of limiting hospices' ability to provide care for
22 patients with long lengths of stay. Here we took half a

1 dozen diagnoses, each of which has among the longest average
2 length of stay, and which account for a notable share of
3 hospice volume. For modeling purposes we took a point at
4 the high end of the length of stay distribution for each of
5 these diagnoses, the 75th percentile, which is the second
6 numeric column up there. We also calculated payments in a
7 high wage area, New York City, and assumed that the mix of
8 care roughly followed national averages, in this case 95
9 percent of care being routine home care and 5 percent being
10 general care.

11 The high wage component here is important because,
12 as you'll recall from your paper, the cap is not adjusted
13 for differences in local wages, whereas payments are. So
14 hospices in a high wage area theoretically would be able to
15 provide fewer numbers of visits than hospices in low-wage
16 areas, all else being equal.

17 So this group of patients with lengths of stay at
18 the high-end of the distribution for diagnoses with
19 typically longer than average lengths of stay in a high wage
20 area would generate just over \$7 million in payments, well
21 under the applicable cap limit of \$7.5 million.

22 So it's true that in no circumstance, based on our

1 analysis, does the cap accommodate the full 180-day
2 presumptive eligibility period. But when you look at the
3 empirical distribution of lengths of stay by diagnosis, the
4 cap does give providers a fair amount of room to provide
5 care to long stay patients. In essence, under this model
6 here nearly all of the hospice's patients could fall into
7 this category and the provider would still remain under the
8 cap.

9 That said, there are some technical problems with
10 the cap that could and probably should be fixed and these
11 are, again, outlined in your paper in a little bit more
12 detail. These fixes would improve the equity with which
13 it's applied to the hospice provider community.

14 In evaluating how to address the hospice aggregate
15 per beneficiary payment limit, it is important to consider
16 these potential actions in the context of the broader
17 Medicare payment system for hospice. This is a payment
18 system that is ripe for a major overhaul and there are many
19 different forms that this overhaul may take. You may wish
20 to start thinking now strategically about what the hospice
21 payment system should look like in the future and the kind
22 of steps that would need to be taken in order to achieve

1 that vision.

2 Again, as I mentioned earlier, over the course of
3 the next couple of months we've got half a dozen, eight or
4 10, different analyses of hospice payment that we'll be
5 looking at and we'll be bringing these to you over the next
6 couple of meetings.

7 We will continue to look at cap issues. We will
8 also continue to refine our payment model, especially with
9 respect to these patients that I mentioned earlier who
10 receive care from more than one hospice because they do
11 present some particularly acute potential inequities in
12 treatment of hospice with respect to the cap.

13 Additionally, we will be analyzing the adequacy of
14 Medicare's payment to hospice including hospice margins. We
15 will be analyzing the composition of hospice's costs and
16 look at patterns of utilization among different demographic
17 slices of Medicare population.

18 We are also planning to but have not yet embarked
19 on analyzing certain physician issues related to hospice
20 care. As you'll recall from a previous discussion, of all
21 of the services covered under the hospice benefit, spending
22 for physician services has been growing faster than any of

1 the other ones and so we'll be looking at some of the
2 factors driving that growth.

3 I hope that these analyses will be helpful to you
4 as you do consider how the hospice benefit should evolve.

5 Lastly, just one note I want to make is that, as
6 noted in your paper, over the summer CMS issued new guidance
7 to hospice providers that requires them to begin reporting
8 detailed information on the services they provide on their
9 Medicare claims beginning in 2008. MedPAC has previously
10 recommended that CMS collect this kind of information and we
11 believe that it will be essential for informing the
12 evolution of the hospice payment system. However, the
13 hospice community has expressed some concerns about the
14 specific data elements that CMS has asked for and the
15 timeline on which the hospice providers have to provide this
16 data. So we'll be working closely with CMS and the industry
17 as appropriate to monitor how this process evolves and
18 ensure that the goal of the data collection effort which we
19 do support achieves its desired result.

20 With that, I will end my presentation and stand by
21 to answer any questions you have or otherwise facilitate any
22 follow-up discussion.

1 MR. HACKBARTH: Thank you Jim. Well done.

2 MS. DePARLE: Thanks, Jim.

3 We've talked about this a couple of times and this
4 was a great paper. It had a lot of interesting information
5 in it, especially on the cap. My concern has been that
6 through no fault of their own some hospices are serving
7 patients in the way they're supposed to be serving them and
8 then getting hit with this cap.

9 In particular, I've been concerned about the
10 retrospective way that it operates. You alluded to
11 technical problems or things that maybe could be done
12 better. And I would hope that we look at the administration
13 of it, depending on where we go with this. But it is
14 unpleasantly reminiscent of the home health interim payment
15 system to me, in the sense that you're going back to
16 providers after they've provided services -- I don't know,
17 is it a year later or 18 months later? A long time.

18 Especially, as you point out in the paper, these
19 providers are, in general, very Medicare dependent. Much of
20 their caseload is Medicare. And you're going back to them
21 and saying you owe us millions of dollars. And that is just
22 not a prescription for a good system or relationship. So I

1 would hope we could look at that.

2 The chart on page seven I had a question about,
3 which is this is in your analysis of hospices reaching the
4 aggregate per beneficiary payment cap. I wondered if this
5 is consistent with what CMS says about the number of
6 hospices reaching the cap?

7 MR. MATHEWS: These numbers are a little bit
8 different. The numbers that CMS reports, I believe, are the
9 ones that are derived from the fiscal intermediaries, who
10 are responsible for keeping track of which providers are
11 reaching the cap and then issuing the subsequent demands
12 notices for repayment for those providers who have exceeded
13 the cap.

14 In the past, we've only had access to the
15 aggregate numbers that the FIs have provided, which did not
16 permit us to kind of dissect them at an elemental level to
17 kind of see what kind of characteristics they had. So we
18 constructed this model independently using our own data.
19 Again, I mentioned we used claims, we used cost reports, and
20 we used provider of services data.

21 In order to get into our analytic dataset for
22 purposes of presenting this information, a hospice had to be

1 represented on all three of those files for purposes of
2 being able to complete a complete record for that provider.

3 As a result, we lost -- I want to say, if I
4 remember correctly -- about 15 percent of providers that did
5 not have at least one of those datasets. So the numbers
6 that we generate here with respect to the counts of
7 providers and the dollar amounts are somewhat lower than
8 what CMS has reported that the FIs have told them.

9 So I've tried to inflate the number of hospices
10 subject to the cap and input the payments associated with
11 them. But those are estimates and they do fall into the
12 category of things that we'll continue to work up.

13 But these numbers are, at least with respect to
14 the counts and the dollar amounts, a little bit lower than
15 what CMS has reported.

16 MS. DePARLE: Just somewhat lower.

17 DR. MILLER: [off microphone] [inaudible] ...we
18 were getting 4.8 in 2004; is that right? And CMS was
19 getting --

20 DR. MATHEWS: About 5 percent. They're close.

21 MS. DePARLE: That's close enough for me. But the
22 thing I'm wondering about is different, is it grosser?

1 Because I have met with some not-for-profit and some for-
2 profit hospice providers and trade associations and I know
3 you have. You may have a better recollection of their data
4 than I do.

5 I recalled a chart that showed a much bigger
6 percentage of all hospices. They weren't breaking it down
7 like this, I don't think, that were getting cap letters from
8 the intermediaries or subject to the cap. Glenn, does that
9 ring a bell to you, too?

10 So I'm trying to put those two together and figure
11 out why their number -- it may be a problem regardless, but
12 it certainly seemed like a much bigger problem based on the
13 numbers they had than what you seem to be finding.

14 DR. MATHEWS: I can't recall the number of
15 providers, but the dollar amount that I have seen reported
16 in the media is about \$200 million. I cannot recall if
17 that's 2005 or 2006.

18 MS. DePARLE: Maybe I'm just wrong then.

19 MR. HACKBARTH: I don't have a specific
20 recollection, Nancy-Ann, but I do know that the one
21 association that we both met with, one of the calculations
22 they did, as I recall, excluded certain types of hospices,

1 provider-based hospices, and they tried to focus on the
2 freestanding and got higher percentages exceeding the cap as
3 a result of that. It may be that number is sticking in your
4 head.

5 MS. DePARLE: That could be. And the other thing
6 -- and you alluded to this in the paper -- but it appeared
7 that there is one fiscal intermediary that has a very large
8 percentage of agencies reaching the cap. I think that's
9 also something that you want to look into further, you said,
10 and I'm interested in learning more about that.

11 DR. MATHEWS: We'll definitely talk to all of the
12 intermediaries who process hospice claims. But again I
13 would point out here that the model we put together was
14 unconstrained by FI and we're still getting estimates that
15 are defensibly close to what has been reported previously,
16 close enough that I feel comfortable putting them up in a
17 public forum here.

18 So to the extent that one FI is acting differently
19 in how they calculate the cap, I would have expected to see
20 a somewhat different and broader set of numbers than in this
21 analysis.

22 MS. DePARLE: And then finally, on page eight in

1 that chart, you do the breakdown of the different types of
2 hospices and this was very helpful. It appears that those
3 that have a higher average number of patients per year are
4 less likely to be the ones hitting the cap. So just for
5 example, this 339 average number of patients, do you have a
6 breakdown of how many of those patients are, on average,
7 cancer diagnoses versus the other diagnoses?

8 I'm surprised that you seem to have found
9 differently than what I have been told, that it's the trend
10 towards non-cancer patient population in hospice that seems
11 to be driving this problem with the cap. It sounds like you
12 have not found that to necessarily be the case.

13 So I was just wondering what is this average
14 number of patients? Does that show a higher number of
15 cancer diagnoses when you have a larger number of patients?
16 Or does it not show that.

17 DR. MATHEWS: I would refer you to slide 11 that
18 breaks out number of diagnoses and share of total cases by
19 cap versus non-cap status for the top eight diagnoses here.
20 We have this information broken down all the way to the top
21 50. What I could anticipate doing next time, if you'd like,
22 is I've written some code to roll these up according to

1 certain categories. So rolling up all cancer diagnoses,
2 rolling up all chronic heart diagnoses. And I could show
3 you how that breaks out by cap versus non-cap. And that
4 would get rid of potentially some of the noise that occurs
5 with breaking out lung cancer from pancreatic cancer to
6 prostate cancer, that sort of thing.

7 But here you can see, when you roll up these top
8 eight diagnoses, they represent a comparable share of total
9 patient cases for cap versus non-cap hospices. Now again,
10 there are some differences in the relatives here that, for
11 example, congestive heart failure, which is one of your
12 longer stay diagnoses, represents a greater share of cap
13 patients than non-cap patients. Again, if cap patients are
14 smaller, those differences in share can have
15 disproportionate effects that might cause them to be more
16 likely to hit the cap.

17 Again, we'll pursue this further. And one of the
18 analyses that I mentioned that we're embarking on now is on
19 a market-by-market basis looking at the composition of
20 diagnoses for cap hospices compared to non-cap hospices in
21 that specific market. So we'll look at are there
22 differences relative to the mortality profile of the market

1 that can be observed between hospices that hit the cap and
2 those that don't.

3 MS. DePARLE: And that's reminding me of one more
4 point which, Mark, you and I have discussed. If you have
5 the time or the ability to do this, it might be interesting
6 to look at the availability of other venues of care that
7 might be viewed, perceived as being analogous or a
8 substitute for hospice. We've talked about this.

9 DR. MILLER: I've been looking for a way to get
10 more of Jim's nights and weekends picked up by MedPAC.

11 But I think your original intuition is the point
12 that kind of came out of this. What you hear in the media
13 is the mix of diagnoses is driving people over the cap.
14 What Jim is at least raising a question about is when you
15 look across diagnosis, you see a difference across all
16 diagnoses in terms of length of stay. And so it's not quite
17 what we've been hearing, and that's what we need to delve
18 into more deeply.

19 But I'm not missing your last point about looking
20 at supply.

21 DR. CASTELLANOS: Jim, I thought that was a great
22 report and I happen to be very involved in the hospice from

1 a clinical viewpoint.

2 One of the issues that I see is what Nancy-Ann
3 said, there's some variability as to what care each of the
4 hospices provide. I'm not quite sure if the guidelines are
5 as clear, specifically on palliation for using radiation
6 therapy or chemotherapy. That's really important,
7 especially in cancer patients. It seems to me that some of
8 the hospices do it and some don't. I'm not sure if it's a
9 guideline issue or what, but you may want to look into that.

10 Specifically, maybe looking at why patients
11 transfer from one hospice to another. Are they transferring
12 for that reason or other reasons? That may do that.

13 Another issue you brought up, and it needs to be
14 clarified, as you know CMS is now requiring them, in their
15 cost report, to provide the additional information in
16 January. They are just asking for RNs and aides. But as
17 you know, hospice is a team effect. It's not just nurses
18 and aides. It's bereavement, it's pastors, it's social
19 workers. And these are all cost issues and they're not seem
20 to wanting to capture than data. And I know that's a cloudy
21 issue, but you may want to look into that.

22 Again another issue, and I'm not sure if it's

1 appropriate, but there seems to be four or five large chains
2 of for-profit hospices and there's some feeling in the
3 industry that these chains -- excuse my language -- but take
4 easier patients. You may want to look specifically at
5 whether the chains really do have a significant difference
6 than perhaps the nonprofit or the community-based hospices.

7 Thank you.

8 DR. MILSTEIN: Is there any research evidence that
9 would shed light on the following question: if Medicare
10 reimbursement of hospices were to shift in the direction of
11 encouraging longer lengths of stay across all diagnoses and
12 toward shifting mix toward diagnoses that have less
13 determinable prognoses, whether or not Medicare total
14 spending would likely increase or decrease? I'm a little
15 unclear as to what other services we're substituting for if
16 we were at the margin to modify reimbursement to encourage
17 the two underlying trends.

18 DR. MATHEWS: Let me see if I can parse out the
19 question a little bit. By way of Medicare policy
20 encouraging longer lengths of stay and encouraging the
21 admission of patients with diagnoses that typically have
22 longer lengths of stay, I don't know that we could

1 effectively say that the current Medicare payment system
2 discourages those types of patients, given the fact that it
3 is a per diem system and that as the presumptive eligibility
4 period works and the patient's eligibility for subsequent
5 hospice election periods, apart from the cap there is
6 nothing that would prohibit them from continuing to receive
7 care, as long as they were certified.

8 MR. HACKBARTH: Could I ask Arnie's question in a
9 different way? In fact, we've seen over time a shift in the
10 mix of patients away from cancer and towards diagnoses that
11 have longer stays and less definitive endpoints. Can you do
12 a time series analysis of the comparative cost of hospice
13 versus other, and look at it when it was predominately
14 cancer patients and then look at it more recently after the
15 mix has shifted?

16 DR. MATHEWS: I got the feeling there might have
17 been two words missing from the question you just asked:
18 comparative cost of hospice relative to...

19 MR. HACKBARTH: To non-hospice for the same
20 diagnoses.

21 DR. REISCHAUER: Let me suggest an alternative way
22 of trying to do this. Whether you could compare folks with

1 the same diagnoses in for-profit and not-for-profit, because
2 you have two groups with very different lengths of stay.
3 And for the people who are in the nonprofit, go back to the
4 period before they were in hospice to make the lengths of
5 stay, in a sense, equal and compare total hospice
6 expenditures plus Medicare fee-for-service expenditures in
7 both groups with each other. And then you could get a rough
8 answer to that question, I think.

9 DR. SCANLON: There's a big selection issue here,
10 in terms of people that have chosen to join hospice verses
11 who the controls are going to be in traditional fee-for-
12 service. Our level of diagnostic information is very high
13 and we don't know the specifics about these people's
14 condition. So I'd worry that the comparison -- whichever
15 way it came out -- wouldn't be definitive in terms of
16 telling us what's happening here.

17 DR. REISCHAUER: But you'd be getting a pool of
18 two different groups, both of which went into hospice at the
19 end.

20 DR. SCANLON: But Glenn is asking for compared to
21 fee-for-service.

22 DR. REISCHAUER: But the point is whether are you

1 saving money -- I thought the question was if we extend or
2 if we relax the requirements so that people get in earlier,
3 do you end up saving Medicare money or costing Medicare
4 money? There's the RAND study that answers a slightly
5 different question.

6 DR. MATHEWS: There is a reasonable body of
7 literature on this specific question and it runs the gamut.
8 There are three or four studies that say hospice saves the
9 program money relative to traditional Medicare, and other
10 studies that say it costs money. I've sort of deliberately
11 avoided having a detailed discussion of the cost-benefit
12 aspect of hospice given that inability --

13 MR. HACKBARTH: You tried to avoid it, rather.

14 DR. MATHEWS: Yes. I get dragged kicking and
15 screaming into it.

16 But for this set of exercises, we've sort of been
17 looking at what's been going on internal to the hospice
18 benefit. But if you wanted to specifically invoke this cost
19 savings aspect of it, which arguably was one of the integral
20 pieces of the rationale for the Medicare benefit when it was
21 established, that would have implications for the rate of
22 payment. If you wanted to ensure that hospice payment rates

1 were set in such a way that would continue to live up to
2 that early expectation of the payment system, we could look
3 at that.

4 But again a lot of people a lot smarter than I am
5 have looked into this issue and they're all over the map.
6 So if you want me to go into it, I'd be happy to do so.

7 DR. MILSTEIN: I'm not asking for a cost-
8 effectiveness analysis of the benefit, but rather the impact
9 on Medicare spending of essentially encouraging longer
10 lengths of stay and higher -- and accepting a higher
11 frequency of diagnoses that have a less determinate
12 endpoint.

13 DR. MATHEWS: I can synthesize some of the
14 literature and I can give you a couple of data points that
15 would be useful for answering that question.

16 Most recently there was a study, I think it just
17 came out last month, by some folks at Duke University who
18 looked at cost of hospice use for patients relative to a
19 cohort of patients both in their last week of life, in the
20 period between their death and the election of hospice, and
21 in their last year of life. And they kind of had some
22 interesting observations about the cost effects of hospice

1 use relative to non-hospice users. I think they found that
2 for decedents with cancer, hospice use was more cost-
3 effective up to 233 days of care. And for non-cancer
4 patients, hospice use was cost-effective up to 154 days of
5 hospice care, above which the cost for hospice patients was
6 greater than non-hospice.

7 But again, this is one study and there are a bunch
8 of others ones out there. But I can include a synthesis of
9 that literature.

10 MS. HANSEN: I think some of the questions
11 actually have been addressed. Just the intuitive
12 observation that some of the non-cancer type of diagnoses,
13 the dementias as well as the cardiac diseases and perhaps
14 even diseases like Parkinson's that's not specifically
15 alluded here, have become a chronic care approach to a
16 benefit that was originally for -- the way it was set up
17 back in the mid-80s -- for the cancer diagnosis that we've
18 been talking about.

19 So I was interested in kind of the continuum that
20 you were looking at that has been discussed for sure, but
21 it's just whether or not there's kind of that shift, is that
22 since Medicare typically doesn't provide long-term chronic

1 care this is implicitly how the benefit can be used,
2 emphasizing more the palliative side than necessarily the
3 hospice side. That's one observation.

4 The other question I had relative to again the
5 break out between people who are dually eligible and how
6 that payment process occurs when you have somebody who is a
7 dual in a hospice program and what the state responsibility
8 is.

9 And then the other side of it is whether or not
10 long-term care insurance also enters into this with when
11 people go into benefit, do they get to use their dollars to
12 help offset some of their co-pays, even though their modest,
13 whether that's also used to help in the payment system.

14 So it just gives a bit of a profile from the
15 public sector as the private paying responsibility and the
16 shift in diagnosis.

17 DR. MATHEWS: For the next set of analyses that I
18 anticipate presenting, we'll look at hospice utilization by
19 a number of demographic characteristics including insurance
20 coverage, fee-for-service, Medicare Advantage, and duals. I
21 had not specifically looked into how the payment system for
22 duals works but that's something I can try and pursue, as

1 well as the effect of long-term care insurance.

2 MS. HANSEN: Just related to my first comment
3 about the trending, it's interesting -- and I'm not current
4 on this at all. But when I was involved with some of the
5 diagnoses with the ICD-9s one of the issues that we had for
6 getting payment for a diagnosis of Alzheimer's or dementia
7 was really not an ICD-9 code that we could bill on. So that
8 was never a Medicare code. So I don't know.

9 What happened was I know there were some research
10 studies done by a number of policy groups to say that in
11 order to come to the right risk adjuster for somebody like
12 that there were some other kind of corollary diagnosis that
13 you can get the profile of the impact of dementia.

14 So it's just interesting that the opportunity to
15 use hospice this way actually embraces the diagnosis without
16 having to do the split out of the ICD-9. So that's the
17 other thing about just the shift. It's just another way,
18 frankly, it seems that the opportunity to care for people
19 who have this chronic long-term condition.

20 MS. BEHROOZI: On the issue that you identified,
21 Jim, about the cap not being adjusted by the wage index but
22 the payments counted against the cap and presumably the

1 costs to the provider are adjusted by the wage index.

2 Being from New York you know I have to say no
3 fair. The chart on page 22 -- I figured you were all
4 waiting.

5 That chart on page 22 shows that my next door
6 neighbor here, his neck of the woods gets like 50 percent
7 more in terms of the maximum days that a beneficiary could
8 receive that the provider could be paid for over what New
9 York would get.

10 So okay, that's not fair to the providers. But
11 I'm really concerned about beneficiary access then, as
12 providers recognize this is happening. And as the cost and
13 wage index continues to go up so the payments continue to go
14 up and the caps don't get adjusted that way, are providers
15 in New York in particular -- or any other high wage index
16 MSA -- is going to start dropping out. And then when it's
17 my turn I won't have one to go to but Tom and his buddies
18 will have plenty of options.

19 DR. MATHEWS: The geographic adjustment is a
20 technical fix that I think there are there some very
21 compelling arguments that support fixing that one. There
22 are a couple of other technical fixes that fall into that

1 category and we're looking really hard at those.

2 MS. BEHROOZI: And so maybe an analysis of how the
3 impact is working might support -- especially to the extent
4 that it might implicate questions about higher spending and
5 things like that. It might be good to show beneficiary
6 impact.

7 DR. KANE: In looking at the differences between
8 cap and non-cap and proprietary and freestanding, are the
9 measures of quality that would be relevant or patient
10 satisfaction and family satisfaction? I just kind of get a
11 feeling we're just looking at the economics but not really
12 whether the effect is -- what people are saying about their
13 experience.

14 DR. MATHEWS: There are -- the National Hospice
15 and Palliative Care Organization conducts surveys of patient
16 and family satisfaction, and independent researchers have
17 also kind of looked into this and have published their
18 findings.

19 I do not believe there are any formal quality
20 measures of hospice being used in the Medicare program right
21 now.

22 MR. HACKBARTH: So that's something we may want to

1 think a bit about for any recommendations. Tom, did you
2 have a comment on that?

3 DR. DEAN: Just to follow up on what Nancy just
4 said, I don't know a lot about hospice but it strikes me
5 that looking at some of these conditions and the lengths of
6 stay, we're really not providing what at least I understand
7 hospice care to be, which is difficult pain control,
8 palliation of unstable conditions, bereavement and that kind
9 of thing.

10 And so I just wonder is this truly just a
11 substitute for nursing home care, which it sort of looks
12 like it is in some cases. I don't know. Like I say, I
13 certainly don't know.

14 MR. HACKBARTH: Which, I think Jim, you pointed
15 out in the paper, was at least part of the rationale for
16 that cap originally was that there was this boundary where
17 potentially this benefit could evolve into long-term care
18 and there was some concern about that and the cap was a
19 means of stopping it at some point.

20 DR. BORMAN: In your chart -- as you looked at
21 this you said at the beginning that the overwhelming
22 majorities are the routine daycare things. But if you look

1 at the categories and what they match up to, pretty clearly
2 general inpatient care day and continuous home care will
3 markedly alter how quickly you get to a cap if you deliver
4 more than those.

5 Now you mentioned that no more than 20 percent of
6 your days could be inpatient to start with. What about the
7 continuous home care? Is there a limit on those kind of
8 days in the benefit? And is there a difference in the
9 providers reaching the cap? Are they more often providing
10 more of these continuous home days? And does that somehow
11 link to the patients that are now moving into hospice, the
12 kinds of patients that move into hospice?

13 That would seem to be the other big driver that's
14 not controlled independently. Do we know something about
15 that?

16 DR. MATHEWS: I do not believe that there is a
17 limit on continuous home care. If colleagues in the
18 audience from CMS, they could correct me on that if I'm
19 wrong.

20 But that would be a driver in a hospice reaching
21 the cap faster, given the expense of that service relative
22 to routine home care. If they provided a higher than

1 average level of continuous home care it would be a factor.
2 But we don't have that on a diagnosis by diagnoses basis.

3 DR. SCANLON: Jim, thank you very much. This has
4 been very, very helpful.

5 I am of a greatly mixed mind hospice. Having
6 seen, as probably everybody has, personally how well a
7 hospice can do in terms of providing benefits and it's
8 something that you want to really protect and preserve. But
9 from a Medicare payment perspective I, at the same time,
10 felt so ignorant about what's exactly happening with respect
11 to Medicare hospices, the trends over time, et cetera, that
12 it's kind of hard to come to conclusions as to what the
13 appropriate Medicare payment policies should be.

14 Like Nancy-Ann I have some flashbacks which really
15 relate to home health, but it's actually a few years before
16 Nancy-Ann's flashback which is the mid-90s when we were
17 having a lot of growth in home health. it was geographically
18 concentrated. We were having a changing industry. We were
19 having a lot more small agencies come into place. And some
20 of the data that you provided us are showing some of the
21 same kinds of things, and trying to understand that more I
22 think is a prerequisite to thinking about anything that we

1 should be doing.

2 Another part about this is that it's not just
3 payment policy that we should be focused on. There's this
4 whole issue of -- we've had 600 new hospices, according to
5 your chart between 2002 and 2005. What are the entry
6 requirements? What are we asking a hospice to demonstrate
7 before we're admitting them to the program? And then once
8 admitted, what are we asking in terms of continually showing
9 capacity to provide the services that we expect?

10 These are the same kinds of issues we've had with
11 respect to other provider types, and it was very true in the
12 mid-90s with respect to home health. We had very low
13 barriers and we were getting agencies that weren't fully
14 capable of delivering the services that we expected.

15 So I think that it's important for us to look
16 there.

17 The other issue, and this goes back to Tom in
18 terms of what's the appropriate services that are being
19 delivered and whether the people are really the right ones
20 for hospice care. What about this issue of certification
21 for hospice? How much of it is that we're relying upon
22 solely upon a physician's signature versus having more

1 information? And I know this is a very dangerous area
2 because again we have flashbacks to the mid-90s. There was
3 the story about the retrospective examinations of whether
4 someone that had been certified for hospice had died.
5 That's not the way this should be approached. The approach
6 should be prospective, which is that we look at a person's
7 condition and make a decision as to whether or not they're
8 appropriate for hospice.

9 So I think that aspect, in terms of a nonpayment
10 approach to making sure that we're getting what we expect
11 from the benefit is important.

12 I agree completely with Mitra. We shouldn't be
13 having a national cap. It makes no sense in terms of
14 equity. We don't do it in terms of payment levels. We
15 shouldn't be doing it in terms of a cap.

16 Having said that, you raise the issue about how
17 should we potentially readjust the cap. I think we need to
18 remember that this is an aggregate cap and that not thinking
19 about it in terms of what an individual patient can get, but
20 where would this cap fit in terms of looking at the average
21 mix that hospices provide and maybe pick out some percentile
22 point on the distribution and say the cap is adequate so

1 that 90 percent, 95 percent of hospices could provide the
2 services they're providing and they're not going to be
3 influenced by this geographically adjusted cap.

4 That, I think, is the way you think about setting
5 an aggregate cap, not in terms of a target for any single
6 individual.

7 I don't know, I mean, if we were to take geography
8 into account, would we have a different number today of
9 hospices that are above the cap by any significant number?
10 Or because we've had such a skewing of the people above the
11 cap geographically would it not make much difference?

12 DR. MATHEWS: Mathematically, if you were to
13 adjust the cap to reflect differences in area wages, as I
14 think it through, this would have the effect of increasing
15 the potential for hospices in high wage areas to provide
16 more services and decrease the potential for hospices in low
17 wage areas to provide those services.

18 And since, when you look at the distribution of
19 where most of the hospices are hitting the cap now,
20 geographically adjusting the cap would have the effect of
21 increasing the number of hospices subject to the cap in
22 those areas.

1 MR. HACKBARTH: Jim, could you just say a further
2 word about that? As I recall, it's states like Oklahoma,
3 Louisiana, Alabama that tend to have the disproportionately
4 high number of hospices hitting the cap; is that right?

5 DR. MATHEWS: That is correct. Those three states
6 do account for more than half of hospices hitting the cap.
7 I'm sorry, Mississippi, Alabama, and Oklahoma.

8 That said, I think there are about 17 states that
9 have hospices hitting the cap in the most recent year.

10 DR. REISCHAUER: Just reminding me about the
11 distribution of growth in home health agencies in the late
12 1990s.

13 MR. HACKBARTH: In fact, that's the point that
14 Bill made that I wanted to pick up on.

15 I've heard from people in the industry, Jim, that
16 the entry requirements are pretty low, that the ease of
17 entry is pretty high. And that often hospices are very
18 small entities with only a few staff -- maybe often is not
19 the right characterization. But there are many that are
20 very small. Could you just talk about that for a second?

21 DR. MATHEWS: Do I have to?

22 [Laughter.]

1 DR. MATHEWS: I mean, I've heard the same accounts
2 but I have not verified those independently. I mean, there
3 are conditions of participation for hospice that have been
4 in existence since -- I want to say very early on in the
5 benefit, '83, I think. CMS did publish a proposed rule in
6 the late '90s, I think, which was never finalized. But the
7 conditions do include things like the hospice has to have a
8 multidisciplinary team that operationalizes a plan of care
9 for a hospice patient and establishes a number of other
10 requirements.

11 I cannot assess how low or high a bar those
12 conditions represent.

13 MR. HACKBARTH: That's fair, I understand. Bob
14 has more questions along this line.

15 DR. REISCHAUER: First of all, I want to say I
16 agree with Mitra and the observations that Bill has made on
17 the issue of the variation in the cap across geography. But
18 Jim, I thought this was a wonderful paper and a good
19 presentation. When I read it, I was quite surprised that a
20 disproportionate fraction of proprietary institutions are
21 hit by the cap. That isn't what one would expect,
22 especially in a world that strikes me as pretty

1 controllable. By just tweaking the diagnoses of people
2 entering, you can make a huge difference in length of stay
3 for your organization, more cancer, fewer Alzheimer's
4 patients.

5 So it's not that they're totally out of -- that
6 this is sort of forces beyond the control. And then you
7 have the ability to turn the mix and quantity of services
8 dials a little bit, also.

9 So I come out of this looking at the fact that the
10 length of stay in proprietary organizations is longer for
11 every diagnoses that you have here --

12 DR. MATHEWS: Can I make a clarification? It's
13 not that the length of stay is longer for proprietary
14 hospices. The length of stay is longer for hospices that
15 hit the cap.

16 DR. REISCHAUER: Which are predominantly --

17 DR. MATHEWS: Yes, but again the hospices that hit
18 the cap are predominantly proprietary but it's not
19 necessarily that the obverse of that is true.

20 DR. REISCHAUER: The question is whether the
21 profit maximizing point is a longer length of stay rather
22 than a shorter length of stay. If that is the case, then

1 one would expect to see the pattern that we see here and
2 some people are going to miss and go a little over and
3 they're going to be disproportionately small ones because
4 the controllability, the variation would be larger.

5 And so I was wondering if we could see the
6 distribution of how close you are to the limit and whether
7 is this something where the same organizations miss year
8 after year or is it sort of a random pick of those?

9 DR. MATHEWS: The next presentation that I would
10 anticipate doing will look at hospice payment adequacy and
11 will include an analysis of margins by different categories,
12 urban/rural, proprietary versus nonprofit. One of the
13 things I'm looking at is margins by cap versus non-cap
14 status. In the context of that conversation, I can kind of
15 walk through what we know about the cost curve for a typical
16 hospice episode where the costs are higher at intake and at
17 the very end of the episode. I can also kind of a weigh out
18 some of the -- lay out some of the theoretical incentives
19 that you've just discussed.

20 DR. REISCHAUER: But if that's the case, then the
21 longer middle period you have, the better the overall
22 situation is.

1 DR. MATHEWS: I would not disagree with that, in
2 theory.

3 DR. REISCHAUER: No, this is all theory. And
4 hopefully you'll delve into this and come up with what the
5 facts look like.

6 DR. MILLER: Again, Jim is being very careful. A
7 different way to say at least one of the points that you're
8 making is that the cap does represent a limiting and
9 presumably something you don't want to exceed because it
10 creates the financial problems. But there also can be a
11 strategy where you operate very close to the cap. And so I
12 think that's what, in a sense, you're trying to get behind.
13 And I think that is something we're going to try.

14 DR. REISCHAUER: And that would lead one to admit
15 earlier patients, I think, in the process.

16 DR. MILLER: I also don't want to be the person to
17 make this point, but since it's been made so many times I
18 just want to think about this a little bit. And I
19 understand, any analyst that looks at this cap is going to
20 immediately start asking questions about geography and case-
21 mix adjustments and all of that. So don't get me wrong when
22 I say what I'm about to say.

1 But also just keep two things in the back of your
2 mind. One of the things that Jim demonstrated is even in
3 this cap, in an area that should be penalized by this cap,
4 which high diagnoses, you still have a fair amount of
5 operating room. That was what he went through. We're
6 talking about less than 200 hospices out of 3,000 that are
7 getting hit at this point.

8 Now it's a growing problem, so don't get me wrong.

9 The other thing I want to say is think of your
10 conversation yesterday about geographic adjustment where
11 people were saying wait a minute, is geographic adjustment
12 really working in some of the physician world that we were
13 talking about? Different kinds of issues because it's
14 physician work. But we want to think hard about how we go
15 through this on geography, case-mix, and what other broader
16 changes we want to make to the benefit at the same time.

17 I would just get you think about that, as well.

18 MR. HACKBARTH: Bill, the last word.

19 DR. SCANLON: I just wanted to put one more thing
20 on the table and we can maybe talk about it in some of the
21 future presentations and that's another area of my
22 ignorance, which is the issue of what's happening with

1 respect to hospice and nursing home residents. Because it's
2 not that hospice is precluded.

3 In fact, I heard that it's increasing in terms of
4 the proportion of long stay nursing home residents that are
5 getting hospice care. And how it relates to the care that
6 the resident or the Medicaid program is paying for in the
7 nursing home is something that I think we should be looking
8 at as well.

9 MR. HACKBARTH: Thank you, Jim. Good job.

10 Next we have a panel of guests on value-based
11 insurance design.

12 Welcome. Thanks for sharing your expertise with
13 us. Rachel, you'll do the introduction?

14 DR. SCHMIDT: I will.

15 Last month we discussed some of the problems with
16 fee-for-service Medicare's benefit design and looked at the
17 potential effects of some of illustrative changes. Today
18 we're going to continue our discussion about benefit design
19 with a look at value-based insurance design, where copayment
20 rates for drugs and services are set based on the benefits
21 and costs of the individual therapy. We have a
22 distinguished panel here to describe this concept and talk

1 about its usefulness and its hurdles.

2 We have Mark Fendrick. He's the Co-Director of
3 the Center for Value-Based Insurance Design at the
4 University of Michigan. He's also a professor at the
5 University of Michigan in the Departments of Internal
6 Medicine and Health Management and Policy. Dr. Fendrick
7 serves on the Board of Directors of the International
8 Society for Pharmacoeconomics and Outcomes Research, the
9 Medicare Coverage Advisory Committee, and is the Co-Editor-
10 In-Chief of the American Journal of Managed Care.

11 Jill Berger is the Vice President, Health and
12 Welfare Management and Design for Marriott International.
13 Ms. Berger is responsible for the strategy, design, and
14 management of Marriott's benefit plans with an emphasis in
15 health plan quality improvement. She serves on the National
16 Committee for Quality Assurance Purchaser Advisory Council,
17 is an active member of the Leapfrog Group for Patient
18 Safety, and is also President of the Mid-Atlantic Business
19 Group on Health.

20 Mike Chernew is professor of the Department of
21 Health Care Policy at Harvard Medical School. Dr. Chernew
22 is the other Co-Editor of the American Journal of Managed

1 Care and Senior Associate Editor of Health Services
2 Research. He is a member of the Commonwealth Foundation's
3 Commission on a High-Performance Health Care System and a
4 member of the Congressional Budget Office's Panel of Health
5 Advisers. In 2000 and 2004 he served on the Technical
6 Advisory Panels for CMS that reviewed assumptions used by
7 the Medicare actuaries to assess the financial status of the
8 Medicare Trust Funds.

9 With that, I'll turn it over to Dr. Fendrick.

10 DR. FENDRICK: Thank you, Rachel, and good morning
11 everyone.

12 We very much appreciate the opportunity to discuss
13 the concept, the implementation, and the data that are
14 available around value-based insurance design.

15 I'm a practicing general internist at the
16 University of Michigan and spend most of my time looking at
17 the clinical and economic implications of medical innovation
18 from the cost of the common cold to Katie Couric's Today
19 Show colonoscopy to the Internet and many other blockbuster
20 drugs and medical services.

21 I view myself as a quality improvement person but,
22 doing this now for nearly two decades, I've come to

1 understand that before we can talk about quality improvement
2 and improvement in length and quality of life we, in every
3 step of the way, need to discuss the issues and the economic
4 implications of what we do. So much so I don't need to show
5 you, but with Peter Orszag now basically saying quite
6 clearly the nation's long-term fiscal balance will be
7 determined primarily by the future rate of health care cost
8 growth, and showing all of these slides that you've seen
9 before. But I feel I need to present them. And the fact
10 that almost all of these presentations by economists and
11 fiscal analysis tend not to talk about the health gains that
12 come along with those health care expenditures.

13 I think the main thing as we talk about value-
14 based insurance design is to, in fact, acknowledge this very
15 important cost quality divide and that, starting out as a
16 quality improvement person, I have now increasingly been
17 forced to become a cost-containment person. I think the
18 very first point that all if you deal with on a regular
19 basis is that there is often a conflict between what we try
20 to do on the quality improvement side, which often costs
21 money, and the pressures to constrain health care cost
22 growth.

1 I find it intriguing at minimum and frustrating at
2 another end that if you look at most surveys in the private
3 sector and looking at those employers that are doing well
4 are high-performing employers, that they are measured in
5 terms of how much money they're spending on health. Those
6 that spend the least amount of money are the ones that are
7 doing best. And if you look at any other aspects of their
8 business or the economy that's usually not the case, where
9 people are frequently being driven to spend less, spend
10 less, spend less without an equal attempt to look at what
11 we're getting in terms of health for those beneficiaries in
12 the design.

13 So if I saw that a high performing plan was, in
14 fact, spending less money but achieving all of the quality
15 metrics that you all deal with on a regular basis, then I'd
16 be happy. It turns out if you look at report, after report,
17 after report in terms of health care cost and health care
18 cost containment, there's no discussion as costs go down are
19 the service that are not being performed those that are
20 viewed as high valued ones, such as immunizations, cancer
21 screenings, and the use of high-value services like chronic
22 drugs for medical conditions?

1 This idea of the pressure is extraordinarily
2 important as we hear about cost-containment when, if you
3 look at the work from our literature -- and that's the
4 Health Services literature -- that every study ever done has
5 shown that we're doing a suboptimal job in terms of
6 achieving those things that we view to be the most important
7 in health. For whatever field you come from, whatever
8 subspecialty, a 75 percent rate in terms of adherence is
9 viewed as extraordinary.

10 And most of the work from Elizabeth McGlynn at
11 RAND and other studies out there in the published literature
12 would show that 60 percent is considered a relatively high
13 bar for immunizations, glucose control in diabetes, beta
14 blocker use after heart attacks, colon cancer screenings
15 across the board. So as long as we acknowledge this idea of
16 underutilization and our need to spend more, we have to
17 understand -- at least from my perspective -- that the
18 pressure is exclusively on cost and less so on health.

19 And I think if the one point I have tried to
20 present to multiple audiences over the last couple of years
21 is we need to bring the term health back into the health
22 care cost debate. Because as we look in every stakeholder

1 discussion, it's cost, cost, cost. And no one's actually
2 asking what are the clinical implications of reducing
3 expenditures in certain areas.

4 So all of you know and it's quite easy, and I'm
5 not a financial person, that the interventions that control
6 costs are quite clear. I think some of you might know that,
7 thankfully, prior authorization has pretty much gone by the
8 wayside. The number I have to dial in Michigan to get prior
9 auth is 1-800-no way, where a high school student tells me
10 on her after school job that she knows the drug to use
11 instead of me in that situation.

12 And all if you acknowledge that, in every
13 situation of prior authorization, it tends not to be driven
14 by quality improvement. These are areas to try to
15 understand and do a better job in terms of allocating our
16 resources to health care interventions.

17 Disease management has been a big topic, I
18 imagine, in this group among others. I think that the
19 disease management evolution is quite illustrative of the
20 malalignment of certain incentives. I think most of us know
21 now that roughly 50 percent of employers are offering some
22 type of disease management program. It is quite pervasive

1 in Medicare as well.

2 It's intriguing to me as a quality improvement
3 person that disease management has not been sold as a
4 quality improvement tool. It's, in fact, at least in my
5 anecdotal experience, being sold as a way to save money on
6 health care. And I find it intriguing that an intervention
7 that actually gets individuals to do more of the right
8 things in medicine, of which those individual services do
9 not save money, it's expected that a program that will get
10 more of those services to be used will actually save money.
11 And that kind of reminded me of the early days of Amazon.com
12 where they lost money on every book and made it up on
13 volume.

14 So I think these issues that we need to again turn
15 to the concept of value and not of just cost or quality as
16 we move forward. Mike and I pretty much believe that by
17 getting individual patients to do what's considered the
18 right thing medically will, in fact, improve outcomes.
19 There are several studies to show that.

20 Given the situation that a great majority of the
21 things we do in medicine do help people at an incremental
22 cost, getting their rates of adherence to improve will

1 likely not lower cost net, although they will provide high
2 levels of value.

3 But from the financial perspective, the reason why
4 we like to focus on disease management is that here are many
5 payers investing in services on one side of the equation.
6 At Michigan we pay a nurse \$65 an hour to call our patients
7 with heart failure and ask them to take certain drugs, to
8 weigh themselves every day, and to follow up with their
9 cardiologist.

10 At the exact same time, every single payer that
11 we've looked at has increased patient copayments or
12 coinsurance or out-of-pocket expenditures for those doctor
13 visits and for those recommended drugs. So if you want to
14 get attention, at least in my experience, with the chief
15 financial officer of a large employer, tell them that you're
16 paying money to get your employees to do something on one
17 side of the equation and then creating a higher barrier on
18 the other side to get them to do that.

19 Because, as an academic researcher, I like to say
20 I pursue private interest at public expense, Mike and I
21 published a paper a year and a half ago looking at was, in
22 fact, this true that people who were in disease management

1 programs faced with similar copayments as those who were not
2 in disease management programs. Until we started informing
3 people about this serious malalignment of economic
4 incentives, in fact it was quite easy to show that there
5 were no co-pay differences for people in disease management
6 programs and those who were not, suggesting that there was a
7 way to better align incentives to get not only better
8 clinical outcomes but a return on financial investment for
9 disease management.

10 Clearly out of the area of my expertise is a great
11 discussion that goes on now and in the future, that is
12 physician and hospital payment reform. I don't think that
13 we'll talk about that today, although all of us know that
14 this will be a key component of cost containment in the near
15 term. What we are here to talk about is the issue of
16 increase in patient cost-sharing, or making beneficiaries
17 pay more.

18 Formularies for drugs is an example, but as you
19 look across the medical care insurance system, both in the
20 private and public sectors, that cost-sharing -- at least as
21 far as we've seen -- is based on the cost of the
22 intervention, not the value. And the fact that people are

1 increasingly pushed to buy the lowest cost services, whether
2 it's their drugs, their doctor visits, their hospital
3 networks which, in many instances, do not have equivalently
4 good data on the quality of care provided.

5 I have said for a long, long time that the most
6 expensive therapy is the one that doesn't work. As I look
7 around the table, I don't see any of the people wearing
8 neckties or blouses that actually went out and purchased the
9 lowest cost one every time. I have tried very, very hard to
10 get multiple stakeholders -- what did I say wrong? I
11 shouldn't comment about blouses, I guess, or neckties.

12 So I think obviously you're seeing the lead-in to
13 the idea of value-based insurance design, benefit design, is
14 in fact not just driving people to the lowest cost
15 intervention but hopefully driving patients, through their
16 copayments, and hopefully physicians, through their
17 reimbursement, to do the thing of highest value, that being
18 the health per dollar spent.

19 Clearly everyone knows that both in the private
20 and public sectors copays for all tiers of drugs have gone
21 up substantially in the last decade. To be honest, I would
22 not be here today if the market-based reformers were right

1 in the fact that they believe that Americans would be able
2 to spend their money wisely on health care services and the
3 fact that when the money was put in the hands of the average
4 informed consumer, they would buy the things that those of
5 us in evidence-based medicine would feel to be high-value
6 services and would stop buying the others. All of you know
7 about the RAND health insurance experiment now over three
8 decades old and every study ever done since then to show
9 that as increasing cost-sharing has been put in front of the
10 American consumer, they not only stop buying the things we
11 don't want them to buy -- the nonessential services -- but
12 they also stop buying those high valued services.

13 One example of that would be a paper recently
14 published by Dana Goldman from RAND showing a substantial
15 negative elasticity when copays are doubled for drugs for
16 diabetes, high cholesterol, or hypertension that I imagine
17 most of the clinicians around the panel and perhaps all of
18 you would agree were things that we would strongly encourage
19 our individual patients to adhere with. You see on the
20 right side that this also goes for antidepressants, as well.

21 So my mother said to me I can't believe you had to
22 spend \$1 million to show if you make people pay more for

1 something they'll buy less of it. But I imagine that that
2 is the beauty about being a grant-funded researcher.

3 This probably was the first paper that really drew
4 direct attention to the impact of variable copays on drugs
5 that are viewed to be highly valuable. Statin drugs are a
6 \$12 billion revenue producing class of drugs to lower
7 cholesterol. Last I checked they are not addictive and they
8 have no street value on the streets of Detroit. And people
9 do not want to have high cholesterol and take these drugs if
10 they don't have to.

11 You can see from this slide, not surprisingly,
12 that my mother was, in fact, correct. I do not want to
13 reopen the debate about whether money is the sole influence
14 of adherence to drugs. It is clearly not. People have
15 challenged us to say that there's lots of evidence that when
16 drugs are free, people don't take them. You can look from
17 this slide and now 15 other papers in literature. Sure
18 there are lots of concerns about adherence to drugs even
19 when they are free. But adherence is always better when
20 they're free than if they're \$25 a month.

21 So I think the issue about whether and how much
22 the copay differential matters, I think the evidence is now

1 quite strong that individuals' out-of-pocket expenditures is
2 an extraordinarily important component to adherence of both
3 low and high value drugs.

4 So it is our opinion that the market does not
5 work. We believe in not a hard hand but soft paternalism in
6 that benefit design should, in fact, create a situation to
7 nudge those individuals to do the things that would
8 hopefully mitigate the negative clinical effects of
9 increasing cost-sharing which, as all of you know, is
10 probably the most widely used intervention now and a very
11 successful one to constrain health care cost growth.

12 But value-based insurance design in its simple
13 message needs to acknowledge a number of things. Most
14 importantly, which I don't think is difficult for most to
15 understand, is that medical services differ in the clinical
16 benefit provided. Although, if you look at almost all of
17 the health plans that are available to most individuals in
18 the United States, there is no acknowledgment of this
19 heterogeneity in terms of the out-of-pocket expenditures.

20 My patients pay the same out-of-pocket to go to
21 see a dermatologist for the seventh time for a rash they
22 don't have as they would to see a cardiologist for their

1 congestive heart failure follow up or their orthopedic
2 surgeon to see their hip replacement follow up after this
3 important intervention.

4 So I think it's not been difficult for us to get
5 people to say yes, there probably should be a situation
6 where the copayments for statin drugs should, in fact, as a
7 class be less than drugs to make my hair grow back or to
8 make my toenail fungus go away.

9 I'll just tell all of you that I've learned
10 recently, dealing with a different stakeholder group --
11 employers, as represented by Jill Berger here today -- than
12 in developing a term that I had not heard of before, the
13 elevator pitch, to the CEO of large companies. I used to
14 basically tell them in one sentence that do you know your
15 employees pay the same money out of pocket for a drug that
16 will save their life from heart disease or diabetes as
17 opposed to one that will make their toenail fungus go away?

18 And I'll tell you that, as I see a couple of nods
19 going on, this is something that draws immediate attention
20 to someone who's paying the bills and has led at least to
21 some momentum behind this concept of value-based insurance
22 design.

1 One is it's probably easy for us to start thinking
2 there are some services that we would encourage, perhaps
3 others we would discourage. But what makes this even more
4 intriguing, particularly to Medicare, is that even when you
5 pick a high-valued service, the clinical benefit from a
6 specific service really varies on who you give it to.

7 And while I applauded and was very much involved
8 in the coverage of colonoscopy for Medicare beneficiaries
9 and have been long involved in the value of colorectal
10 cancer screening, I will tell you that I've been quite
11 public in telling you that the data would suggest that if
12 you have a first-degree relative with colon cancer, you
13 should be paid to get a colonoscopy. Not just from the
14 clinical aspects of your high risk, but now that the cost of
15 treating metastatic cancer in the colon is so high that the
16 economic implications of preventing this disease are
17 extraordinary.

18 Fifty-year-olds and up should get it free. But if
19 you're a 26-year-old fan of Katie Couric who's just worried
20 about colon cancer and don't have a family history, it is my
21 strong belief that you should pay full freight. Because
22 while the evidence is so strong in this person, very strong

1 in that other group, and not there at all would allow us
2 ultimately, in the era of a fully expanded information
3 technology system, to set up a benefit design that is truly
4 personalized in terms of information that might be available
5 through a patient history, health status assessment, and
6 electronic medical record.

7 So what the value-based insurance design packages
8 do is they take this across-the-board out-of-pocket cost
9 system which we believe does not reflect any of the
10 multibillion dollars that we've invested in clinical
11 research and sets coinsurance based on the assessment and
12 the benefit achieved and, quite simply, the more beneficial,
13 the less expensive it is to the patient.

14 I think it's worth commenting just for a minute or
15 two on consumer-directed health plans, given that they are
16 the singular most important initiative from the market-based
17 reformers. High deductible consumer-driven health plans, in
18 my opinion, connect the advantage of a better informed
19 consumer.

20 So we love consumerism. I think this is a very
21 important thing. I'm never sure how consumerism has gotten
22 inextricably linked to the idea of higher out-of-pocket

1 expenditures or high deductibles. So while we like
2 consumerism, I'm not so sure that it has to be always
3 related to high deductible health plans.

4 Mike and I have long believed that the more you
5 make people pay for something, the less they'll buy. And
6 one of you should be a surprised that all of the data that
7 are coming in regarding consumer-directed health plans are,
8 in fact, doing a good job at constraining health care cost
9 growth.

10 But what I've tried so hard to get people to
11 understand is as the costs go down, we need to really look
12 very carefully and seeing what are those services that would
13 have been bought that weren't. And if you told me that it
14 was always those things that we viewed to be as frivolous, I
15 wouldn't be here today.

16 I'll tell you that if you look at the data that
17 are emerging, this was a poster presented at the Academy of
18 Managed Care Pharmacy last spring, looking and confirming
19 once again that my mother was right. If you look at those
20 individuals in the high deductible consumer-directed plans
21 in the light tan compared to the traditional three-tiered
22 copay that most of you probably have in your benefit

1 program, versus those few champion companies that have
2 decided to make these essential classes of drugs for asthma,
3 diabetes, cholesterol reduction, and high blood pressure
4 reduction for free, you can see A, that money matters; and
5 B, that money is not the only issue. That even in the
6 setting of free drugs that there is not a single instance
7 where three-quarters of the individuals are taking the drugs
8 as the physicians recommend. So we need to do more on top
9 of copay relief.

10 So what we have suggested as consumer-directed
11 health plans move forward is that if we could redefine the
12 services that are covered in terms of first dollar coverage,
13 it would do a very good job in terms of our minds in
14 mitigating the concerns we have about the negative health
15 effects of high deductible plans.

16 I think most of us know that there is major
17 initiatives, particularly here in D.C., around expanding
18 substantially the monies available for comparative
19 effectiveness research and information technology to allow
20 us to better set up these plans to allow certain services to
21 be covered and those not. Obviously, the added expenditures
22 as you expand those services available under CDHPs, at least

1 you'd be able to know that those were services recommended
2 by evidence-based medicine, HEDIS, NCQA, the U.S. Preventive
3 Services Task Force, that we would finally be able to answer
4 that question about what, in fact, are we getting for our
5 health care dollar. You would know directly, as you saw
6 expenditures on the first dollar covered services under CDHP
7 go up, at least you'd be happy to know that those
8 expenditures were exactly those things that we wanted to see
9 spent on.

10 So we'll have a lot of discussion about the
11 economic effects of value-based insurance design because I
12 can't imagine anyone would argue that as we lower barriers
13 for high-valued services we would see improved clinical
14 outcomes. It's just the question is how much this is going
15 to cost. Both Jill and Mike will likely touch on this, but
16 I think conceptually, as we've been forced to leave the
17 quality improvement side and look at the cost containment
18 side, the first phase, of course, is that good medicine
19 might prevent hospitalizations and ER visits and other types
20 of things. Mike will certainly talk about that in a
21 particular experiment that we've been involved in.

22 There are some data that would show that as

1 adherence rates go, in fact, up or down in this study by
2 Mike Sokol in looking at diabetics, that it again should be
3 no surprise that although you're spending more money on
4 drugs, in the light blue, they are, in fact, offset by all
5 cause medical and drug costs as people adhere to their
6 drugs.

7 I think the most interesting area, which falls
8 outside of my own expertise to really ultimately show the
9 value of improved medical services and better health, is
10 this idea of reduction in nonmedical costs such as
11 absenteeism and disability and improvements in presenteeism.
12 This is an area where I believe the peer-reviewed
13 literature, the controlled studies, are just evolving
14 although there have been a number of claims over the year.

15 I think going back through this literature I can
16 only really find one control study, again looking at
17 individuals with diabetes mellitus that does, in fact, show
18 that patients with good control compared to poor are more
19 productive and less likely to be absent at work, suggesting
20 that there would be benefits to employers like Jill Berger
21 in addition to what she's seeing in terms of her medical
22 claims costs.

1 The last area, which is a tough one, is in fact
2 subsidizing the incremental costs of the low copays of the
3 high-valued services with raising coinsurance for those low
4 valued ones. I'm happy to report thus far that we do not
5 know of an employer or plan that's done this thus far,
6 although from an actuarial perspective and those looking for
7 a short-term return, this would be the easiest way to do
8 that. Thankfully, there are a number of various consulting
9 and actuarial firms who know very, very precisely how much
10 utilization will change in terms of drugs or other
11 nonpharmaceutical services as you change copays by very
12 little amounts.

13 The last thing I'll say goes back to this nuance
14 about the idea of the value of medical services not only
15 depend on what you do to them but who you give it to. I'll
16 just tell you that the better that you're able to find the
17 individual who's likely to have the preventable expensive
18 adverse event, the quicker you'll be able to achieve a
19 financial ROI with copay design. I think the best example
20 of this that's been understandable in my experience with lay
21 audiences, the idea -- going back to the statin drugs and
22 cholesterol reduction -- is if you target your copay relief

1 to only individuals who have had heart attacks, similar to a
2 pilot study that Aetna has underway, because these people
3 are at such high risk of another one, you're going to see
4 the benefits of that heart attack reduction in increase in
5 adherence of statins, which only subsidizing a very few
6 people of statin use, which is around 15 to 20 percent who
7 have already had an event.

8 that is very difficult to do from the
9 administration standpoint. And if you were to expand your
10 statin copay reduction program to everyone, obviously you'll
11 see greater health benefits but it will take you a longer
12 time and cost you a lot more money in terms of subsidized
13 prescriptions and copays to achieve those clinical benefits.

14 This is a segue, I won't go to this because most
15 people will agree that there probably is some merit in the
16 concept of using our clinical nuances in creating benefit
17 design. I really do believe that the challenge is not
18 buying into the concept but making it happen. It's much
19 easier for me, as opposed to going through this slide and
20 I'll be happy to turn over the microphone to Jill Berger,
21 who will be able to tell you her own experience and how to
22 make a value-based insurance design implementation a real-

1 life reality.

2 Thank you very much.

3 MS. BERGER: Good morning. Thank you for this
4 opportunity to speak to you all today.

5 We actually completely concur with Mark in many
6 cases, although I never thought I'd say that.

7 But before I go into the case study talking a
8 little bit about what Marriott has done for value-based
9 insurance, let me tell you a little bit about Marriott.

10 We have about 91,000 eligible associates across
11 the United States, about 71,000 participating, so about
12 160,000 covered lives. This is in almost 2,000 hotels
13 across the country. The one takeaway, I think, from this is
14 our challenges are we are very spread out. So as we think
15 about ways to bring health and wellness to our associates,
16 it is a challenge, certainly a challenge folks at CMS would
17 understand.

18 We also have a very diverse population, another
19 thing I think everybody can relate to. So when we talk
20 about consumerism, our goal really is to work with our
21 associates to give them tools to understand and take a more
22 active role in their health care, certainly that presents

1 challenges as well.

2 We offer 50 HMOs across the country and three
3 national PPOs. What we try to do is give our associates a
4 choice between an HMO and a PPO. About 70 percent of our
5 associates are in the HMOs. So they like the plan design.
6 It's a lower paid population. They want the predictable
7 out-of-pocket costs. And 70 percent of our plans are self-
8 insured, which gives us a little bit more flexibility in
9 what we offer.

10 To give you a sense of our strategy, one of the
11 arguments I always have with Mark is where he says employers
12 want to pay less. I actually think employers don't
13 necessarily expect -- we're realistic -- to pay less. We're
14 trying to mitigate the cost increases. Although I think
15 you've drunk the Kool-Aid on that.

16 So what are we trying to do? We are trying to
17 attract and retain talent. This is why we offer benefits.
18 This is why we're not looking to get out of it. We know
19 it's a reason that people come to Marriott. But we are
20 experiencing large cost increases. And in the past our way
21 to deal with that was -- and granted, we got a lot of this
22 advice from consultants -- raise your copays. If you raise

1 your copays, you'll decreased utilization, you'll save
2 money, and everybody will be happy.

3 So we did that. And we gradually increased copays
4 over the years. And then we started to see the results on
5 the other side. So where some things became expensive, if
6 you have a chronic condition you have lots of meds, you have
7 lots of doctor visits, the copays become unaffordable.

8 So one of the things that we have learned over the
9 past few years and working with people like Mark and Mike,
10 we have to become smarter in our plan design. Our goal
11 really is to incent the essential care. We're actually in
12 the midst of defining what essential care is. But we're
13 starting to. Once we define the essential care and we even
14 figure out a way to identify those who need the essential
15 care, the administration on the other side is difficult. So
16 this is going to be a journey, not a destination.

17 And so we are developing longer-term strategies to
18 identify our associates who have a high risk illness and
19 work with health plans actually who can identify them and
20 manage the high risk illnesses, can improve patient safety
21 and increase productivity.

22 So that gives you a sense of our strategy. One of

1 the ways that we can get to where we want to go is we have
2 to work with the right partners. And so a lot of what Mark
3 has talked about, when we look at somebody, when we really
4 want to target -- if we start to look on our drugs and
5 target those with a heart attack, for instance, who should
6 pay less for a beta blocker -- the only way we're going to
7 be able to do this is working with a high-tech company who
8 can help us get there. And so we work with a company who
9 can take the data from all of our health plans and bump it
10 up against knowledge to identify gaps in care and identify
11 those who need essential care.

12 So we work with ActiveHealth Management. They
13 collect, and this kind of depicts what they do. They
14 collect claims data, pharmacy data, lab values in many
15 cases. They put it into a CareEngine. They have about
16 2,000 matrices where they identify ways to improve care.

17 Now when ActiveHealth started, they used to report
18 these gaps to providers. Some of the providers would report
19 back hey, I know this patient needs a beta blocker but I
20 can't get them back in the office. I can't get them to do
21 what I need them to do. And so what we started to do was
22 send the same messages to our members, to the patients. And

1 when I say we, it's ActiveHealth. ActiveHealth works in
2 conjunction with most of our health plans.

3 And so we allowed them to send these messages to
4 our members and built a couple of programs around the member
5 messaging to make sure that if members had questions that
6 they could be supported. And so we did this through a
7 program called Informed Care Management and health advocates
8 and health coaches. All of this is beginning to make a
9 difference.

10 So we've got the high-tech company and we
11 introduced the value-based formulary. Again, one of the
12 things that our nurses -- nurses were hearing from our
13 members the same thing their physicians were hearing from
14 our members' physicians is they can't afford --
15 affordability is one of the reasons why our folks are not
16 compliant with drugs.

17 So we did offer copay reductions for certain
18 classes of drugs, mainly related to diabetes, heart disease,
19 and asthma. And we chose those diseases: one, we took a
20 look at our population, we took a look at our expenditures,
21 and those are our most costly conditions that we can affect.
22 And there is medical literature out there that tells you if

1 folks become more compliant with the drugs in the classes
2 listed here, it will mitigate cost increases because
3 hopefully you're going to prevent some adverse things from
4 happening.

5 So what we did is we made generic drugs free. We
6 made them free because they were only \$5 to begin with.
7 Again, go back to our plan design, they're the least
8 expensive drugs. Those were the ones we were trying to
9 incent. So we made generic drugs free, and we had a 50
10 percent brand reduction.

11 You know, we don't really know what the right
12 numbers should be yet and that's one of the things that
13 we're trying to study. But at least it's our first step
14 into incenting the right drugs.

15 And then ActiveHealth identifies the members.
16 They look at those members who are currently taking the
17 drugs and communicate the new program to them because we
18 want them to stay compliant. And also identify those
19 numbers who are not taking the drugs so we can begin to
20 first inform them that these drugs are now more affordable.
21 ActiveHealth also informs the physicians. And hopefully, we
22 can incent them to become more compliant.

1 Our goals for this program are to improve
2 compliance, improve quality of care, decrease adverse
3 events, decrease hopefully health care cost increases -- I
4 should add that word -- for both members and employers, and
5 improve satisfaction.

6 You know, when we think about value-based
7 formularies, I can tell you also another reason why we
8 started with drugs is it was doable. We worked not only
9 with ActiveHealth but also Express Scripts, who was our
10 pharmacy benefits manager, who completely bought into this
11 and enabled it.

12 One of other things is we think about our
13 population. If we're going to incent something, we have to
14 make sure that they get the incentive at the point of
15 service. If they can't afford the drug, they're not going
16 to be able to pay full price and then submit a claim to get
17 half of it back. They have to get the incentive at the
18 point of service.

19 So again, starting on the drug side enabled us to
20 do this.

21 And so we implemented this. And then we were able
22 to study the effects, working with the University of

1 Michigan. The study design is a pre/post control group. We
2 used another employee who also used ActiveHealth, all of the
3 same programs that we did with the exception of the value-
4 based formulary. And what we did is we wanted to model what
5 happened with the five clinical categories and then analyze
6 patient specific data.

7 Basically, what we wanted to look at were the
8 financial and clinical outcomes of the value-based
9 formulary. What happened? And what we want to see is
10 decrease in adverse events and a decrease in the health care
11 trend.

12 The first step in doing our analysis is to ensure
13 that it was implemented properly, but also we want to
14 compare the differential change in outcome between Marriott
15 and the control group, and again look at the adherence rates
16 before the intervention and after the intervention, look at
17 those who were currently non-adherent, what happened, and
18 those who were currently adherent, did they remain adherent?

19 So the initial findings showed that members' out-
20 of-pocket costs for brand-name targeted drugs decreased by
21 27 percent whereas the control group members' costs went up
22 about 4 percent. Members out-of-pocket costs for targeted

1 generic drugs felt about 65 percent while the control group
2 members' costs fell by only won percent. So step one showed
3 that we implemented it correctly.

4 We also did the financial outcomes, which Mike is
5 going to present. I can tell you in year one, just looking
6 at the preliminary results, we lost money which actually
7 isn't a surprise. It did take a while to get it implemented
8 properly, working with Express Scripts and ActiveHealth.

9 But also we have an employee population that once we have a
10 message, and the message is hey, these drugs are now
11 cheaper, they're more affordable, we need you to go back and
12 consider taking them, it takes several years to get that
13 message out.

14 Also it didn't look at productivity savings,
15 didn't look at disability savings.

16 So in year two Aetna actually, one of our health
17 plans, it's about 40 percent of the folks who had this
18 value-based formulary, looked at our 2006 data. It's
19 starting now to show a savings, which is good. We're just
20 digging into the numbers so we do need to take a look at
21 that.

22 But the other thing we have to consider, when we

1 put this value-based formulary in place and we listed the
2 five classes of drugs, we made those drugs available to
3 everybody unless there was a reason that we did not want to
4 incent that drug. So ActiveHealth could weed out those
5 folks who are on a drug that might be for diabetes but
6 because of lab tests that came in, we don't want to incident
7 Glucophage or something like that. So that was our first
8 step.

9 Our next step is to take a look at all right, for
10 those who are on a beta blocker who have had a heart attack,
11 we want them to stay on the beta blocker. Maybe we'll make
12 those drugs free. We want to add further incentives. So
13 that's our next step for this year and into 2008.

14 The good news, actually Kaiser has put this in
15 place for us, which we were very happy about. And they're
16 doing it as a pilot. And I think that was brave of them.
17 We're fully funded with Kaiser so they're taking the risk on
18 that. But the good news is others are beginning to see the
19 need for value-based formularies.

20 What's next for value-based formularies for us, we
21 just implemented a smoking cessation program where we made
22 some of the drugs for those programs free, as well as the

1 counseling. We made office visits for preventive care free,
2 another area -- once we studied our data, we saw our HEDIS
3 data just was abysmal. It didn't even reached the national
4 averages.

5 So again, we can at least take out the financial
6 barriers that prevent folks from getting their preventive
7 care and we're beginning to look at cultural barriers and
8 the other barriers, as well.

9 But I have to say that this isn't as easy as you
10 think. We did this for all of our self-insured plans. And
11 actually for 2008 even most of our fully insured plans are
12 doing this. You can put zero dollar copay on the ID card
13 but physicians are not used to this. So either they don't
14 understand not to take a copay when the patient goes into
15 the office, or they mistakenly code it with a diagnosis and
16 it doesn't get paid free for the member.

17 So again, this is all a journey. It's a lot of
18 communication. We can do the communication with our
19 members. We're looking with our health plans to do the
20 communications with the physicians.

21 What we wanted to do in 2008 but decided to do
22 some pilots to see how it works is for those folks that are

1 diabetics, that have a heart condition, that have asthma,
2 when they go to get their preventive care, when they go to
3 get their glucose tested, the other exams that they need,
4 we'd like to make those office visits free, too. Again, we
5 want to incent that care.

6 Administratively we haven't figured that out yet.
7 That's our next step, is really to figure out the
8 administration.

9 We also implemented a personal health record. We
10 did it through ActiveHealth again. They have all of our
11 data. One of the reasons we want to do this is they can
12 collect all of the data from the claims data, from lab, from
13 x-rays, from pharmacy. And for those members that have
14 Informed Care Management or use a health advocate, they can
15 collect data from members that they normally wouldn't get.
16 Do you smoke? What is your family history? Mark talked
17 about the importance of that. What are your over-the-
18 counter drugs that you're taking? And put that in the
19 CareEngine, as well. But we want more of that data. So
20 personal health record, where we have everybody complete it,
21 will get us more data.

22 That's easy to implement. Now we have to get

1 people to use it. So we've got quite a few challenges.

2 But I would say we are convinced that using
3 evidence-based medicine to identify those who need essential
4 care and then putting a plan design in place to incent that
5 essential care is really our next step and an important
6 piece of our strategy.

7 That's what I've got and then Mike is going to
8 talk about the results of some of the studies.

9 DR. CHERNEW: I can say hello and it's wonderful
10 to be here, thanks for having me, while the slides are
11 coming up.

12 The slides have fewer typos in them than the
13 handouts so I'll mention them as we go along.

14 This is a topic we've been involved in for a long
15 time and I'm thrilled to be able to come here and talk with
16 you about it. It's a little awkward because some of you may
17 know I'm a proponent of value-based insurance design, and I
18 really am, and I'm a big fan of everything that Jill has
19 done. I think she's shown leadership in a whole range of
20 ways.

21 I was asked to be a bit of a skeptic, which as an
22 economist is easy. So I'm going to be a little skeptical

1 and hopefully we'll have some more skeptical questions as I
2 go through.

3 One of the things that I want to say when people
4 talk about value-based insurance design is exactly what "it"
5 is, exactly what value-based insurance design matters in
6 your conclusions. So I want to draw your attention to two
7 particular design distinctions.

8 The first one is what I call service-specific
9 programs. You may have heard what Pitney Bowes did or what
10 Jill described at Marriott. I consider those service-
11 specific interventions because they basically focused on
12 particular services, in their case chronic disease
13 medications, and lowered the copays for those services for
14 all of the people who may be using those services without
15 distinction.

16 That's a different design than what happened at
17 say the University of Michigan, or as Mark described at
18 Aetna. At the University of Michigan, they focused on only
19 patients with diabetes. So at the University of Michigan
20 you got a lower copay for your diabetes medications and your
21 depression meds and your blood pressure medications, but
22 only if you had diabetes. Some Mark and I might have been

1 employed at the same place and we might pay different copays
2 for the same meds, based on our clinical conditions. So
3 it's more of a targeted program that Mark spoke of.

4 The second distinction I want to talk about is
5 people often talk about the value-based insurance design
6 program as only lowering copays. In fact, that's what
7 Marriott did and what most of the other firms have done,
8 they just lowered copays. But in fact, conceptually you
9 could have a value-based insurance design program where you
10 try and hit any financial program you want. But instead of
11 doing it with one level set of co-pays by spreading them --
12 this is the sign for spreading them -- by spreading them to
13 encourage the things you want to encourage and discourage
14 the things you don't. Again, you'll ask me how can I
15 distinguish that, and that will be 12 o'clock and we'll run
16 for our planes.

17 But that also is a value-based insurance design
18 program. And that flexibility allows you to hit financial
19 targets a lot easier than if you just say I want to hit
20 those financial targets by lowering copays. So I think it's
21 important to realize the distinction between those different
22 types of services.

1 The questions I want to talk about, what are the
2 barriers to VBID implementation? What are the economic
3 effects of value-based insurance design? And how can value-
4 based insurance design be implemented in Medicare?

5 Most of what I talk about and most of what's been
6 talked about hasn't been Medicare-specific. I do want to
7 say a little something about how these ideas, if not the
8 details of the programs, can be implemented in Medicare. I
9 think that's very important. And I do think there's a broad
10 analogy.

11 So some barriers to value-based insurance design
12 implementation. The first one is implementation. That
13 tends not to be a problem in these programs that are
14 service-specific. It's easy to lower copays for certain
15 chronic disease medications. And you could lower copays for
16 certain other types of services if you didn't want to make a
17 distinction by disease. It's harder, as Jill mentioned,
18 particularly for non-pharmaceutical interventions when you
19 want to make some distinction by disease. And there are
20 some companies that are working to do that. Marriott and
21 the myriad of vendors that they work with, I think, are
22 pretty much at the forefront of that.

1 There are legal barriers. A lot of time when you
2 talk about folks, they worry, if you want to do this, stay
3 within your HSA, there's a question. Can I lower copays for
4 this and for that? And my sense of this -- I'm not a lawyer
5 -- is that the law is unclear in a range of ways. There's
6 concerns about discrimination. There's concerns about the
7 tax rules for HSAs. But a lot of folks have done this and
8 at least through some legal departments they've deemed that
9 these type of things are implementable and you've seen them
10 implemented. That doesn't mean that the law couldn't be
11 clearer to encourage this more.

12 Then one of the big questions you hear is what's
13 called beneficiary acceptance, particularly in the targeted
14 programs. But the idea is if I lower somebody's copays
15 because they have asthma or diabetes, someone else who
16 doesn't have those diseases is still paying the higher
17 copays. They might be upset. And you worry about the
18 equity of encouraging better treatment for some diseases
19 than others.

20 I will tell you at the University of Michigan the
21 experience was not oh, you lowered copays for these other
22 people, you jerks. The experience was much more, through

1 almost every e-mail, you're wonderful, you've really helped
2 us out, we think you're great, thank you, thank you, thank
3 you. I think there's not a lot of people trying to get
4 diabetes so they can get lower copays.

5 So I admit that this is potentially a problem but
6 none of the people I've known -- and you can speak with Jill
7 -- who have done these types of programs, have reported a
8 lot of negative response to what other people were getting.
9 But again, some of these programs are novel. So I say so
10 far, so good.

11 The economic effects. Will it save money? I
12 don't like that question. I'm going to say something about
13 it. A better question is how do we finance health? What
14 we're trying to do through VBID and a whole range of things
15 is to make people healthier. The question becomes how do we
16 pay for that in one-way or another?

17 One way to pay for that, of course, is through
18 offsets, which I'm going to talk about. But there's other
19 ways. Even if VBID costs money, I would argue that doesn't
20 mean we should charge people more for their chronic disease
21 medications. We should find a way to make sure that people
22 are taking things that we deem are essential.

1 Now if they're not essential or not appropriate,
2 that's a separate question. But the question should not be
3 will this program save money? That shouldn't be the hurdle.
4 It's not the hurdle when you set someone's broken arm or a
5 whole range of other things. The question should be how do
6 we finance the health care benefits that we want to give to
7 people? I think that's a crucial distinction.

8 And that leads us to my third question, which I
9 like even better, which is how do we enhance value? How do
10 we make the health care system more efficient in providing
11 benefit for the amount of money that we spend?

12 So I like this slide because it's soothing. It's
13 dolphins and tuna. But the basic idea behind saving money
14 in these cases is there are some people that would have
15 taken their medications anyway and other people that
16 wouldn't have. When you lower copays, typically if you
17 lower copays for everybody, the benefit from that is to
18 identify the people you want to target. In the fishing
19 analogy, the tuna, the people who you want to catch.

20 But the problem is you often end up lowering
21 copays for people that would have taken the medications
22 anyway. So you're not getting any incentive effect for

1 those people. And so if you knew, if everyone had on their
2 forehead, sort of tattooed, I'm not going to take my
3 medication unless you lower my copay to \$5, you could go
4 around and have a benefit design. And they walked in,
5 they'd show their forehead, they get...

6 But that doesn't work so well. And so the
7 challenge in this program is how to separate that out. And
8 that's what's going to drive the economics of the program.

9 The perspective is key. And there's going to be a
10 typo on the slide that you have, but it's right on the
11 screen.

12 The one perspective is the aggregate perspective,
13 which the key point about that is -- and I'm going to use
14 Jill because she's so nice to be here. She's not quite the
15 audience, but for my example.

16 When Jill's company, Marriott, lowers copays for
17 their workers, for people that would have taken the
18 medication anyway there is a shift in spending. The \$5 that
19 would have been spent by the employee that's been reduced is
20 now picked up by Jill. In the aggregate perspective, that
21 nets to zero. The \$5 was spent. It's just a question of
22 who.

1 In a payer perspective -- and this is below and
2 this is the part that's wrong on the handout but right on
3 the slide -- that's a cost to Jill. Jill paid five more
4 dollars. Someone else got the \$5. And that makes the
5 aggregate perspective cheaper. The employer perspective is
6 more expensive. The aggregate perspective is appropriate
7 for cost-effective analysis. It's what economists tend to
8 look at societally. And they deal with the distributional
9 issues separately.

10 And in the aggregate perspective, the only real
11 cost is the cost of the extra medications that are being
12 used if it's a formulary as opposed to some other service,
13 as opposed to the shift.

14 So the results from the literature -- and I say
15 literature/press. There's a lot of press on this point. As
16 an academic, I have to be skeptical of the press because
17 otherwise what would I do? Pitney Bowes, for example, they
18 report a 6 percent decrease in overall diabetes costs and
19 savings exceeding \$1 million. They report savings even in
20 their Rx spend, in some presentations I've seen, from this
21 type of intervention.

22 The city of Ashville had a comprehensive

1 intervention where they targeted diabetes. It was run
2 through the pharmacists so it was more than just copay
3 reductions. But they reported also a reduction in annual
4 per participant total cost for diabetes of a per person cost
5 of over \$1,000, which is nontrivial.

6 I don't want to go through a big discussion of
7 evaluation here. But I will say if you read those and we
8 had a discussion over cantaloupe or whatever else you can
9 eat over there, I might be skeptical of some of those
10 things. There's a stronger controlled study done by Amitabh
11 Chandra and Jon Gruber look at what happened when public
12 employees in California were charged increased copays. So
13 that's not VBID lower copays, that's increasing copays, but
14 there might be a symmetry.

15 They found the medical offset was 20 percent
16 overall. That means for every extra dollar you would charge
17 to employees -- save because employees are paying more -- 20
18 percent was extra medical costs. In the VBID context, that
19 would mean every dollar you spent in giving employees a
20 break, you would get 20 cents back because medical costs
21 would go down by 20 cents. In the highest spenders, the
22 most targeted group, you got a 50 percent offset.

1 The key thing is there's no doubt, that I'm going
2 to present some numbers. I think it's not quite -- because
3 everything is refutable -- but it's close to irrefutable
4 that if you lower copays, people buy more stuff. And if you
5 lower copays on good stuff, they buy more good stuff.

6 The question is because that stuff is good, the
7 evidence would suggest and we find, you get health benefits.
8 This is just a numbers issue. It's just an actuarial
9 question. How big are those health benefits relative to
10 the amount that you had to spend? What was the baseline
11 risk and how much did you reduce that?

12 So here's some results from a study we've done
13 where a VBID initiative increased adherence about three
14 percentage points. The way I really should have phrased
15 that is non-adherence went down by about 10 percent. So
16 copays were lowered by 50 percent and non-adherence went
17 down by about 10 percent. If your adherence is 100 percent
18 in the beginning, you're not going to save a lot of money by
19 lowering copays to folks because you don't have that much
20 room.

21 The way to think about this, think about that
22 number of tuna in the sea and how many of those people you

1 can reel in by lowering copays. We found about 10 percent
2 by a reduction. And that actually is in a line with the
3 rest of the literature on the responses to copays.

4 And I think prevented about six adverse events.
5 So six people didn't have heart attacks, which is really
6 good, particularly if you're one of those six people.

7 And the question becomes can the non-drug savings,
8 the savings in terms of those adverse events, offset that?
9 So this is where I'm going to ring my hands and be sort of
10 dismal economisty and break out into a sweat.

11 The actuarial analysis and the econometric
12 analysis suggest pretty clearly that the answer, even in the
13 short term, was yes, you could save money. The problem was
14 there were huge standard errors around the estimates. There
15 was a range of issues with the nature of the control group
16 and what the trends were. What I can say is the firm that
17 implemented this clearly had better experience than any
18 trend analysis would have suggested they had. Whether
19 that's completely attributable to the intervention is what I
20 worry a lot about and stay up at night thinking about.

21 So we did what I call some plausibility analysis
22 to see well, knowing what we know clinically and knowing

1 what we know about the adherence effects, how much money
2 could you have expected to save based on working that
3 through? The answer is going to be it's plausible -- I'll
4 show you some numbers in a second -- that the overall cost
5 from the aggregate perspective was a wash. It's plausible.

6 It's unlikely, in my opinion, that the payer
7 themselves in the first year saved money.

8 So to give you some numbers, the increased drug
9 spend was about \$2.51 overall for people in the study.
10 That's not for the whole plan, \$2.51. That's just for
11 people who were eligible for the lower copays. They spent
12 about \$2.50 more per member per month.

13 the payer spent \$7.73. So that's over \$5 more.
14 The reason, of course, is the \$2.50 is just the extra drugs.
15 The \$7.73, that's the extra drugs plus the extra amount that
16 the employer was paying for the drugs that would have been
17 bought anyway.

18 So then the question was how much money was saved
19 on less medical spend? Now remember these numbers are
20 almost all accruing to the employer because the copays for
21 the workers were small for like the hospitalizations and
22 these other big ticket things.

1 So if you believe that this extra people, if you
2 believe a given person, when they take their medication
3 versus not, if they're non-drug spend goes down by 17
4 percent, if that's the magnitude that you believe the
5 savings is, you would get a wash from the aggregate
6 perspective. And I will tell you that from the literature
7 that's in the range of plausibility. You can find
8 literature for people with chronic diseases and you might
9 say oh, you're not actually crazy and you could talk to a
10 group as distinguished as yourselves and say that with a
11 straight face.

12 For the payer to have saved money in the short run
13 you need to have non-drug spending go down by about 50
14 percent for those three extra people that took their meds.
15 And that's a lot for the literature to really justify. And
16 so that's where I think the numbers are.

17 Now I should say there's a few things about the
18 analysis that's important. We didn't include any
19 productivity gains in here. So those numbers, 17 percent of
20 48 -- that assumes that there's no productivity value. And
21 I think the productivity value is important. I can't
22 measure it so it doesn't get on my main slide. It gets on

1 my little three bullet point slide.

2 But the productivity things matter. There's no
3 disability savings associated in our numbers. There's also,
4 in any of our societal costs, there's no social security
5 implications. So no one's gone through to figure out what
6 it costs or saves Social Security if people are healthier.
7 And that's a complicated question that I really don't want
8 to get into. But if you manage chronic disease better, I
9 should say that's a good thing. I feel very strongly that's
10 a good thing. But the fiscal ramifications extend more
11 broadly than our analysis has attempted to do. And I'm not
12 going to make any policy conclusions about that except to
13 say again, as strongly as I can, we really do want people to
14 take their chronic disease medications. And the idea of
15 charging them more for it is probably not a good thing. The
16 idea of charging them less for it probably is a good thing.
17 And it's just we have to figure out how we're going to deal
18 with that.

19 The drivers of performance of these types of
20 programs depend on a few things. How many patients respond?
21 I told you what our numbers were. They're pretty consistent
22 with the literature.

1 What's the initial compliance? If there's low
2 initial compliance, that's going to make it look a lot
3 better because it's lot more tunas and a lot fewer dolphins.

4 How effective are the service? It works a lot
5 better if the services that they're taking are very good at
6 reducing the risks of adverse events?

7 What are the costs of those adverse events? If
8 they're very expensive, it's going to save you a lot more
9 money than if those adverse events are cheap.

10 And then again, the key is often going to be can
11 you target patients? Targeting high risk noncompliant
12 patients is going to give you a lot better financial program
13 than targeting everybody.

14 There was a study, I'm sure you're familiar with,
15 by Allison Rosen, a colleague of ours, in 2005 that talked
16 about giving medications for free for people with diabetes
17 in Medicare. And she said that could pay for itself. What
18 makes that work? The baseline risk is what makes that work.

19 Medicare is a wonderful place to do this
20 conceptually because you have beneficiaries that are at risk
21 of adverse events that are higher than some of the leading
22 folks that have a bunch of working age people. Right?

1 They're not going to see as good a return as the Medicare
2 program would because the risk in the Medicare program, the
3 amount of money on the table that you can save is so much
4 higher.

5 Let me give you my quick summary. Unless properly
6 targeted, copay reduction only VBID program -- just lowering
7 copays -- will typically not save money for the payer.
8 Whether they save money overall, maybe. But they're not
9 going to save money for the payer.

10 So if the question was could you save money by
11 lowering copays, for most employers from their perspective
12 there's not enough money on the table to save money by
13 lowering copays unless you target it well.

14 That said, and I should stand up or turn around or
15 get a cheer or something. Even so, that still might be a
16 good thing to lower copays. Aggregate costs are going to
17 rise a lot less. Maybe they will going to be negative. But
18 you're going to see the profile from the aggregate
19 perspective is going to be a lot better. And more
20 importantly, health improves.

21 So the question becomes how do we finance it? One
22 way is you could raise copays for other services, services

1 you think aren't important. And of course, if there's a lot
2 of service you don't know the evidence about, you don't have
3 to raise copays all that much because you're spreading it
4 potentially across a big set of services.

5 In Michigan, I think it was like a dime for all
6 things that weren't advantage you would have to raise copays
7 to offset because you're targeting and so it's just how the
8 math worked.

9 You could raise premiums. Maybe people would pay
10 for better health.

11 You could lower wages, which is how economists
12 thing. I'm not telling you to lower wages. Do I have to
13 leave now?

14 But economists think better health gets paid for
15 by workers that have lower wages. And of course, if they're
16 willing to do that, that's a good thing. I'm not arguing
17 for lower wages.

18 And then, of course, the one that I have to put on
19 here because I'm the skeptic is, of course, you could decide
20 societally we want to actually pay for more health by
21 raising taxes or some other distributional mechanism.

22 The key point behind value-based insurance design

1 that I really need to stress is in order to manage the
2 system the way in which I think we want the system managed,
3 we need to be more clinically sophisticated. In a range of
4 ways, pay-for-performance, disease management, we have
5 become much more politically sophisticated. That's a really
6 good thing.

7 In the area of what we charge patients, we haven't
8 historically been clinically sophisticated at all. And the
9 idea behind value-based insurance design is to extend that
10 same notion of clinical sophistication that goes behind pay
11 for performance, that goes behind disease management to the
12 incentives that patients face.

13 And the interesting thing is many of those other
14 programs, in pay for performance, for example, involve
15 services the completion of which require not only the
16 providers to recommend them but the patients to do them.

17 And so I can't emphasize enough, I believe, the
18 necessity of thinking about the synergy between what's going
19 on on the payment side and the patient side. And that's
20 really the crux behind value-based insurance design.

21 My last slide is just going to have a few things
22 to do with Medicare. And I'm a little insecure saying this

1 in front of this group but in the Medicare health support
2 program -- I maybe shouldn't say can't use financial
3 incentives. But the Medicare health support programs are
4 limited in the way in which they use financial incentives.
5 They could have a nurse -- my understanding is they could
6 have a nurse sit outside your door and every morning ask you
7 what medications you've taken. But if they were going to
8 lower your copays \$5 they would run -- or maybe \$5 wouldn't
9 make any difference. But if they were to lower your copay
10 substantially, there would be some issues about the legality
11 of doing that. So there's an asymmetry in how they're
12 allowed to incent people to do things, which I think is at
13 least useful to think about.

14 Of course, you can do a lot of these things in the
15 special needs plans or in Medicare Advantage programs
16 generally where you could set formularies in different ways.
17 We haven't seen a ton of that, although I'm hoping we will
18 see more.

19 There's issues related to adverse selection and
20 other things that go on that I think are important to think
21 through. But I think that when one thinks about the ideal
22 benefit design for patients in a Part D plan or even outside

1 of a Part D plan, you really would want to make sure that
2 you don't disincent people from taking the medications that
3 you know and the clinical evidence is strong is really very
4 good for them and may provide -- the money you spend on
5 that, some portion of that money -- maybe all of it -- will
6 come back to you in the end.

7 That requires some bit of finagling in certain
8 settings but I do think for Medicare it's an important way
9 to make the program a little more clinically oriented, which
10 is what I would like to see happen.

11 Thank you.

12 MR. HACKBARTH: Thank you. Let me just do a
13 little meeting management here first. We're running a bit
14 long. We're scheduled to be finished at 12 o'clock and I
15 know people have airplanes to catch and the like.

16 What I'd like to do is to extend to 12:15, which
17 will allow us maybe 20 minutes or so for some discussion and
18 then 10 minutes for a comment period. So if people can hang
19 in for that extra 15 minutes, I'd appreciate it. If not, I
20 understand.

21 Let me begin with a question about Medicare and
22 how this applies to Medicare. In Medicare, we've got a

1 design now where we have the drug benefit provided through
2 independent private insurers. And then for most
3 beneficiaries still the rest of the insurance coverage
4 provided through traditional Medicare.

5 Does that division inhibit this because you've got
6 different pockets? And for example, Humana, if they change
7 and adopt this for their drug program, savings may accrue
8 somewhere else in terms of lower disease, chronic disease
9 costs.

10 Help me just think through that issue. And John,
11 you probably have something to say on this as well.

12 DR. CHERNEW: Yes.

13 MR. BERTKO: This one seems to be complicated. so
14 in Mike's example, and Mark, I think, using the diabetes
15 one, nobody's going to take insulin and various things who
16 doesn't need it. So that one might be doable.

17 When you get to anything like the statins or some
18 of the others where there could be off label use, you can do
19 it within a SNP. But can you do it in a regular PDP, a
20 prescription drug only plan? That would seem to be
21 difficult. I don't really know the answer to that.

22 But how do you prohibit people who might be given

1 a prescription for this who don't fall into the targeting
2 criteria?

3 And I completely agree with Mike about how narrow
4 and specific the targeting needs to be in order to be cost-
5 effective.

6 DR. CHERNEW: But your question, though, was the
7 incentives. So the incentives to do this in an MA plan or a
8 SNP are a lot greater than the incentives to do this in a
9 straight PDP, for the exact reasons you said, implementation
10 aside.

11 DR. FENDRICK: But I think briefly, from the
12 clinical standpoint, it's proven to be extraordinarily
13 difficult, even for those champion plans and companies, to
14 get down to this fine granular level of targeting. Which
15 again, to my very first point, is not driven by maximizing
16 health outcomes, but in terms of getting cost-effectiveness,
17 as you say, John.

18 I still think that while I'm sure we're going to
19 talk a lot about targeting, is this generalized concept that
20 almost every American now, on a given class of a formulary
21 pays the same amount of out-of-pocket independent of what
22 the condition is. I think most people are happy to

1 acknowledge in every stakeholder group that we probably,
2 whether it be for primary or secondary prevention, using a
3 statin should probably be lower than a non-sedating
4 antihistamine.

5 So people say I can't get to that level of
6 information technology to find the heart attack patients. I
7 would argue strongly that should not preclude the discussion
8 of just doing some kinder, simpler VBID interventions that
9 will get to that same price point that Mike had mentioned.

10 DR. MILSTEIN: In modeling impact of value-based
11 insurance design, the analyses that you described are what I
12 refer to as sort of static analyses, opportunities on a one-
13 time basis to reduce spending, improve health, or some
14 combination thereof. Any comments or any attempt at --
15 admittedly highly speculative modeling -- on what might
16 happen, how it might affect I'll call it the drug
17 development financing pipeline if Medicare began tilting
18 toward drugs that were more cost-effective?

19 DR. CHERNEW: That's a harder question than the
20 hard question I thought you were going to ask. The hard
21 question I thought you were going to ask was over time won't
22 this get better, which Jill alluded to? Which I think it's

1 plausible. In fact, we saw some of that. But one has to go
2 through exactly what the numbers are to decide what you
3 think about that.

4 I think that the economics would suggest that that
5 would be true, but empirical evidence that would suggest
6 that that would be true is really difficult to come by. You
7 certainly would like that to be true to make sure that you
8 would want your innovation in areas that provided the best
9 health and were the most productive in that regard.

10 MR. BERTKO: A somewhat related question and it's
11 two parts. The first is in today's environment, it looked
12 like you guys talked about maybe five possible conditions to
13 which this might apply. And I'm just going to ask about how
14 many total conditions you think?

15 And then secondly, do you see that comparative
16 effectiveness offers a way to work on a greater number of
17 conditions? Would this be one of the things we could use it
18 for?

19 DR. FENDRICK: As a person who performs this type
20 of research, obviously the self-serving statement. This is
21 a full employment act for me and I want to make sure that's
22 clear.

1 I think that what this does is say an awful lot
2 about the fact that how much more research we need about
3 what is not only the better intervention from the clinical
4 side but the better intervention from the financial side.

5 We are all fully supportive of the efforts
6 happening inside the Beltway and elsewhere, state level and
7 plan level, in terms of increasing the amount of reality-
8 based effectiveness trials in the community. But as we have
9 been asked to comment by the Institute of Medicine, is that
10 comparative effectiveness research is merely just a tool to
11 say what the data are on the clinical side. And most of you
12 know more than me that the politics are not, in fact, to
13 show what's better or what's not but ultimately how it
14 shifts from the quality improvement to the cost containment
15 side.

16 The point about this turns to my very early point
17 is that in those very early areas of medicine where we have
18 Grade A evidence that it's clearly the right thing to do --
19 beta-blockers after heart attacks and glucose control and
20 any other thing -- we've shown that the evidence enough,
21 even if it's perfect, we've done poorly in that situation.
22 So obviously the more evidence the better.

1 But we argue very, very strongly that the system
2 has to be able to reflect that evidence to align incentives,
3 as Mike said, across the board. I think the disease
4 management copay example is the best one to show that the
5 silos still aren't talking together. And the quicker we get
6 them to do so the better off we'll be.

7 DR. CHERNEW: Are you going to answer the number
8 of diseases this would apply to?

9 DR. FENDRICK: I've told people for a very long
10 time that the sad part from the clinical side and the good
11 part from the economic side is that the areas that we have,
12 John, in terms of that we would strongly recommend copay
13 relief in terms of not only returning health but ROI is in
14 fact, 10. You've mentioned many of them. Most of them are
15 in the pharmaceutical areas.

16 And thankfully, on the non-pharma areas Medicare,
17 whether they've done it intentionally or not, have really
18 aimed to improve coverage and reduce out-of-pocket
19 expenditures for the beneficiaries in the health maintenance
20 exam, in the cancer screening opportunities that you
21 provide.

22 But as Jill said, it's easier on the pharma side.

1 If we really were to make an investment into diagnostic
2 testing and procedures, I think once the infrastructure is
3 in place somewhere that was at least presented in recent
4 legislation, we'll be able to get larger population
5 discussions, as well as returns on investment in the short
6 term.

7 What I want to say, unfortunately which is going
8 to come up, is we can all go down the list, depending on how
9 far, to the 10 or 12 or 15 things that we consider good.
10 And Mike knows, when we started 10 years ago, I was
11 unwavering on my 10 things. And I've been convinced, given
12 the cultural context of various regions and plans and
13 employers that it doesn't matter to me anymore what you
14 consider to be value. Let's just encourage those things.

15 There always is that question of what would you
16 discourage? I think for this group we want to be known as
17 the team that led to a strong scientific argument to remove
18 barriers to get good things to the right people. I think
19 the much, much harder part, which is largely driven by the
20 fiscal part and not the economic side, is to decide what are
21 those things that we should discourage?

22 What I've seen nationally is trying to discourage

1 the use of high value branded drugs as opposed to low value
2 inexpensive drugs really does strongly draw attention to the
3 fact that we care much more about cost than we do about
4 quality.

5 MR. DURENBERGER: Just by way of quick background,
6 I got here by starting out in 1973 in Minneapolis-St. Paul
7 with a lot of major companies which were doing both health
8 management and prospectively health care management.
9 Doctors at Honeywell, doctors at General Mills, things like
10 that and so forth.

11 So this isn't a new phenomenon but it got killed
12 and now it's being brought back, or so it seems to me. I
13 just think I'm just noticing in the last couple of years --
14 and Jill, you're a great example of it, as are others of
15 your colleagues -- that this whole movement needs to be
16 strongly supported on the research side, as I think she has
17 indicated.

18 My question is probably in two parts, and this is
19 sort of like why are we doing this at MedPAC?

20 I also come from a community which most recently
21 has a great big managed care plan which bought Golden Rule
22 and bought Definity and claimed that somehow or other it was

1 improving value in health care. But its former CEO was
2 probably the first guy that talked to me about what you just
3 talked about today. McGuire believed that despite all the
4 things that at that time employers wanted, what the country
5 really needed was a basic benefit which would describe in
6 value-based terms with subsidy alternatives depending on who
7 can afford it and so forth. But he's the first person who
8 made the argument to me that this is an important thing to
9 do.

10 But my question is from your experiences,
11 particularly as we sit here as MedPAC with sort of a basic
12 benefit that we're trying to pass off some of that benefit
13 structure to Medicare Advantage plans without telling them
14 what we really expect from them other than go sell more
15 product, how important is it to do the work of defining a
16 basic benefit along the lines that you've talked about as
17 soon as possible rather than allowing 1,000 flowers to bloom
18 and everybody comes up with their favorite this, that and
19 the other thing?

20 Is this not a really very, very important part of
21 getting health care costs under control, beginning down a
22 line of private side/public side, using the current tax

1 subsidies and so forth, to develop a better understanding in
2 people in this country about what is health and how do you
3 management it? And whose role is what? And how do you
4 reward it? And what is health care? And how do you reward
5 those most appropriate clinically beneficial therapies?

6 Do any of you have a response on that?

7 DR. CHERNEW: I don't know why I get to respond.
8 I think that people have pushed us to define one value-based
9 insurance design plan that we can go around and say this is
10 the plan, here's what it would be, do this. We've been very
11 resistance to do that because Mark won't do it and he's the
12 doctor.

13 But also, in part, because there seems to be
14 different views on a range of things. I think that it is
15 not so important now to have one particular plan structure
16 that everyone would have to offer unless you're concerned
17 about adverse selection issues like in Medigap markets with
18 the A through J. So that's an important question that
19 hasn't been studied very well in this.

20 I will say from our experiences -- very, very
21 limited -- you don't see very many people switching
22 employers because oh, this employer wanted -- because they

1 have a little bit less on what their diabetes meds are. But
2 that's not to say when people are choosing health plans,
3 we've done some preliminary analysis, I'm sure you've seen,
4 on the Part D plans that people aren't very aware of what
5 drugs they take and what the benefit structures are.

6 And so I think the challenge is going to be how
7 well the risk adjustment is working. If you were going to
8 apply this to Medicare that becomes crucial. And then how
9 you might want to try and standardize. Because I would
10 worry in some plans, particularly on the plans where they're
11 on the hook for medical costs, that if you offered really
12 good chronic disease management programs you would get a lot
13 of people that had chronic disease. And I think that's just
14 a shame, right, because you don't want to be in a situation
15 that discourages that.

16 And maybe standardization would help. In the
17 private sector, I think that would be an impediment because
18 people would have different opinions and they would not
19 necessarily --

20 MR. HACKBARTH: Let me follow up on that. Given
21 your response to my question, that the incentives under the
22 Part D program aren't quite right because of the different

1 pockets. It may be that the only way that you're going to
2 get it in Part D is to mandate it as part of the benefit
3 design and do it earlier rather than later.

4 DR. CHERNEW: So for a Part D plan where it's just
5 a drug cost because they're not taking on other costs
6 necessarily, you still would have an adverse selection
7 problem because you'd have more people taking those drugs.
8 But you would have to worry about the selection and
9 mandating certain types of services would matter.

10 The problem you always run into, and I wish I knew
11 clinically more, is what has been so useful is people that
12 have moved incrementally. So maybe it applies to 10 areas,
13 maybe 15. You've seen it done in like five. And you don't
14 want the doing it in five to preclude the other areas. So
15 you want some flexibility.

16 Although I do think there's some ideas -- diabetes
17 would be one -- where I think the world would be a better
18 place if there were certain standardized rules in those
19 particular disease areas.

20 In fact, and this is an economist not a physician
21 speaking so I could let Mark comment. I do think there's
22 some areas where these types of things are amenable where

1 you could implement it in a really somewhat feasible way.
2 And I think focusing on those areas instead of waiting for
3 the perfect design is useful. And we have, Michigan and a
4 lot of other places, has focused on areas like diabetes
5 because you can identify people with diabetes easier. Even
6 John mentioned this. There's some real advantages to that.

7 Although as Mark mentioned, Aetna is doing some --
8 cardiovascular disease is really a big area. Some time and
9 resources to understanding what type of benefits are
10 important for people with cardiovascular disease really
11 could help people. The level of standardization is more of
12 a political question in some ways.

13 MS. BERGER: One of the things that, to answer
14 your question, we think a lot about this. And we think
15 possibly that if we were going to plan the perfect plan
16 design that it would actually be a little different for
17 everybody. It would depend on their diseases. It would
18 depend on their stage in life. So that really further
19 complicates it. But we actually think that's an important
20 thing to do.

21 DR. FENDRICK: Just a quick comment to the
22 Senator's point about cost control. I think that as sitting

1 on the Medicare Coverage Advisory Committee, where we're not
2 allowed to talk about cost and talk only about quality, so I
3 came here because I know you talk about cost and I hope
4 you're allowed to talk about quality. So it's a really
5 important idea that at the highest level of what's
6 happening, even in this agency, that as you say, Glenn, the
7 pockets may not be talking to one another.

8 For economists to say well, the way to get costs
9 under control is to prevent the idea of health enhancing,
10 cost improving technologies, which is 99.9 percent of the
11 things I could do. Economists could say that that actually
12 means like how politically palatable would it be to shut
13 down the NIH and all other privately funded research because
14 we have this insatiable appetite for improved health.

15 I think the purpose of VBID is to come to MedPAC
16 to say current systems of cost-sharing are hurting people
17 and our estimate are killing more people than this whole
18 safety issue which has caught Americans' attention.

19 And while we are never going to suggest that all
20 things should be free for all people, that we've invested
21 billions in this country to determine what helps and what
22 doesn't help individuals in the Medicare sector. And as

1 Mike told me 15 years ago, and it took me 14 years to
2 understand, that it's all about aligning incentives.

3 As long as we continue to pay doctors to go to the
4 plate, as opposed to hit singles, doubles, and home runs,
5 you're never going to have the situation where you're going
6 to have this ultimate -- for me the holy grail of where I am
7 getting paid when I'm actually doing the things that my
8 training has told me that I should be doing and not being
9 paid as handsomely for those things that don't work or don't
10 help people and might actually harm people in the long run.

11 MS. HANSEN: I have one question and it's related
12 to something, Jill, you brought up and the population of
13 your associates. You said that you're beginning to tackle
14 the whole issue of your diverse populations, since you do
15 have oftentimes many from a lower socioeconomic group and
16 their racial components. And to relate it back to Medicare,
17 I think it's Jack and his team at NASI that did the whole
18 Medicare disparities, that there still is that.

19 So could you describe some of the efforts being
20 made right now to deal this whole model vis-à-vis some
21 different populations for this impact?

22 MS. BERGER: When we think about the VBID model

1 and we think about our different cultures, the one place
2 where we're beginning to tackle it is communication.
3 Actually, a couple of places, communications and then
4 understanding the difference in the ethnic group. We're
5 working with Kaiser pretty closely on this, as well as Aetna
6 because they're spending a lot of time thinking about this.

7 We actually first thought we could begin to target
8 materials to some of our cultures, our African-American
9 culture, Hispanic culture, Asian American cultures. But
10 it's actually hard for us to really make sure that if we
11 target somebody that it's correct.

12 So we're looking to our health plans to help us do
13 this. We are putting together materials that we're hoping
14 will resonate with various groups.

15 We're also going a lot more local than we ever
16 have before. So we're learning about our various cultures
17 in Orlando, for instance, where we have a big Haitian Creole
18 population. This is a population that I'm not sure a lot of
19 folks truly understand. We do know that the closer we bring
20 access the better and we're working with some provider
21 groups that are coming into the property and working with
22 our different cultures.

1 So a lot of it is communication. And it's
2 teaching our different ethnic groups how certain diseases
3 may affect them differently. And that's some of the work
4 that we're doing with Kaiser.

5 So we're just scratching the surface. There's so
6 much more that needs to be done that we're trying to learn
7 about.

8 DR. CHERNEW: I would just add, in other research
9 that we've done in terms of income, so it's a different
10 split, lower income people are much more sensitive to higher
11 copays. In economics that's what you would expect. In some
12 things, that might not bother you as much as in other
13 things. But if we're concerned about disparities and you
14 want to worry about health effects, it's really important to
15 make sure that certain subgroups of people don't pay a lot
16 for certain types of medications. Maybe a lot of
17 medications but there are some that you could really point
18 to, these are really high value medications. And at a
19 minimum you want to make sure that you're not charging low
20 income people who have had coronary events a lot of money
21 for their statins.

22 DR. STUART: I know we're pushing the time limits

1 so I'll be very, very brief.

2 I want to thank you for coming and I hope you come
3 back because I think this is really important for Medicare.
4 But I think there are some real challenges that the
5 Commission is going to need to deal with.

6 You indicated that standalone PDPs have less of an
7 incentive to put these into place than the MA-PDs. I would
8 suggest that they have no financial incentive to do so.

9 In fact, they couldn't do it anyway because they
10 don't have the medical claims that would be necessary to do
11 the targeting. They'd have to use the drugs to target the
12 disease, which kind of gets around one of the problems. So
13 that's a problem for us.

14 The second problem is a bête noir that I've had
15 for a long time, which is we get no information. CMS does
16 not get any claims information or event level information
17 from MA plans. And so even though they were the ones that
18 would have the greatest incentive to employ these value-
19 based insurance designs, we're not going to know it on the
20 basis of what we get from the plans. And I think that's a
21 real problem.

22 And then lastly, ironically, risk adjustment can

1 work against us in this regard because if you're successful
2 in reducing complications from disease through these
3 mechanisms what that's going to do is it's going to reduce
4 the risk score. So the revenue that the plan gets from
5 doing these things is going to go down.

6 So we're not very aligned with our incentives, I
7 think, in terms of being able to bring this off. And I'd
8 like to suggest that the Commission spend some time in
9 figuring this out and have this as the agenda item in the
10 future.

11 DR. KANE: I guess Bruce helped clarify my
12 question. At what locus between Medigap and Part B and Part
13 D, where do you put the responsibility for designing copays?

14 But I was wondering to what extent at least
15 information could help us, if there could be something like
16 do the drug plans even know compliance? The PDPs, do they
17 have a sense of the compliance? And could they be reporting
18 on compliance and possibly eventually be held at risk over
19 time for the Part A/B complications that occur if compliance
20 is not improved? Could there be some kind of a linkage
21 between the A/B experience of -- I don't know but I'm just
22 trying to think about how you use information, at least.

1 DR. STUART: It depends on how you define
2 compliance because of its compliance with the drug for a
3 particular disease then the answer is the PDPs won't know
4 about it unless the drug is used only for that diseases.

5 DR. KANE: Maybe John can clarify that.

6 MR. BERTKO: In certain very limited categories,
7 and let's take diabetes, you'd know what the compliance is
8 for those drugs. You're right on a wider scale, though.

9 DR. KANE: You can pick certain conditions that
10 you wanted them to report on compliance. And if those rates
11 were not good, you'd hold them accountable for some Part A/B
12 expenditures. I don't know, it seems like that's the only
13 level you could do it though. You'd really have to really
14 know ahead of time.

15 It's worth talking about, I agree.

16 DR. CROSSON: I just want to thank the panel
17 because I think this is a very important movement, notion,
18 potential change not just for the Medicare program but
19 across the country. It's one, as Jill has mentioned, that
20 we've been interested in.

21 Having said that, it is a good deal easier, as I
22 think each of you have pointed out at some point in the

1 presentation, to figure out what barriers to drop, what
2 copayments to lower, what copayments to make disappear, and
3 where improvements can accrue than it is to figure out the
4 other side of the financial equation, which is what not to
5 pay for, what barriers to put in place, et cetera.

6 The case of the 26-year-old woman who's concerned
7 about colorectal cancer and has no family history, that's
8 kind of an obvious one. But the fact is that more broadly
9 it's a good deal more complicated than that.

10 So we've been doing some modeling here to try to
11 figure out what sort of interventions of that kind could, in
12 fact, balance the finances of this. I'm talking about, on
13 the plus side, dropping the barriers completely to the
14 management of chronic disease including no copayments for
15 office visits, drugs, et cetera. What would it take to do
16 that?

17 One of the things we've focused on, and this is
18 all just modeling, we haven't actually done it yet, is the
19 notion of shared decisionmaking. That's the other piece of
20 consumerism, if you will, that has some value to it.

21 At least on a preliminary basis, it looks to us
22 that if we actually took some of the products and notions

1 that Dr. Wennberg developed over time and expanded those and
2 targeted some of the high-cost discretionary procedures,
3 leaving the ultimate decision up to the patient and the
4 physician but invested in that, that we might in fact recoup
5 the costs of the barrier dropping, if you will.

6 And I just wonder -- and sort of as a first step,
7 I just wonder whether that has had thought of, looked at, or
8 modeled at all, outside of what we've done?

9 DR. CHERNEW: Thought of, most certainly. I don't
10 know an organization that implemented a program like that,
11 so I don't think it has been studied in great detail. As
12 Mark mentioned early on, we've been hesitant for a range of
13 reasons to say this particular service should be charged
14 more.

15 I think one thing to think through is all of this
16 is, at least in the commercial sector, done in the backdrop
17 of rising cost-sharing that people are facing. Something is
18 going to be done. Something is being done on cost-sharing.
19 So the question is at the margin how are you adjusting
20 things?

21 I don't think you're going to find one service and
22 say oh, we're going to pay for better chronic disease

1 management by charging everybody for some procedure that we
2 think is overused. But I think in the context of generally
3 rising cost-sharing, you could work out a program to hit
4 your financial targets.

5 There are consulting firms that would tell us you
6 tell us your financial target and we'll give you that
7 financial target with a more clinically sensitive copay
8 structure. I just haven't seen the --

9 DR. CROSSON: And we like to save money on
10 consultant costs.

11 DR. CHERNEW: And in the leadership of your plan,
12 they're very clear in chronic disease management programs.
13 So the real question is what happens to the whole mass of
14 stuff that's outside of that without actually targeting any
15 particular part of that mass.

16 MS. BERGER: We've actually modeled this a little
17 bit. I'm sure it's very simplistic. Do you know why we
18 haven't done it yet -- although I know we'll be there for
19 2009 -- is trying to figure out how we communicate it to the
20 members. Everything we've talked about we're trying to
21 figure out how to communicate it.

22 One thing I'm convinced about, but I could be

1 wrong. I'm convinced that our folks just don't know what
2 the drugs cost and they're either pleasantly surprised when
3 they go to the pharmacy or not. And so we're trying to do a
4 better job communicating that. Because we have that three
5 tiered plan design that Mark presented. And then on top of
6 that the VBID.

7 But that's what we're trying to figure out, is the
8 communication piece.

9 DR. FENDRICK: Jay, you as a clinician, understand
10 that the real problem with the creating barriers side is
11 that second point about the clinical heterogeneity. Most of
12 the things that all of us would argue would be low value
13 services, there is almost always a situation where patients
14 clearly benefit.

15 And until you create that information technology
16 and comparative effectiveness research to basically say I
17 believe that back pain surgery is probably clinically
18 indicated about 15 percent of the time. And if you just put
19 high copays for back surgery we get in the whole
20 dolphin/tuna situation.

21 But because we're getting close to the end, and
22 you mentioned shared decisionmaking, comparative

1 effectiveness research, information technology, I think I
2 have to say, given that this is the only opportunity I'll
3 get to present to the Commission, that there is a profound
4 belief that comparative effectiveness research and
5 information technology, in and of themselves, are going to
6 be important mechanisms to health care cost containment.
7 And it is my personal opinion, doing this for 20 years, that
8 given A, experiences that we've shown with new medical
9 interventions; and B, our unwillingness to disadopt things
10 unless we have something better and more expensive on the
11 critical arena, that unless benefit design is literally
12 there the day the research comes out and the information
13 technology is set up that because of the underuse problem
14 none of our simulations suggest that you'll get any cost
15 savings at all.

16 That in fact, because of the underuse problem of
17 these things that we like and we find to be important, that
18 any advantages you get in terms of this proposed, we're
19 going to stop doing the bad things, will be completely
20 overwhelmed by doing more of the health producing but cost
21 increasing interventions.

22 MR. HACKBARTH: Bob, you get the last word.

1 DR. REISCHAUER: This is really a comment. I was
2 a little surprised by, I think both Mike and Jill mentioned,
3 that there was fairly widespread beneficiary acceptance of
4 moving in this direction. I wonder whether, as this goes
5 forward and matures, that will be the case or whether it's
6 transferable into Medicare.

7 One dimension where you might expect some
8 resistance to develop is privacy. The more granular you
9 get, the more Marriott or a plan or something knows about
10 your condition, your behavior, et cetera, et cetera -- and
11 it might be that people are positive about people caring
12 about them but we have some subset of the population that
13 seems to resist or think that this is not good.

14 The other area is we're talking about targeted
15 interventions here. And maybe for the University of
16 Michigan population or Marriott, where most people are
17 healthy most of the time and they don't want diabetes and
18 they probably think -- they haven't listened to Mark yet and
19 they think well, there is an advantage, if we can treat
20 diabetes more effectively it's going to lower our insurance
21 costs overall and this is good. So there will be a benefit
22 for the non-targeted person.

1 That's not really true in Medicare where everybody
2 has something and there's going to be this well, why did you
3 do it for them when my little area doesn't cover as many
4 people, there aren't as many people, but it's equally
5 expensive. And then of course, there are all the interest
6 group that will say yes, this is effective and this is
7 important, you have to do that. And so suddenly the dike
8 breaks.

9 MR. HACKBARTH: Due to the inevitable time limit,
10 we're going to have to just let that stand on its own merit,
11 which is substantial.

12 So thank you very much. This was a very
13 interesting and helpful discussion. We really appreciate
14 your spending the time with us.

15 We're going to have a very brief public comment
16 period. I apologize for our running late and ask those who
17 make public comments to understand if Commissioners need to
18 leave to catch airplanes. The airline industry has not
19 agreed to hold its planes for MedPAC, at least not yet.

20 So if you have a comment to make, please keep it
21 very brief, no more than a minute or two.

22 I would remind everybody that staff goes to great

1 lengths to reach out and get information from people who are
2 interested in these issues. That is the single most
3 effective channel to communicate with the Commission. And
4 please don't consider the public comment period as your
5 opportunity. It really is not.

6 Having said that, if there any public comment, now
7 is the time.

8 MS. ARMSTRONG: Thank you.

9 Thank you, Chairman Hackbarth, Dr. Reischauer and
10 Dr. Miller and MedPAC Commissioners. My name is Lois
11 Armstrong and I'm the President of the National Alliance for
12 Hospice Access.

13 First of all, we do want to thank MedPAC for
14 meeting with us and for reaching out to us and listening to
15 our analysis and perspectives regarding the cap. We look
16 forward to being helpful in any way that we can.

17 I'm going to take up just a couple minutes of your
18 time because I want to put a face on this problem. I
19 recognize that you're sitting in Washington and looking at
20 it from far away. I don't know what we hospice providers
21 look like to you when we hit the cap, but I want you to see
22 that I am such a provider.

1 Let me tell you about our alliance. It's a
2 growing grassroots organization of hospices. Our members
3 are either family-owned or community-based not-for-profits.
4 We have over 130 providers in 20 states. And we are serving
5 9,000 patients every day. Our members are independents. In
6 other words, they do not have access to public markets,
7 venture capital, or private equity.

8 In my real life, I have managed hospice programs
9 for 20 years. I've managed large community-based not-for-
10 profits. I've managed for-profit programs.

11 Today my family, along with another, owns a
12 hospice that serves Northeastern Oklahoma and we are being
13 required to pay back a great deal of money to Medicare for
14 the year 2005, regardless of the eligibility of our patients
15 or their right to have the services that we provided to
16 them.

17 As we have reviewed before, in 1998 Congress gave
18 eligible beneficiaries the right to have as much hospice
19 service as they needed to do as long as they remained
20 medically eligible with a medical prognosis of six months or
21 less if the disease followed a normal course.

22 In summary, Congress expanded the benefit in 1998

1 and now guarantees medically eligible beneficiaries
2 unlimited days of care but simply neglected to ensure that
3 providers would be paid.

4 NAHA estimates regarding the cap are somewhat
5 larger than MedPAC's. We base these on published material
6 by Palmetto GBA and also Medicare's own cost reports. Our
7 estimates say that these cap repayments have grown from
8 under \$5 million in three states in 1999 to approximately
9 \$200 million in over 25 states in 2005. They've been
10 roughly doubling every year.

11 Independent hospices like the ones in our
12 coalition don't have the money to repay. We spent it two
13 years ago providing hospice services to Medicare
14 beneficiaries who were eligible to receive these services.
15 These hospices are being driven into an economic crisis, yet
16 their only fault was serving all of the eligible
17 beneficiaries in their community.

18 In summary, the cap is not limited to a few
19 states. At least 25 states have cap issues in 2005 and
20 these data are two years old. Our members come from West
21 Virginia and Los Angeles and Idaho and Minnesota. Our
22 hospices serve the rural, the poor, and urban ethnic

1 communities. This cap is a systemic problem because we are
2 admitting patients under criteria that Medicare asked its
3 fiscal intermediaries to develop for each of the non-cancer
4 diagnoses.

5 But the cap hits all of us, whatever our state, at
6 average lengths of stay well under 180 days.

7 Duke University recently --

8 MR. HACKBARTH: Thank you very much.

9 MS. ARMSTRONG: I'm going to take one more second.

10 MR. HACKBARTH: People have time constraints.

11 MS. ARMSTRONG: Chairman Hackbarth, everything we
12 know about end-of-life care tells us that quality and cost
13 benefit.

14 Thank you.

15 [Whereupon, at 12:24 p.m., the meeting was
16 adjourned.]

17

18

19

20

21

22