

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
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COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, J.D., Chair
JACK C. EBELER, M.P.A., Vice Chair
MITRA BEHROOZI, J.D.
JOHN M. BERTKO, F.S.A., M.A.A.A.
KAREN R. BORMAN, M.D.
PETER W. BUTLER, M.H.S.A
RONALD D. CASTELLANOS, M.D.
MICHAEL CHERNEW, Ph.D.
FRANCIS J. CROSSON, M.D.
THOMAS M. DEAN, M.D.
JENNIE CHIN HANSEN, R.N., M.S.N., F.A.A.N
NANCY M. KANE, D.B.A.
GEORGE N. MILLER, JR., M.H.S.A.
ARNOLD MILSTEIN, M.D., M.P.H.
ROBERT D. REISCHAUER, Ph.D.
WILLIAM J. SCANLON, Ph.D.
BRUCE STUART, Ph.D.

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

2 MR. HACKBARTH: I'd like to welcome our guests in
3 the audience.

4 Today we do have a final vote scheduled for after
5 lunch on the disclosure recommendations that we discussed
6 for the first time at the last meeting. We will also, later
7 on today, discuss draft recommendations on hospice services.

8 This morning we have two sessions on Part D and
9 then one on delivery system reform. To initiate the
10 discussion on Part D, Rachel.

11 DR. SCHMIDT: Good morning. Before we get
12 started, I'd like to acknowledge work of Shinobu Suzuki and
13 Hannah Miller, who contributed to this analysis.

14 Part D is about to start it's fourth year, and
15 we're approaching almost 26 million enrollees and about \$50
16 billion in benefit spending. This morning I'm going to walk
17 you through what we've learned from looking at Part D
18 enrollments for 2008, as well as what plan sponsors are
19 offering for 2009. Remember that the open season for Part D
20 runs from November 15th through December 31st, so now is the
21 time of year when beneficiaries have the opportunity to
22 choose among their plan alternatives.

1 Let's start with the overall sense of how Medicare
2 beneficiaries get prescription drug benefits. CMS estimates
3 that about 90 percent of beneficiaries either have Part D or
4 another source of drug coverage that is at least as
5 generous, which we called creditable coverage. The 10
6 percent of beneficiaries who either have no coverage or
7 coverage of lesser value are shown at the top of this pie
8 chart.

9 I'm going to focus on the beneficiaries in Part D
10 plans, so going clockwise around the pie there, the next two
11 pieces of the pie.

12 At the start of 2008 there were about 44 million
13 Medicare beneficiaries. Over 17 million, or 40 percent,
14 were enrolled in stand-alone prescription drug plans. So
15 those people usually get traditional fee-for-service
16 Medicare benefits for their Part A and Part B services and a
17 stand-alone plan for their drug benefits. Nearly 9 million
18 beneficiaries or 18 percent were in Medicare Advantage
19 prescription drug plans where enrollees get their medical
20 and drug benefits combined through one private plan.

21 If we look just at the stand-alone PDP enrollees,
22 about 8 million beneficiaries or 18 percent of all Medicare

1 beneficiaries receive Part D's low-income subsidy, which is
2 extra help with premiums and cost sharing. Another 9
3 million, or 22 percent, are in stand-alone plans but do not
4 receive the low-income subsidy. So nearly half, 45 percent,
5 of PDP enrollees receive the low-income subsidy. That's
6 important to note because LIS enrollees tend to be sicker,
7 tend to use more drugs, and are therefore costlier and also
8 pay less in cost-sharing.

9 Among Medicare Advantage drug plan enrollees about
10 1.5 million, or 3 percent of all Medicare beneficiaries
11 receive the low-income subsidy and about 6.5 million, 15
12 percent, do not. That means 18 percent of Medicare
13 Advantage drug plan enrollees receive the low-income
14 subsidy. So a much smaller proportion of MA-PD enrollees
15 receive the subsidy than PDP enrollees.

16 During the first two years of Part D, the market
17 shares among PDP sponsors were pretty concentrated and
18 didn't move much. In Part D's third year, 2008, they are
19 still pretty concentrated but we've seen a little more
20 movement.

21 These pies, on the left-hand side is 2008 and on
22 the right is 2007. I know the printing is small but we'll

1 just focus on the larger chunks of the pie. The largest
2 sponsors, United Healthcare and Humana, each lost a few
3 percentage points of the market share, picked up by some of
4 their rivals. Both of those sponsors had some sizable
5 increases in monthly premiums for 2008 and their loss of
6 market share mostly had to do with not bidding low enough to
7 keep their premiums below the maximum amounts that Medicare
8 will pay for enrollees who receive the low-income subsidies.
9 Bot sponsors loss LIS enrollees for 2008 because their
10 premiums were too high to qualify and CMS reassigned those
11 LIS enrollees to other plans with lower premiums.

12 Just to go over this quickly on the MA-PD side of
13 things, market shares have remained pretty stable. The same
14 two sponsors, United and Humana, combined have about a third
15 of the market and their market shares haven't changed much.

16 On this slide, I'm going to talk about the
17 distribution of enrollees in 2008 in terms of the kinds of
18 benefits they're getting now. So just to be clear, we're
19 talking about percentages of people, not percentages of
20 plans.

21 In 2008, enrollees in Medicare Advantage drug
22 plans are much more likely than PDP enrollees to be in a

1 plan that has enhanced rather than basic benefits. Enhanced
2 means a higher average benefit value. The most typical way
3 that sponsors enhance a plan is by charging no deductible,
4 but they can do other things like charger lower copayments
5 or cover certain drugs in the coverage gap. You can see
6 from comparing the columns in the table that a larger share
7 of MA-PD enrollees are in plans with enhanced benefits
8 rather than PDP enrollees, and a larger share of MA-PD
9 enrollees do not have to pay a deductible and more of them
10 are in plans that cover some drugs in the coverage gap.

11 MA-PDs can use some of the financing from the MA
12 payment system -- called MA rebate dollars -- towards
13 lowering Part D cost-sharing and premiums or enhancing their
14 drug benefits. At the same time, don't forget that nearly
15 half, 45 percent, of PDP enrollees receive the low-income
16 subsidy. The LIS fills in the coverage gap. Most
17 beneficiaries who receive the LIS were auto assigned into
18 basic stand-alone prescription drug plans rather than an MA-
19 PD. So while these individuals are in basic plans, they
20 have more complete benefits because of the LIS.

21 You may be wondering how many people hit the
22 coverage gap. Last week CMS organized a symposium to look

1 at 2006 and 2007 Part D data. Now let's go over their
2 coverage gap findings. Let's focus on the right-hand side
3 of this slide, which is for 2007, when more people had been
4 enrolled in Part D for a full year.

5 CMS estimates that 32 percent of Part D enrollees
6 had spending high enough to reach the coverage gap. A
7 little more than half of these individuals, 17 percent of
8 all Part D enrollees, received the LIS, which fills in the
9 coverage gap. A few percentage points of the remaining 14
10 percent of Part D enrollees were in plans that provided some
11 benefits in the coverage gap, and usually those were just
12 generic drugs, not brand name drugs.

13 CMS estimates that in 2007 9 percent of Part D
14 enrollees had drug spending high enough that they passed
15 completely through the coverage gap and into Part D's
16 catastrophic phase, where Medicare picks up most of the
17 costs. Most of these individuals received the LIS, which
18 for full benefit duals eliminates copayments entirely once
19 they reach that level of spending. So 2 percent of all Part
20 D enrollees have spending that is at the catastrophic phase
21 and do not receive the low-income subsidy.

22 Now let's turn to what plan sponsors are offering

1 for 2009. This time I'm going to be talking about
2 percentages of plans, not percentages of people. You can
3 compare the PDP offerings to MA-PD offerings down the two
4 columns of the slide. There will be about 7 percent fewer
5 PDPs in 2009. Even though sponsors are withdrawing some
6 plans from the market, the median region of the country will
7 still have 49 PDPs available. By comparison, there will be
8 about 6 percent more Medicare Advantage drug plans and the
9 distribution of those plans is changing. There will be
10 fewer private fee-for-service plans and growth that more
11 than offset them in local PPOs and HMOs. A larger share of
12 MA-PDs have no deductible, 88 percent compared with 55
13 percent of PDPs.

14 In 2009, a larger share of MA-PDs than PDPs
15 include some gap coverage, 52 percent compared to 25
16 percent. About a third of the MA-PDs that include gap
17 coverage cover some brand name drugs as well as some
18 generics during the gap phase. By comparison, nearly all of
19 the PDPs that have some gap coverage cover generics but not
20 brand name drugs.

21 Once again enrollee premiums are increasing. The
22 bars on the left of this slide show what the average

1 enrollee paid in 2008 and the bars to the right show our
2 estimates of what enrollees would pay if they remain in the
3 same plan for 2009. We know for certain that some
4 beneficiaries will switch plans. For example, some low-
5 income subsidy enrollees will get reassigned. These
6 estimates do not take that into account. But to give you a
7 sense of things, when CMS looked at the same sort of thing,
8 they estimated with reassignments and voluntary switching
9 that it would reduce the average premium by about \$2.

10 On the far left, the average enrollee in a PDP
11 paid about \$30 per month in 2008. And that's an average for
12 basic and enhanced benefits combined. If they remain in the
13 same plan, enrollees can expect to pay \$37, or \$7 more per
14 month. MA-PD enrollees pay a combined premium that covers
15 their Part D benefits and their regular medical benefits.
16 But if we just look at the portion of that combined premium
17 that is attributable to their drug coverage, we estimate
18 that the average MA-PD enrollee will pay \$15 per month in
19 2009.

20 You can see that the dollar amount of MA-PD
21 premiums is a lot lower than PDP premiums. Now some of the
22 MA plans are probably managing their benefits better, but

1 the difference also reflects what we talked about earlier,
2 the fact that MA-PDs can use rebate dollars from the
3 Medicare Advantage payment system to lower their opinions.

4 Overall, the average enrollee paid about \$25 per
5 month for Part D coverage in 2008 and if they stay in the
6 same plan their premiums will increase by about \$6 next
7 year. That's about a 24 percent increase.

8 This is several years in a row of premium
9 increases which are probably more noticeable to PDP
10 enrollees. Since most of the low-income subsidy enrollees
11 pay no premium, this chart takes them out and then looks at
12 the distribution of premium increases for the remaining PDP
13 enrollees if they stay in the same plan for 2009. In the
14 dark blue you can see that 7 percent will see premiums
15 decrease but the other 93 percent will face higher premiums.
16 For about 60 percent of these people that increase will be
17 \$10 per month or less and about a third will face premium
18 increases of \$10 or more per month.

19 So why are premiums going up? One reason is that
20 for 2009 CMS moved to full involvement weighting to set plan
21 payments and enrollee premiums. In the first few years of
22 Part D, CMS used general demonstration authority to phase in

1 enrollment weighting. This meant that Medicare was
2 subsidizing Part D payments and premiums more than called
3 for by law. For 2009 we'll be at the statutory level of
4 subsidy and premiums will be somewhat higher as a result.

5 The other major explanation is simply that plan
6 sponsors bid higher and there are several reasons to bid
7 higher. One is just the drug costs are going up and, of
8 course, plans need to anticipate that and build that into
9 their bids.

10 But another reason may be that since a few Part D
11 enrollees seem to switch plans voluntarily -- even in the
12 face of premium increases -- there's less pressure for
13 sponsors to bid low.

14 And finally, we've heard anecdotally that some
15 sponsors do not think they are paid enough to cover the
16 costs of providing drug benefits to low-income subsidy
17 enrollees. If that's true, some sponsors may not want to
18 bid too competitively. They may prefer that their plans
19 have premiums higher than the LIS thresholds.

20 We just talked about enrollee premiums going but
21 costs are likely to increase for the Medicare program as a
22 whole, too. This chart shows the year-to-year change in

1 what, on average, plan sponsors bid as the cost of providing
2 basic benefits. I want to call your attention to two things
3 on this slide. First is the drop in the average bid between
4 2006 and 2007. Since sponsors didn't have past claims to
5 look at when they were bidding for the program's first year,
6 many of them bid too high. That's one reason why the
7 average bid for 2007 fell. When CMS reconciled payments
8 with plans for the 2006 benefit year, plans owed Medicare
9 over \$4 billion because their prospective payments had been
10 too high.

11 CMS recently completed that reconciliation process
12 for the 2007 benefit year and this time the net amount plans
13 owe Medicare is just about \$18 million, with an M. That's
14 another piece of evidence that plan sponsors got better at
15 bidding.

16 The other thing I want to point out on this chart
17 is the 11 percent increase in the average bid between 2007
18 and 2009. That's the two right-hand bars. This could be
19 troubling but let's look a little more closely at this. The
20 thing that's driving this increase is what plans are now
21 expecting in the way of catastrophic spending by their
22 enrollees. In particular, there are certain drugs -- like

1 for conditions like rheumatoid arthritis and multiple
2 sclerosis, that are very high cost and users of those
3 therapies tend to have very high spending that puts them all
4 the way through the coverage gap and into the catastrophic
5 phase of the benefit where Medicare is picking up most of
6 the cost through individual reinsurance.

7 The increase in average bids for 2009 may be an
8 artifact of people focusing on this catastrophic spending
9 more than before because CMS just started asking sponsors to
10 provide more information with their bids about spending for
11 very high cost drugs. Still, we want to keep our eye on
12 this category of spending. Even though the numbers of
13 people who use these types of drugs is very small now, it's
14 growing, as are the prices for these drugs.

15 For 2009 there's a large turnover of plans that
16 bid low enough that they qualify to remain premium-free to
17 enrollees who receive the low-income subsidy.

18 One thing that was new for 2009 was that CMS moved
19 to a different method for setting the maximum amount that
20 Medicare will pay for an LIS enrollees premium. In the
21 past, CMS was phasing in a method that would have weighted
22 each plan's premium by its total enrollment. Instead, CMS

1 used each plan's LIS enrollment. They did this out of
2 concern that in parts of the country where many enrollees
3 are in Medicare Advantage drug plans the ability of MA-PDs
4 to buy down their Part D premiums with MA rebate dollars
5 would lead to lower LIS premium thresholds and fewer
6 qualifying PDPs. CMS believes that its new method led to
7 less turnover among qualifying plans than would have been
8 the case under the old method.

9 Still, even with the new method, there was a big
10 reduction in qualifying plans. Across the country 308 PDPs
11 qualify in 2009 compared with 495 in 2008. The median
12 region of the country will have nine PDPs available at no
13 premium to LIS enrollees, compared with 15 last year or
14 2008. There are a couple of regions where there are only
15 one or two PDPs that qualify, Nevada and Arizona. Those are
16 areas where there are more LIS enrollees in Medicare
17 Advantage drug plans.

18 All together, CMS expects to reassign 1.3 million
19 LIS enrollees to lower premium plans offered by a different
20 sponsor. That means those individuals may need to change
21 some of the medications they use if the new plan's formulary
22 doesn't cover their current drugs or seek formulary

1 exceptions. 1.3 million is about the same magnitude of
2 assignments as we saw for 2008.

3 I will leave you with a list of topics that you
4 may want to discuss. The first two are related to each
5 other in that they reflect the two blocks of beneficiaries
6 for which Part D plans compete. The first bullet is about
7 the low-income subsidy, the fact that one trade off
8 beneficiaries make when they sign up to receive Part D's
9 extra help is that they may get reassigned to a different
10 plan from year to year. Those reassignments are one way to
11 maintain competitive pressure within Part D but there may
12 also be consequences in terms of beneficiaries' medication
13 adherence, their health outcomes, and other types of
14 Medicare spending.

15 Another issue is that among beneficiaries who
16 choose a plan on their own, few seem to be switching from
17 year to year. If this continues, what are the implications
18 for plans' incentives to bid low?

19 And finally, you may want to discuss the increase
20 in plans' average bid for 2009, particularly plans'
21 expectations about catastrophic spending.

22 Thanks.

1 MR. HACKBARTH: Okay. As we did at the last
2 meeting, we will use our three round approach to the
3 discussion. The first round is just clarifying questions
4 for Rachel, and then we'll go around and give everybody an
5 opportunity to make a brief comment or ask a question. And
6 then in the last round we'll try to focus in on a few
7 particular issues that came up in the earlier discussion.

8 So first-round from Arnie.

9 DR. MILSTEIN: Rachel, at the very beginning of
10 this program we discussed what could be done to make it
11 easier for beneficiaries to ascertain which plan might be a
12 better deal for them. Has there been any progress along
13 those lines in terms of -- if I'm a Medicare beneficiary, my
14 claims history is known. From that, there's such a thing as
15 software that could predict which drugs I might use and
16 allow me to figure out of the plans available to me which
17 would result in the least amount of total out-of-pocket
18 spending, including my monthly premium. Is there any
19 progress along that line so it becomes easier for
20 beneficiaries to discern which plan might be a better deal
21 for them?

22 DR. SCHMIDT: The tool that is most available to

1 folks is the plan finder that's on in Medicare's website,
2 Medicare.gov. There have been some improvements in that
3 over the years. I think, when we initially started talking
4 about Part D, you mentioned wouldn't it be nice to be able
5 to pull up past claims history and that's a not something
6 that is available on the plan finder so far.

7 Among the same lines, you recall we had some
8 presentations by Jack Hoadley about beneficiary-centered
9 assignment, just for the particular population of LIS
10 enrollees who gets reassigned from year to year. So we've
11 had some discussions about the pros and cons associated with
12 that. I don't think that that is something that CMS is
13 going forward with at this time.

14 DR. MILSTEIN: Can you address anything that's
15 been done or not done to reduce -- again if I want to get
16 the best deal -- minimizing my switching costs, so there
17 isn't chaos in my medication flow if I try to pick a better
18 plan?

19 DR. SCHMIDT: Let's see, there's been some
20 discussion of trying to -- the policy now is that there's a
21 30 day transition period. If you switch a plan they have 30
22 days in which to get a temporary fill of your current drugs.

1 That is supposed to give you some time to go back to your
2 position and either ask them to get a formulary exception
3 for you or consider other medications that are on your new
4 plans' formulary.

5 There is not been a change of policy with respect
6 to that. There are different policies, for example, for
7 people who live in nursing facilities. They have a longer
8 period of time for that transition.

9 In terms of other things that one could do, I
10 think there's been some discussion in the past of trying to
11 standardize the sort of information that beneficiaries
12 receive at the pharmacy counter if they find, during course
13 of switching plans, that they need to prior authorization
14 and that sort of thing. But my sense is that that's not
15 routinely used by all plans and can still be a complicated
16 hurdle to try and manage.

17 DR. CASTELLANOS: Rachel, I appreciate the
18 discussion. What I want to focus in on is the 1.2 million
19 people in the LIS program. These are an extremely
20 vulnerable population. Most of them have multiple
21 comorbidities. They have Medicare and Medicaid. And with
22 Medicaid, especially in my state, Florida, a lot of them

1 have a hard time finding a primary care doctor. Medicare
2 does a good job, Medicaid for reimbursement doesn't. And
3 with a limited number of primary care physicians this
4 population has a hard time getting a physician. We talked
5 about consequences of switching.

6 To take off on Arnie's point, these patients are
7 not getting help with plan changes. I know in your material
8 that you sent out to your preliminary work, you mentioned on
9 page two that they can get a transitional supply and then
10 they should ask their physician to help navigate the
11 coverage rules.

12 I'm going to be honest with you, I don't know
13 anything about that. And I don't know where -- if I don't
14 understand it, I don't understand how they understand it.

15 And I know you talked a little bit about going
16 online. I think you should go online and look at it. I did
17 and it's totally confusing to me.

18 So what I'm saying is that we have a very
19 vulnerable, vulnerable population with multiple
20 comorbidities and we need to do a better job.

21 MR. GEORGE MILLER: Thank you. Thank you, Rachel.

22 Along the lines that Ron just talked about, I was

1 wondering if there -- and it may be that this information is
2 too new. But have there been any studies on the impact of
3 beneficiaries who need to change plans and either are being
4 forced to change or they chose on their own to change? And
5 if so, what does that data show? And have we been able to
6 measure the impact?

7 Or maybe it may be just too new, quite frankly.

8 DR. SCHMIDT: I think you're right, it is too new.
9 We do know there are a small number of individuals who
10 receive the low-income subsidy who do switch plans on their
11 own. I think last year it was on the order of 400,000 so
12 out of 9 million.

13 We, as you know, just received the Part D claims
14 information, and that's what we think are one of the more
15 important studies that research organizations or ourselves
16 need to accomplish, is trying to track what's happening to
17 these individuals who are switching plans. Is it affecting
18 their medication adherence? Are we seeing increases in
19 hospital utilization or not? Does it vary by the
20 therapeutic category? Those kind of questions.

21 MR. GEORGE MILLER: And if they're able to make a
22 smooth transition, they get the same type of drugs or if

1 it's different, what impact it has on them? Do they go to
2 the hospital more? As Ron said, primary care is a difficult
3 thing.

4 Thank you.

5 DR. CROSSON: ,Rachel with respect to the number
6 of PDP plans who have now failed to qualify, I guess there's
7 a trade-off between incremental increases in the premium, a
8 cutoff point, and then the number of affected beneficiaries
9 and all of the chaos that could take place.

10 So my question is do you know what the range of
11 let's say overage for those disqualified plans is? I mean,
12 are these mostly falling a few dollars over? Or is a much
13 broader range than that?

14 DR. SCHMIDT: To tell you the truth, I don't have
15 that data at my fingertips but I'd be happy to come back to
16 you with that information.

17 Last year I think we did, in the chapter, include
18 how much would an LIS enrollee have to pay if they wanted to
19 stay in the same plan. They would have to pay that marginal
20 amount difference. In most cases, I think it was \$5 or
21 less.

22 MR. HACKBARTH: Any other clarifying questions?

1 If not, I have Bruce and John and Mike and Tom.

2 DR. STUART: I have a question on something it
3 isn't a part of this chapter at this point, and that is the
4 benefit structure with respect to the copayments. We know
5 that most of the plans that are actuarially equivalent are
6 using copay structures rather than coinsurance.

7 Last week CVS announced that it was going to offer
8 400 generic drugs, a 90 day supply, for \$9.99. And if you
9 work the math out, it comes out to \$3.33 a month, which
10 isn't significantly lower perhaps than Wal-Mart and Target
11 and all of the others that have this large number of generic
12 drugs that are available for \$4 on month.

13 So that's really the motivation for my question in
14 terms of do we have any idea how many plans have a generic
15 copay level that is higher than the amount that individuals
16 would pay if they went just out of plan and went to one of
17 these retail establishments?

18 The second question I like to ask, it actually
19 gets -- if you could look at slide eight. The way the
20 Medicare program works is if individuals reach a certain
21 level of true out-of-pocket payments and there is still some
22 of the year left, then the additional expenditures will be

1 picked up in part under that the catastrophic level.

2 But if an individual reaches the initial coverage
3 gap and does not expect to hit the catastrophic coverage,
4 then there's no point at all in terms of keeping track of
5 out of network use or anything else. And it's just going to
6 look as though, if you're tracking the actual use in-
7 network, it's going to look like there's a big drop and
8 researchers are going to examine that and they're going to
9 say oh, well, demand increase.

10 But it could be out of plan use. So there are
11 several threads here but they get back to that question of
12 the distribution of the generic copay level.

13 DR. SCHMIDT: Yes. In terms of the second topic
14 you raised first, we aren't going to know for sure until
15 MCBS data -- your favorite dataset -- becomes available for
16 the first few years of the Part D program to try and get a
17 sense of when people hit the coverage gap whether they are
18 seeking other coverage, they out-of-pocket on their own and
19 not having that increase to their true out-of-pocket limit
20 or not. So we don't know the answer to that.

21 In terms of your first question, stay tuned
22 because next month we hope to be back and we'll provide some

1 information about what's happening with cost-sharing. I
2 will also try and look into the question of how many plans
3 have generic copays that seem to be higher than some of the
4 things that you're seeing out there available to everyone.

5 DR. DEAN: To Bruce's comment, I can tell you
6 definitely that it happened with the VA system. The VA
7 copays are significantly higher than a lot of these things.
8 And I've had a number of people that get their drugs through
9 the VA system who drop that for certain ones and get it from
10 what Wal-Mart because it's cheaper.

11 MR. BERTKO: Good report, Rachel. I wanted to
12 mainly make a comment here, which is to say something you
13 said a little differently. Connecting the low-income
14 comments here to the presentation we had last month from
15 John Hsu of the Kaiser Foundation. If you remember his
16 chart roughly, the difference between the 108 percent
17 payment and the amount needed for the low income was about
18 another 5 to 8 percent or so. So that says on average
19 across it, if a plan enrolls a low-income person, you're
20 probably underpaid by that 5 to 8 percent, which is a
21 significant amount of money and could account for some of
22 the plans bidding higher because in the bid, the actual

1 costs have to go in to drive the bids upward if you have a
2 significant portion, 45 percent again on average, or to get
3 rid of them by bidding higher to exceed what the expected
4 threshold is.

5 Patient-centered stuff like that Jack Hoadley
6 thing would only have a perverse incentive of saying if
7 you're actually going to assign it to people even more so
8 because you've got a wide formulary or low hurdles for
9 management. And those plans will have to change the way
10 that they operate.

11 I would only comment here that we need again
12 emphasize the need for CMS to improve the risk adjuster so
13 that, in fact, the churning and the reassignment here is
14 reduced by paying the appropriate amounts, as opposed to
15 letting this somewhat flawed part of the competition
16 mechanism continue to operate as it is in the status quo.

17 MR. HACKBARTH: Remind us, Rachel, of the next
18 steps on the risk adjustment discussion?

19 DR. SCHMIDT: We do intend to have some discussion
20 of John Hsu's work in our March chapter. We're also going
21 to be discussing with CMS some -- I think they've done some
22 internal looks at the risk adjuster. So we're going to be

1 comparing notes with them and having some discussions about
2 that.

3 DR. CHERNEW: First, I have what probably was a
4 clarifying question, but I wasn't sure so I will ask it now.
5 Are the plans eligible for the low-income subsidy enrollees,
6 is that computed by region as opposed to -- so you're not
7 worried about some --

8 DR. SCHMIDT: Yes.

9 DR. CHERNEW: So you always have at least one.

10 DR. SCHMIDT: Right. There's an average that's
11 calculated in each of the 34 PDP regions. But another
12 component of it is that it's that average or the minimum PDP
13 premiums. So there's at least one PDP premium available.

14 DR. CHERNEW: What happened, of course, as the
15 number of plans eligible for the low-income subsidy shrinks,
16 the number of low-income subsidy enrollees going to any one
17 plan rises, exacerbating the problem that John and John were
18 talking about.

19 And they sort of can't get away -- there's always
20 some plan in those regions who are going to get those
21 enrollees, one way or another. So you could see those
22 premiums elevate quite a lot more rapidly in those regions.

1 That would be interesting to see.

2 DR. SCHMIDT: Right. Actually, we have some
3 concern about using LIS enrollment as the way of weighting
4 to figure out this thresholds because necessarily some will
5 have higher than average premiums and some will have lower
6 than average. So it's kind of guaranteeing some turnover.

7 DR. CHERNEW: My second question is I've seen this
8 number a lot, the 10 percent of people without any
9 creditable coverage from your first slide. Has there been a
10 tracking of how the new enrollees each year, the 65-year-
11 olds who are coming into the program new each year, how
12 their choices have or haven't changed with regards to Part D
13 participation? Are we seeing -- particularly if some
14 premiums have gone up are we seeing fewer of them
15 participate? Are we seeing people -- there's this penalty
16 if you wait to get in you have to pay a higher premium for
17 waiting. Are we seeing any of the people who maybe didn't
18 start originally now participating? Or if you don't join
19 when you're 65, you're just out because you have to pay this
20 penalty?

21 DR. SCHMIDT: That's an interesting question. I
22 have not seen any analysis on the entering cohorts thus far.

1 But you're right, that would be something good to look at.

2 DR. DEAN: This is partly a clarifying question
3 and partly a comment. In the data that you have, was there
4 any comments about access to pharmacy services? I think
5 I've raised this before, that there is a real serious
6 concern in rural areas about loss of pharmacies period.
7 I've got some day here about there's just been a steady
8 decline of rural independently owned pharmacies over the
9 last years and it looks like the rate of decline is
10 increasing. And even more worrisome is the pharmacies that
11 are the only pharmacies in their community, there's been
12 about a 10 percent decline over the last five years and that
13 rate seems to be accelerating, as well.

14 So I wonder, I know that it's happened with
15 individual selection of plans. They sign up for a plan and
16 then they realize that it's not accepted by the one pharmacy
17 that they have easy access to. I wonder, just as a
18 question, is the -- when people are reassigned, is that a
19 factor that's taken into consideration, to make sure that
20 the plan they get reassigned to is actually accepted by a
21 pharmacy in their area?

22 And secondly, on the broader question of the whole

1 access to pharmacy services in general in rural communities
2 is a serious issue.

3 Now obviously Part D is not the only issue, but
4 most of the pharmacists will tell you that it is a
5 significant issue in the ability to maintain independent
6 pharmacies.

7 DR. SCHMIDT: No, pharmacy access is not an
8 explicit criteria when thinking about where to reassign
9 beneficiaries.

10 But having said that, if a local pharmacy is an
11 out-of-network pharmacy, any pharmacy that has a LIS
12 enrollee who comes to fill a prescription has to charge the
13 copayments that are appropriate to LIS enrollees, which are
14 reduced copayments. So by virtue of the LIS benefit itself,
15 those copayments are set.

16 Rural independent pharmacy access is, as you said,
17 a wider issue. There are some trade-offs. There is wider
18 availability of mail-order prescriptions. But if you have
19 an acute condition and you need an antibiotic right away,
20 that's not necessarily going to help you. Yes, that's a
21 continuing issue.

22 I think if you recall a presentation from earlier

1 in the fall, we talked about that being something that we'd
2 like to look at, how is cost-sharing different for rural
3 enrollees in Part D versus others that live in more urban
4 areas. We might be able to pick out whether they're using
5 mail order more extensively, whether they're having to pay
6 out-of-network copays, which tend to be higher, or not.
7 Those kind of questions.

8 DR. DEAN: A quick follow-up, mail-order is an
9 option but it has a lot of problems. Without getting into a
10 long discussion of that, there really are a lot of problems
11 in terms of timeliness and knowledge of the pharmacist as to
12 what else is going on with that particular individual.
13 Anyway, I could go on for a long time, but I won't.

14 MR. HACKBARTH: Let me ask you a question, Tom.
15 In your initial comment, you phrased it as independent
16 pharmacies, as opposed to pharmacies in general. Could you
17 just explain why, just focus on the independents as opposed
18 to pharmacies in general?

19 DR. DEAN: I'm not sure, that's the data that I
20 have, it's how it's broken down. I think the assumption is
21 that they are really the only ones that are there. Wal-Mart
22 and CVS are not going to be in my community. The only

1 chance that we have are the small independents.

2 Now there may be some smaller or middle sized
3 communities where maybe that isn't true. But at least the
4 ones that I'm -- that's a good question. Let me find out.
5 That's how the data has been collected, but I'm not sure I
6 can really honestly answer that except that, like I say, in
7 most small communities they are the only ones that are
8 there.

9 MR. EBELER: Thank you, Rachel.

10 Two questions. One is in the chapter you mention
11 there's about 12.5 million LIS eligibles and about 2.6
12 million who we've not yet reached. Do we know if that
13 number is declining? And if not, are there efforts underway
14 to figure out how to help the firms reach that population?

15 DR. SCHMIDT: It's kind of hard to compare these
16 numbers from year to year because the numbers of eligibles
17 kind of the depends on rough guesses of people's assets and
18 income. The data on those are imperfect. So we don't know
19 for sure whether that number is declining or not.

20 I think that CMS is trying to make some effort at
21 better outreach towards finding these individuals. For
22 example, there's a little bit more tailored information

1 that's available through their website for states that are
2 trying to reach out, and SHIPs and that sort of thing.

3 This is just a very, very difficult population to
4 reach and I'm not saying that we've necessarily made all of
5 the strides that are necessary yet, but I think there are
6 some efforts.

7 MR. EBELER: Thank you.

8 DR. MILSTEIN: We are in the first round of
9 comments now; is that right?

10 MR. HACKBARTH: Right.

11 DR. MILSTEIN: This program is one of Medicare's
12 attempts to test whether or not markets work for Medicare.
13 For this to just be a reasonable test I, first of all,
14 totally support John's comment about getting the adjustment
15 right.

16 Secondly, I think we're not even close to doing
17 everything that current technology allows in reducing
18 beneficiary burden in finding the best deal, the best option
19 for them. I think most of us have had the experience for an
20 aunt or an uncle or a parent, going on the chooser website.
21 I think it's better now than it was before.

22 My intuition is, certainly from hearing from

1 beneficiaries on this, is that particularly for perhaps
2 lower income or less well-educated beneficiaries it's still
3 too darn hard and too easy to get confused. I'd like to
4 suggest we consider a suggestion that rather than say the
5 only way you can find a better deal among these plans is to
6 find a patient, friend or relative to help you figure it
7 out, is that we consider suggesting that Medicare use what's
8 called wizard technology where you don't have to even -- it
9 doesn't even have to dawn on you that there might be a
10 better deal. There's software that is sort of looking at
11 your claims data and your claims history, actively
12 evaluating the plans available to you, and actively letting
13 you know when there is likely a better deal for you to pick,
14 and facilitating you're picking that better deal. It's
15 called wizard software. I think that's more along the lines
16 of what might be a better fit for my parents, than what's
17 going on now, which is them dialing for kids to try to help
18 them figure it out, and kids sometimes coming up with
19 different answers. It's not easy.

20 The second thing is that if this is going to work
21 better and be a test of whether or not exposing people over
22 the age of 65 to the opportunity to improve the value of

1 their care through more discerning consumer decisionmaking,
2 it sounds like we should think about in this chapter things
3 we could suggest to CMS that would reduce the beneficiaries'
4 risk in making a switch.

5 Because it sounds to me like okay, you can do it
6 but you have to line up all your doctors and get them to --
7 is that something, for example, for which there should
8 either be, if not a third-party, is that something for which
9 we might have higher expectations of the receiving plans?
10 What can we do to aid and abet the receiving plans taking on
11 that burden for the beneficiaries so that beneficiaries
12 don't have to call every doctor that has prescribed for them
13 and explain what needs -- I think, for example, if one is
14 trying to change your primary financial services firm, one
15 of the burdens in making that switch is filling out a
16 billion forms to tell the firm you were with you want to
17 switch over, et cetera.

18 Now what would often be the case is the firms who
19 are receiving the new account will take care of all of that
20 for you. They send you like nine forms to sign and then
21 it's done.

22 Is there an opportunity in this chapter to suggest

1 options for doing something equivalent so that the clinical
2 risk of making a switch, in terms of interruption of flow is
3 something that my parents don't have to try to figure out?
4 That there's a receiving plan or a third party that might
5 give them some help on that?

6 Because unless we do more to make it easier for
7 beneficiaries to gravitate toward the better value options,
8 the possibility of using this market mechanism to improve
9 value received by the beneficiary seems to be low.

10 DR. REISCHAUER: This is just a comment on what
11 Arnie is talking about, and I could be dead wrong here. If
12 we had some magic machine that would tell us what the
13 optimal plan was for each person and the government
14 contribution stayed the same, then premiums charged would
15 have to go up because there would be less of it being paid.
16 And those who have the least usage would have more of an
17 incentive to gravitate towards plans where there aren't a
18 lot of people using a lot of drugs, which puts then a bigger
19 burden on the risk adjustment process.

20 There is no right or wrong answer to this. It's a
21 matter of values. But it's not just sort of a real simple
22 gee, if we could get everybody in here, everybody would be

1 better off. There would be a whole lot of people who would
2 be worse off because they would be the ones who were paying
3 the higher premium but not taking usage of a lot of these
4 things.

5 DR. MILSTEIN: This is actually an interchange
6 that we've had before and I completely agree with the point
7 but I think it leaves out another component, and that is
8 that there are other opportunities within these plans, if
9 they faced much more value sensitive customers, to improve
10 the value of their product. It's the dynamic effect that I
11 think is the main rationale for this because I think the
12 point you make is right, there will be a certain amount of
13 just pure redistribution.

14 MR. BUTLER: Agreeing with Arnie, as I almost
15 always do -- I think you said that last meeting -- it almost
16 feels like we're all a little bit shocked that we made it
17 through this first wave and got everybody signed up and it's
18 been fairly stable and provided a lot of value, and that
19 we're about to go into a new period of destabilization,
20 maybe in part because retirees' income because of the market
21 is suddenly not there and they're going to have to look at
22 the cost proposition again. And how we can make that easy

1 and impractical seems like a little bit of a daunting task.

2 But more specifically, I'd like to go to slide 13
3 because you asked questions at the end about three issues.
4 The last was related to the catastrophic spend. This one
5 got my attention when you see 25 percent increase in one
6 year from the 28 up to the 35.

7 If the system is about to go haywire or go in
8 directions that we think might not be what we were thinking
9 a couple of years ago, tell me a little bit more about how
10 you look at that 35 and how we should be thinking about
11 that?

12 DR. SCHMIDT: I gave the caveat on this slide that
13 it may be just that people are focusing on it more in the
14 bidding process than before. But I also raised it as an
15 issue because by and large the catastrophic spending, a lot
16 of it takes the form of individuals who are taking very high
17 cost drugs.

18 I think in the future the Commission intends to
19 start taking a look into the issue of biologics a bit more,
20 the category of one type of these high-cost drugs.

21 There has been broader discussions across the
22 government in terms of things like patent protection, the

1 length of patent protection, and that sort of thing. I
2 think we'll come back to you with some informational
3 briefings on the state of that discussion. That's not
4 something that we've gone into in the past in terms of
5 MedPAC's purview, but I think it has strong implications for
6 the costs of the Part D program. For that reason we'll
7 probably be coming back to you with more information about
8 it.

9 DR. MARK MILLER: The only thing I would say about
10 that, which is this is not anything in terms of the
11 technical response, is sometimes we see things like this --
12 and this is for the public too to know -- and we bring it in
13 front of you because there's people here who might have
14 particular insight from their experience about what might be
15 going on. So sometimes it's a two-way street on some of
16 this.

17 MS. BEHROOZI: Thanks, this is a really great, I
18 think, beginning of the use of the data, along with things
19 about program structure and things that we've been looking
20 at before.

21 But it seems to me, and I might be transferring
22 from one substantive area to another here, but that when we

1 didn't really have Part D drug data we did focus groups, the
2 staff would do focus groups to ask beneficiaries for some of
3 the information that now we're going to be looking to the
4 data, it seems to me, to get information on.

5 In the paper we asked the question how have
6 reassigned beneficiaries, the LIS beneficiaries, fared in
7 past years. The paper talks about looking at either press
8 coverage or looking forward to Part D claims information.
9 But I would suggest that we really ought to return to the
10 focus groups, or not exclusively but add data to the focus
11 groups and continue doing the focus groups.

12 It kind of goes to Arnie's point which still, as
13 perfect as that wizard can make the presentation of options,
14 it still assumes rational economic behavior on the part of
15 the beneficiary. There's already some evidence that non-LIS
16 beneficiaries faced with higher premium payments aren't
17 looking to change. Maybe there's other stuff going on and
18 it's maybe not stuff that we can necessarily guess at or
19 make be the burden of the receiving plans.

20 Maybe there's just stuff people are scared of or
21 comfortable with or receiving misinformation about. Maybe
22 information is part of the issue. So I think we really need

1 to understand more about why people don't act economically
2 rationally or what the burdens are for them when these
3 changes are made so that we can develop policy proposals to
4 address those things.

5 DR. SCHMIDT: Just to put in a plug for my
6 colleague, Joan Sokolovsky, we do think that the focus
7 groups that we've brought to you in the past have been
8 extremely useful and we're going to be doing more focus
9 groups on a continuing basis. It's somewhat difficult to
10 get together focus groups of people who are receiving the
11 low-income subsidy and talk to them, especially ones who
12 have had to go through this transition. But we will look at
13 other types of research data, not just some of the program
14 information data, to get at those questions.

15 MS. HANSEN: This is relative to the low-income
16 subsidy populations that oftentimes is both more expensive
17 and uses more drugs. When there is the behavior of
18 switching, one of the things it would be great to look at in
19 the focus groups is particularly people have health literacy
20 limits in terms of their understanding, as well as language
21 differences and what barriers that produces.

22 The thing that is -- and I don't know what policy

1 lever can do as it's really a marketplace issue -- but I
2 sense that we might find in the focus groups when they
3 switch from one plan to the other what happens is the clock
4 starts again. Besides filling out the forms, it's going
5 through, testing the formularies, and finding out whether or
6 not they have to switch drugs and all of this.

7 I just wonder what that kind of ultimate impact
8 is. I think you alluded to it, that we would do some more
9 studies. But since this is typically a higher use
10 population, and the clinical implications might be greater,
11 it would be just great to kind of keep a spotlight on that
12 group.

13 I fully agree that one of the things I would like
14 to make sure that that kind of work is done on the risk
15 adjuster your so that the plans, whether they are MA-PD or
16 stand-alones, have enough financial incentive to keep the
17 LIS population. What I fear, of course, is that the squeeze
18 continues to occur, that the tiering of, on the one hand,
19 intentionally making it available as a benefit but then when
20 you have no plans to really offer it, we end up creating a
21 lack of access for this population.

22 That's it. Thank you.

1 DR. CHERNEW: This idea of switching is important
2 in part because it disciplines plans in terms of what they
3 do and it looks that there's a lot of potential variation
4 across markets. So I was going to encourage you to both
5 look at switching and how that varies across markets, to see
6 if some places where there's a density of plans maybe more
7 switching seems to perform better. Or maybe worse because,
8 as people have mentioned, there can be a lot of drawbacks to
9 switching as well; right?

10 But I think understanding in the spirit of how
11 these things are working across different markets with
12 different attributes, in terms of different numbers of low-
13 income subsidy people, different numbers of plans, different
14 amounts of switching, given the variation across markets,
15 tracking that at a more regional level or smaller level I
16 think would be really important to understand where this
17 problems is that might need to be addressed.

18 MR. HACKBARTH: I think I heard three really big
19 themes. One is the switching issue and the ease of
20 switching and what can be done to facilitate.

21 A second is access related issues.

22 The third is this risk adjustment, which seems to

1 me very important because of its potential for destabilizing
2 the basic model that the programs build on.

3 So as always, Rachel, great work and we look
4 forward to hearing more on those issues.

5 Our next item is also Part D related, medication
6 therapy management.

7 DR. SOKOLOVSKY: Good morning, everybody.

8 Last spring, a number of you -- and in particular
9 you, Jack, Bruce and Jay and Mitra -- expressed a lot of
10 concern about the lack of information, particularly about
11 the quality of pharmaceutical care that beneficiaries were
12 receiving under Part D. As an interim step, we have been
13 looking into medication therapy management programs because
14 that's the one aspect of the Medicare drug benefit that is
15 specifically designed to improve the quality of care
16 received by high-risk beneficiaries.

17 Today we're going to tell you about what we know
18 and what we don't know about these programs.

19 Congress requires all PDPs and MA-PDs, with the
20 exception of private fee-for-service plans, to offer this
21 program to beneficiaries with multiple chronic conditions,
22 multiple prescriptions each month, and high drug costs --

1 estimated at least \$4,000 a year in drug spending. The
2 programs are designed to increase medication adherence,
3 improve appropriate prescribing, educate beneficiaries about
4 their medications, and detect and prevent potential drug
5 interactions or other adverse events.

6 Clinical pharmacists have been providing
7 medication reviews and other clinical services to patients
8 for many years, but no generally accepted definition of
9 medication therapy management existed in 2006. Since the
10 programs that did exist targeted different types of
11 patients, provided different kinds of interventions, and
12 measured results in different ways, CMS had no clear way of
13 proscribing exactly how the program should work in Part D.
14 As a result the programs offered by plans, as you'll see,
15 are very variable.

16 We interviewed about 30 stakeholders, including
17 pharmacists and representatives from health plans, PBMs,
18 pharmacies, companies that provide MTM services under
19 contract to health plans, and representatives from trade
20 associations. We asked them about their experiences with
21 the program and if they had any suggestions about how the
22 program could be improved. We'll talk about some of the

1 ideas for strengthening the program in this presentation.

2 I should also mention that we asked physicians and
3 beneficiaries about medication therapy management in our
4 2007 focus groups but none of them had any experience with
5 the program.

6 Now Hannah is going to tell you some more about
7 what we do know and what we don't know about these programs.

8 MS. HANNAH MILLER: We do not know exactly how
9 many people are enrolled in MTMPs. According to CMS, 8.4
10 percent of beneficiaries enrolled in plans with MTMPs were
11 enrolled in their plan's programs in 2007. Our interviewees
12 agreed that MTM enrollees make up a small proportion of
13 Medicare beneficiaries. We estimate though that
14 approximately 14 percent of Part D beneficiaries, which
15 would be about 3.4 million, spent more than \$4,000 per year
16 on Part D drugs in 2006. This number shows the potential
17 for MTM enrollment.

18 Plan sponsors must provide descriptions of their
19 MTMPs as part of their annual Part D bids. Their
20 descriptions must include information about their program's
21 eligibility requirements, enrollment methods, intervention
22 strategies, and outcome measure.

1 Plans have taken varied approaches to these
2 aspects of MTMs. They may use more or less restrictive
3 criteria to target eligible beneficiaries, use different
4 enrollment methods, provide different sets of interventions,
5 provide services in a variety of settings, and collect a
6 variety of outcome measures.

7 CMS is using information from bids to compile some
8 summary statistics about how MTMPs look under Part D. In
9 the follow, I will describe differences in eligibility
10 criteria, plan interventions, and outcome measures used
11 across plans.

12 CMS requires plans to provide MTMs to
13 beneficiaries with multiple chronic conditions who are
14 taking multiple drugs. Plans have interpreted this standard
15 in different ways. The minimum number of chronic conditions
16 required for beneficiaries to qualify for MTM ranges from
17 two to five. Despite this range, the vast majority of plans
18 have beneficiaries have just two or three chronic conditions
19 to qualify for MTM, and only 4 percent of plans require that
20 beneficiaries have five or more chronic conditions to
21 qualify.

22 In addition to specifying the minimum required

1 number of chronic conditions, plans may choose to target
2 specific conditions. According to CMS, 90 percent of 2008
3 MTMPs indicate that specific chronic conditions apply for
4 eligibility into the MTM program. The mostly targeted
5 conditions are listed here. There appears to be some
6 consensus regarding the specific conditions to target.
7 About 99 percent of plans include diabetes is one of their
8 targeted conditions, for instance, and these same conditions
9 were the mostly frequently targeted in 2007.

10 Plans must also designate a minimum number of
11 prescription drugs to qualify for their MTMPs. CMS data
12 reveals great variation among plans. In this chart, which
13 shows the distribution of minimums, you can see that the
14 minimum number of covered Part D drugs ranges from two to
15 15. Despite the variation, about 86 percent of plans
16 require that beneficiaries take eight or fewer covered Part
17 D drugs to qualify for their programs and less than 1
18 percent of all plans target only those who take 15 or more
19 covered Part D drugs.

20 Each plan sponsor provides a unique set of
21 services under its program. The 10 most common
22 interventions in 2008 are listed here. A plan could satisfy

1 its MTM criteria by doing any one or part of these
2 interventions. For instance, a plan could run a program
3 that includes just a newsletter while another plan could run
4 a program through which community pharmacists visit
5 beneficiaries' homes to review their medication regimens in
6 person.

7 Once a beneficiary is enrolled in the program, the
8 plan must arrange for program interventions to occur. Plans
9 employ a variety of models of service delivery. If a plan
10 contracts with community pharmacies to provide MTM, it will
11 provide the enrollee's name and contact information to the
12 nearest participating pharmacist. The pharmacist will then
13 contact the beneficiary and arrange a time and place for a
14 medication review.

15 Generally, participating pharmacies will set aside
16 a room for private consultations. Sometimes the pharmacist
17 will meet with the beneficiaries at their homes.

18 Alternatively, plans might use in-house call centers to
19 administer MTM over the phone.

20 Our interviewees disagreed about the most
21 effective way to provide MTM services. Some believe that
22 beneficiaries benefitted most from face-to-face interaction

1 with community pharmacists. Others argued that centralizing
2 the program at a call center allowed the plan to provide
3 more specialized services to beneficiaries with specific
4 conditions. There is insufficient data to support any
5 particular method.

6 After a pharmacist conducts a medication review,
7 he might call the physician to let her know that the review
8 occurred and to inform her of its findings. Most MTMPs
9 interact with both the beneficiary and his or her
10 prescribers. However, as you can see here, about 10 percent
11 of plans do not reach out to physicians. In these cases, if
12 the program identifies that an enrollee is taking
13 inappropriate drugs or drugs that are causing side effects,
14 it is up to the beneficiary to address the issues with his
15 or her prescriber.

16 Plans collect data on a wide spectrum of outcomes
17 that include process measures, economic measures, and
18 quality indicators. Many plans also monitor patient
19 satisfaction. However, plans are not required to report
20 these outcomes to CMS. The Agency currently collects a
21 limited set of data on MTMPs. All plans must report their
22 number of eligible beneficiaries, number of enrolled

1 beneficiaries, the method of enrollment, the number of
2 disenrolled beneficiaries and a reason for disenrollment,
3 and total prescription drug cost per MTM beneficiary per
4 month.

5 Since 2007 plans have been required to report the
6 number of covered Part D 30-day equivalent prescriptions per
7 MTMP beneficiary per month. And most recently, CMS has
8 begun requiring plans to report the names of plan members
9 enrolled in MTMPs. The Agency may be able to use this
10 information in the future to measure the effect of MTMP
11 interventions on beneficiary health outcomes, drug costs,
12 and other medical spending.

13 DR. SOKOLOVSKY: Jack and Bruce, you both
14 expressed concern that stand-alone drug plans or PDPs face
15 misaligned incentives and insufficient data to assure
16 quality pharmaceutical care to beneficiaries. So we've
17 tried to look at the difference between the programs
18 provided by the stand-alone plans and Medicare Advantage
19 plans.

20 Whereas Medicare Advantage plans, or MA-PDs, might
21 save on medical costs if they provided MTMPs that increased
22 beneficiary adherence to appropriate pharmaceutical

1 regimens, PDPs will not benefit by that. In fact, they may
2 have increased spending if drug adherence increases.
3 Furthermore, PDPs would not have the additional medical data
4 to tell if the pharmaceutical care is appropriate.

5 However, we found no evidence that PDPs, in the
6 aggregate, provided less inclusive programs to their
7 enrollees than MA-PDs. Our interviewees noted that they
8 provide identical programs to health plan and stand-alone
9 drug plan enrollees who meet their criteria for enrollment.
10 In fact, CMS data indicate that PDPs tend to have more
11 inclusive MTM eligibility criteria than MA-PDs. The minimum
12 number of chronic conditions and the minimum number of drugs
13 required for beneficiaries to qualify for services both tend
14 to be lower in PDPs than MA-PDs. However, MA-PDs much more
15 likely to have contact with member physicians than PDPs.

16 After almost three years, analysts have very
17 limited information about whether MTMPs are improving the
18 quality of care for their beneficiaries with multiple
19 medications. For example, given the small number of
20 enrollees and the variety of eligibility interventions and
21 outcome measures, we have no systematic evaluations as of
22 yet. For example, we don't know, do the programs improve

1 patient adherence? Do they result in more appropriate
2 prescribing? Do they affect drug spending? And do they
3 effect utilization of other medical services? We don't know
4 any of that information yet.

5 CMS is trying to see what they can take from the
6 experience of the past three years. They have established a
7 work group within the Agency and they hope to analyze data
8 to see which programs show the most positive impact on
9 medication use. They have also hired a contractor to help
10 identify standardized outcomes that could be measured by all
11 Part D sponsors. Staff will closely follow the results of
12 this program and report back to you about it. However, it's
13 unlikely that we will have results for several years. In
14 the interim, you may want to discuss whether there are some
15 steps that the Agency could take right now.

16 Many of our interviewees suggested that the
17 program would be improved if requirements were more
18 standardized. For example, we spoke to one plan
19 representative who directs a program with very inclusive
20 eligibility requirements. For example, plan members need no
21 more than two chronic conditions to qualify for enrollment
22 in the program. And the plan provides multiple

1 interventions to enrollees. He told us that without more
2 standard requirements he had to justify his program two
3 different ways. He had to answer questions from corporate
4 officers about why their plan had such an inclusive program
5 when other programs could be approved that required
6 enrollees to have 10 to 15 separate prescriptions each
7 month. On the other hand, he sometimes had to answer to
8 outside groups who questioned why the program did not
9 provide more services.

10 I'll talk about how requirements for eligibility,
11 interventions, and outcome measurements could be more
12 standardized next, but first I want to mention the issue of
13 documentation and reporting. Pharmacies emphasized to us
14 that current MTM practices leave them with very high
15 administrative costs. Pharmacists must be trained
16 separately to participate in each plans' program because
17 plans use different types of documentation and different
18 modes of reporting. These added costs affect the
19 willingness of pharmacies to participate in multiple plan
20 programs, especially given the small number of referrals
21 that they tell us that they're currently receiving.

22 Remember, to participate, a pharmacy has to create

1 a private space for patient counseling, and it may have to
2 increase staffing. A dispensing pharmacist cannot stop
3 dispensing prescriptions in order to provide medication
4 therapy for an enrollee. So the pharmacist has to set up an
5 appointment with the enrollee and the pharmacy must have
6 another pharmacist available to dispense prescriptions.

7 This multiple documentation and reporting may make
8 it harder to make a business case for pharmacies to
9 participate in a program. Some interviewees suggested that
10 stakeholders have to work together to create a standard
11 operating platform and an implementation template.

12 As Hannah showed you, some programs have very
13 restrictive requirements compared to all other programs.
14 CMS provided very flexible criteria because it didn't know -
15 - and in fact still doesn't know -- what program structures
16 are best. However, there are some programs that seem
17 unlikely to have much positive impact. And I should mention
18 here that our interviewees all agree about this, as well.
19 And remember that costs for these programs are built into
20 the bids and Medicare is paying for these programs. These
21 are not demonstration projects.

22 Since plans have to describe their program in

1 their plan bid, and CMS has to approve the bid, the Agency
2 has the ability to strengthen requirements by not approving
3 programs that are so different from the average program.
4 For example, it could limit the number of required chronic
5 conditions. It could require more significant interventions
6 than plan that solely send newsletters to their enrollees.
7 It could require programs to notify prescribing physicians
8 in cases where they discover potentially dangerous drug
9 interactions or side effects. Remember, no matter what the
10 pharmacist discovers about the drugs, it is the physician
11 who must decide whether to change prescriptions.

12 One addition it could make to requirements, the
13 research literature suggests that many patients are confused
14 about their physicians' instructions when they leave the
15 hospital. For example, they may be switched to a new
16 hypertension agent and not realize that they are supposed to
17 stop taking the old one. They may not know why they are
18 taking a new drug and neglect to take it as a result. They
19 also may not understand when and how they are supposed to
20 take it. CMS could require MTMPs to undertake a medication
21 review when an enrollee leaves the hospital or post acute
22 care setting.

1 Lastly, they could require plans to measure and
2 report certain standard outcomes. Although we may not yet
3 know which outcomes are most likely to be improved through
4 participation in an MTM, CMS could define outcomes of most
5 importance and move quickly to see if MTMPs can improve
6 these outcomes and what kinds of interventions are most
7 likely to be effective in doing so.

8 You may want to discuss whether you wish this
9 chapter to make specific statements about standardization or
10 whether there are other ideas you would like to emphasize.

11 MR. HACKBARTH: Thank you. So we'll do the three
12 rounds. Round one is clarifying questions. And by
13 clarifying questions, I mean like what does column two in
14 table A mean? Or what's the statutory requirement for this?

15 The second round will be an initial comment or a
16 question, and we want to keep those brief. The goal there
17 is to make sure that everybody gets a chance to contribute
18 to the discussion before we delve into any issues in detail.

19 And then the third round is to do that more
20 detailed discussion.

21 So let me ask for clarifying questions first.

22 DR. STUART: Thank you both. This is really

1 interesting. The clarifying comment is really the
2 assumption -- and I think I helped drive that in my comment
3 earlier this year -- which was that you would expect that
4 the financial incentives would encourage the managed care
5 plans to provide a product that would result in reduced
6 spending on the A and B side because they would get the
7 opportunity to take advantage of that.

8 And then when we find that there's no difference
9 between the two, my question is really about the assumption.
10 Is that a legitimate assumption? Or is it really that both
11 types of plans treat this as essentially a tax that they
12 have to bear and really have no expectations about
13 successful outcomes?

14 DR. SOKOLOVSKY: I'm going to take that as a
15 rhetorical clarifying question.

16 [Laughter.]

17 MR. HACKBARTH: That is always the presenter's
18 prerogative.

19 MS. BEHROOZI: I think it's sort of along the
20 lines of tax.

21 As I understand it in the -- I'm not going to say
22 all that stuff about what a great paper it was, because

1 that's for the next round.

2 As I understand from the paper the plans, the PDPs
3 and MA-PDs, can incorporate the cost of their programs as
4 part of their administrative costs. So they essentially are
5 getting reimbursed for the cost -- in their bids. They're
6 getting reimbursed for the costs of the program; is that
7 right?

8 DR. SOKOLOVSKY: [off mic] [Inaudible]

9 MS. BEHROOZI: Do you know whether the plans make
10 any payment to the pharmacies associated with participating
11 in the programs?

12 DR. SOKOLOVSKY: Part of what they have to
13 describe in their bid is if they're going to use outside
14 personnel -- some use contract in-house people. But if
15 they're going to use outside personnel, they have to
16 describe the reimbursement structure. And it's generally a
17 fee-for-service to the community pharmacist.

18 MS. BEHROOZI: Thank you.

19 DR. CASTELLANOS: This is just a clarifying
20 comment on your initial introduction, and we talked about it
21 ahead of time so it's not going to be blind sided. Let me
22 just clarify this.

1 The physician writes the prescription, and the
2 patient takes it. And then there's a whole bunch of people
3 in between, the health plans, the pharmacists, et cetera.
4 You said in your focus groups to talked to everybody. And I
5 know you talked to the physician and you talked to the
6 patient. But you said none of them knew -- the physician or
7 the patient didn't know very much about it. Maybe you could
8 explain that.

9 DR. SOKOLOVSKY: Again, we don't know how many
10 people are in these programs. But from everything we've
11 heard, it's a small program. We could not find a physician
12 who was familiar with the program, who had heard of the
13 program at all, nor any of the beneficiaries. We did find
14 some pharmacists who did not themselves participate in the
15 program but knew of other pharmacists that had.

16 DR. CASTELLANOS: Thank you.

17 DR. CHERNEW: On page eight you listed the 10 most
18 common interventions. My question is did you include as a
19 possible answer to that modifying copays or some other
20 method to increase adherence utilization of these services?
21 Or was there a list that they had to check off and these
22 were the things they checked?

1 DR. SOKOLOVSKY: This information comes directly
2 from CMS. Plans have to talk about what interventions they
3 provide and CMS essentially listed the information that the
4 plans gave them. So if there were some that very few plans
5 did but some did, it might have made the list.

6 DR. CHERNEW: But if they had some other program
7 outside of their medication therapy program to achieve these
8 goals which aren't limited to just medication therapy
9 programs, those interventions may or may not be on this
10 list?

11 DR. SOKOLOVSKY: They wouldn't be on this list
12 because this is specifically the MTM.

13 MR. BERTKO: Joan, clarifying question. If I
14 heard you right, you mentioned that some of the push back or
15 comments from the pharmacists were that they needed to get a
16 second pharmacist in order to administer the MTMP. I live
17 in a relatively small town and typically when I get a
18 prescription filled I call it in or I await. Any push back?
19 I mean, that's the circumstance to require two pharmacists?

20 That's also in the context of knowing in most of
21 our pharmacies there is a little area where people can talk
22 to the pharmacist about how the drug works.

1 DR. SOKOLOVSKY: In no case can somebody who's
2 enrolled in a program come to a pharmacy and say okay, I'd
3 like my medication reviewed. In every case it has to be
4 scheduled in advance.

5 If this was a larger program, so that there were a
6 fair number scheduled at a given time, a pharmacy would have
7 to provide a different pharmacist to do the dispensing
8 because somebody could not stop dispensing for these
9 reviews, which tend to take about an hour.

10 However, we talked to one pharmacist who has been
11 providing these services at a chain pharmacy for two years
12 and in this past year he's had two clients. So I don't
13 think that would strongly affect the staffing of that
14 pharmacy.

15 MS. HANSEN: I'm intrigued with the fact that this
16 is a benefit, of course, but that all groups don't seem to
17 really know about it. It's interesting to go on to the
18 website itself, Medicare.gov. If you typed in MTM, you have
19 no hits whatsoever. So even in the course of trying to find
20 it it's not there.

21 So is there any reason we know as to why even the
22 fact of this benefit isn't even known on our website?

1 DR. SOKOLOVSKY: Largely I think it's because
2 again each plan would decide who was qualified and then
3 reach out to try to get them to enroll, as opposed to a
4 beneficiary seeking it out.

5 But I should say that two of the largest plans
6 that we spoke to make the service available to any
7 beneficiary that's in their program, although they only
8 report back to CMS on the ones that would qualify under the
9 \$4,000 a year spending and the multiple chronic conditions.
10 So there are some plans that will presumably in the
11 enrollment information that an enrollee receives understand
12 that they can get a medication review by their plan.

13 MS. HANSEN: To clarify, the medication review
14 could be as simple as a letter to say you should be
15 reviewing your medications?

16 DR. SOKOLOVSKY: No, a medication review would
17 have to be the pharmacist looking at all of the drugs that
18 you are taking. And also, in the kind that we heard about
19 from pharmacists who have been doing this for multiple
20 years, they are also questioning about over-the-counter
21 drugs and nutritional supplements. But they're not
22 necessarily getting all of that within this programs. But

1 at least they would know all of the drugs that somebody is
2 taking.

3 MR. HACKBARTH: Let's move to round two. Let me
4 see hands. We'll go the other way this time, starting with
5 starting with Jay.

6 DR. CROSSON: Thank you. Just a couple of
7 comments.

8 In our program, this is a relatively small piece
9 of our activity, despite the fact that we have probably as
10 low a threshold as you can have, two conditions/two drugs.
11 The vast majority of our beneficiaries can't be projected to
12 hit the \$4,000 threshold, and therefore don't qualify. That
13 has a lot to do with drug use management, but particularly
14 the use of generics and the acceptance of generics.

15 In addition, as Joan had mentioned, because of the
16 reasons that Bruce brought up earlier -- that is, the fact
17 that we have a combination of Part A, Part B, and Part D --
18 we do, in fact, employ the vast majority of that list as a
19 regular part of the clinical management of our patients, not
20 just Medicare -- not all Medicare beneficiaries, not just
21 Medicare beneficiaries, but also our younger members.

22 One thing I would say, though, is that our

1 experience suggests that any of these types of interventions
2 really only succeed in the long run if they are incorporated
3 into the clinical care of the patient and the further that
4 they are removed from that. And the fact that in 10 percent
5 of instances the physician is not notified of a problem is
6 pretty shocking. It would seem to me that at the very least
7 we should make a recommendation in that area.

8 And further, I think if it's possible to suggest
9 to CMS if this program is going to continue or perhaps be
10 expanded that efforts be made to incorporate it as closely
11 as possible into the clinical care of the patient as it can
12 be designed.

13 DR. CHERNEW: The comment I want to make is that
14 I'm very interested in making sure that people take the
15 appropriate medications. That said, the side that we don't
16 know if it works, we don't know -- there are so much things
17 we don't know, I'm extraordinary hesitant to suggest any
18 ways that we try and improve or prescribe a change to the
19 program.

20 It strikes me that until we know, we should let
21 the plans try and do what they want to do and hope -- for
22 example, this idea that the MA-PD plans aren't doing more

1 even though they have incentive to do it, my guess is that
2 they're just doing a lot -- I hope they're doing a lot of
3 other types of things and other activities to try and
4 improve the care, although again we don't know that.

5 But in response to this, and all the set of
6 questions you had at the end, my view is I'm very hesitant
7 to try and improve the program until I know more about the
8 merits of the aspects of the program.

9 MR. EBELER: Let me build on Mike's comment a
10 little bit. I think this presentation links, in part, to a
11 slide that Rachel presented that Peter flagged, which is the
12 portion of the Part D bid that goes to the high-cost/high-
13 risk beneficiaries, which is also who we're talking about
14 here. It strikes me we want to know more about how to make
15 sure they are getting the best clinical care at the best
16 value we can achieve.

17 I had the same reaction. That strikes me as the
18 critical task. I had the same reaction to the chapter that
19 Mike did. Until we know more, it's hard to figure out
20 against which benchmark to standardize as you go forward
21 here. I guess it may be possible to flag some outlier
22 programs but it's just hard to go down that path.

1 It seems to me you also flagged, on your final two
2 slides, the idea of pushing hard on outcome measures. I
3 guess it strikes me that's a more logical short-term way to
4 go so that we can try to learn more and push towards that as
5 we get this clarification.

6 DR. KANE: I actually probably have a clarifying
7 question, as well as my comment. Is this meant to be just a
8 community based program? Or does it also address people who
9 are in the institutional settings?

10 DR. SOKOLOVSKY: People who are in institutions,
11 the plan can divide their program in terms of community and
12 institutional.

13 DR. KANE: So they have both.

14 DR. SOKOLOVSKY: Apparently the literature
15 suggests that this is for community and institutional.
16 They're essentially depending on the consultant pharmacist.

17 DR. KANE: I remember a year or so -- I can't
18 remember, it's been too many years now. I had this picture
19 in my mind of the pharmacy management challenge of nursing
20 homes with this new benefit. And it looked like 16
21 different plans kind of converge on some poor nursing home
22 benefit management company and then they have to somehow

1 figure out how to administer that.

2 It seems to me that would be very interesting to
3 focus on. I think the community setting piece maybe there's
4 just not enough going on to care about. But the people who
5 are most likely to be eligible for this, with all of these
6 chronic conditions and all these drugs, it seems to me many
7 of them are in institutional settings. If I were going to
8 put some energy and research into this question, I would
9 want to know more about how this was working out where the
10 really vulnerable people are, who can't really fend for
11 themselves. That's where medication management, it seems to
12 me, will have biggest bang for the buck.

13 So that's one comment, is I'd like to know much
14 more about the institutional patients.

15 The other comment is do they actually articulate
16 how much they're spending in the bid or planning to spend in
17 the bid?

18 DR. SOKOLOVSKY: If they have -- if they are using
19 community pharmacists, for example, they have to have a fee
20 schedule.

21 DR. KANE: But they're not saying how much the
22 total amount of their administrative costs -- they are? I

1 think it would be very --

2 DR. SOKOLOVSKY: It's not broken out for us.

3 DR. KANE: But they have some kind of total cost
4 in the bid about MTM - I mean, I think just at a minimum we
5 should have some idea of how much they're asking for in the
6 bid and how many beneficiaries seem to be served by that,
7 just as a starter. And then some sense of what's the costs
8 -- in their bids what are they saying they want to be paid
9 for this? And then how many people are being served by
10 that? And get a sense of the variability there as a way to
11 gauge how much this is -- you know, whether we're paying for
12 something we're getting nothing for.

13 DR. STUART: I would like to also build on the
14 comment that Mike made, and this is this extraordinarily
15 thin evidence base that we have. But the problem is
16 actually twofold. The first part is that if you look at
17 that list of interventions on slide eight, we know very
18 little about whether these things work in any population
19 group. This literature is not well developed. So this is
20 an area that I'm concerned about.

21 But the second piece is even worse, and that is
22 the targeting of this benefit to people who have -- and the

1 first element of that target actually is you have to have an
2 expectation of more than \$4,000 per year in drug spending.
3 Now that is pure blue sky. There is nothing out there that
4 provides any evidence at all that that is a reasonable way
5 to target the benefit.

6 In fact, it probably doesn't make sense to target
7 on the basis of drug spend at all. If you're going to
8 target, it probably makes sense to look at other factors
9 other than drug spend because, among other things, people
10 who are more adherent on their drug regimens are going to
11 cost more. So you may be focusing on the people who are
12 actually doing pretty well.

13 So I think these two elements combined make me,
14 again, very, very hesitant to recommend that we develop
15 further standards here.

16 As optimistic as I am that some of this is going
17 to become better known through the CMS Work Group and the
18 contract that they've developed, I think this is something
19 that MedPAC itself should develop a more intensive agenda
20 than just simply focus groups. I think the idea of trying
21 to figure out ways that you can identify problematic
22 prescribing and targeting with some data mining activities

1 would be well worth it so that you can at least address that
2 particular issue.

3 DR. CASTELLANOS: Joan, again I appreciate you
4 talking with me ahead of time about this.

5 To me, carrying on from what Jay said, this needs
6 to be incorporated in the clinical program. And if there
7 ever was a place, it would be in the medical home. This is
8 one of the things we want the medical home to do, recognize
9 the MA plans don't have medical homes but the PDPs do.

10 As far as outcome measures, something Mike said
11 was very important and it's really important to the
12 physician community. I don't want to know if the patient
13 has the medication. I want to know if the patient is taking
14 the medication. So adherence is really important. But more
15 important, and you can correct me, but I understand the
16 outcome measures are not going to be reported to CMS. And I
17 don't understand that.

18 DR. SOKOLOVSKY: Right now the list of outcome
19 measures which I think are in your mailing materials are
20 really more about how many people are enrolled, many people
21 are disenrolled, and so on.

22 The other outcomes that plans measure, and they do

1 measure, they report to CMS what they measure. But so far
2 they have not reported those outcomes, the ones that they
3 find internally usable.

4 DR. CASTELLANOS: Thank you.

5 DR. DEAN: As is evident by the comments, this is
6 a very complex undertaking, and I certainly appreciate your
7 efforts to try and describe it because it's a sort of a
8 nebulous thing. But it's terribly important.

9 Just in response to Nancy's question, at least in
10 our area medication reviews by pharmacists are a standard
11 part of nursing home care. I get regular reports from
12 pharmacists that look over the list of medications of all
13 the patients and everything. So I think it's already
14 happening there.

15 I was going to say exactly the same thing that Ron
16 just said and follow-up on what Jay said, that this has got
17 to be part of clinical care if it's going to have any
18 effectiveness. Because neither the physician nor the
19 pharmacist has all the information that's necessary to make
20 these decisions and to decide what is appropriate or what is
21 inappropriate. There are a lot of drugs that have relative
22 indications or relative contraindications. And if the

1 pharmacist doesn't know why that particular drug was
2 prescribed and all of the information about it, they are
3 going to make some recommendations to stop something that
4 was maybe done for a good reason but it may not appear in
5 the clear indications.

6 And likewise, a lot of times we, as physicians,
7 don't have access to some of the more esoteric pharmacologic
8 information or possibly some of the interaction information,
9 or especially the options in terms of more efficient use or
10 other drugs that might be less costly and so forth.

11 So it's really got to be a joint effort and, as
12 Ron said so well, it is the ideal responsibility for a
13 medical home structure or ideal indication for a medical
14 home structure where you've got these different disciplines
15 working together.

16 And finally, I think probably the biggest reason
17 for the relatively low participation is the fact that a lot
18 of -- at least in my patients -- the people that need it the
19 most are the ones that are least likely to ask for it
20 because they simply don't realize that they're getting this
21 all mixed up. I have some relatives that I can point to,
22 some very close relatives, that were bad offenders on this

1 category. I thought my parents were taking their
2 medications properly and they clearly were not.

3 So I think just offering it is clearly not
4 adequate. There needs to be a much more aggressive approach
5 to supervising medication use.

6 DR. BORMAN: Certainly, as a surgeon, I don't
7 prescribe lots of different classes of drugs for lots of
8 people over the long term, so I really have no dog in this
9 hunt as a practitioner, other than to say I think the
10 practitioner does have to be fairly central to this, as Jay
11 and Ron and Tom have already said. I agree with Jay, it's
12 appalling that 10 percent of the time, at a minimum,
13 physicians weren't involved in the loop. Given the expense
14 level here, you would think this might be something of a
15 proxy for relatively high risk patients who are on some
16 rather intensive drugs like Biologics.

17 My question would be from a very broad level.
18 What I think I hear a bit is we're not really sure that we
19 need this entity as we think of our delivery system going
20 forward, rolled out in this particular way. I think we all
21 agree that there's an important place for medication
22 reconciliation, medication management, in a value cost

1 effective way. Where this particular activity fits into it,
2 I think is hugely unclear. I think John has wonderfully
3 highlighted the fact that it's even less clear when we look
4 into it.

5 I agree with the sense that the Commission,
6 particularly important staff time/resource, going way far
7 down this road seems to me to be counterproductive given the
8 other things that are on our plate. I would see this maybe
9 as more of the stay tuned or perhaps a focus question or
10 two. Because as this rolls into medical home or, in my
11 view, for example the discharge from the hospital medication
12 piece, that seems like it ought to fold into our
13 consideration of A plus B quality and where patients are
14 vulnerable, what we do to address that, as opposed to again
15 this sort of isolated little piece that's out there by
16 statute.

17 Which gets me to my question of, on the first
18 slide, you introduced this by saying that Congress required
19 Part D plans to offer this to enrollees of a certain level.
20 Am I correct in that since this is a legislative mandate
21 stipulated benefit if, as a result of other changes in
22 delivery, this became unnecessary or from data became

1 evident that it were superfluous, would it take legislation
2 to make it go away?

3 DR. SOKOLOVSKY: Yes.

4 MS. HANSEN: It's interesting because I actually
5 have some thoughts just to maybe counter a comment, Karen,
6 that you had relative to this that. A, that it is in
7 statute and it's hard enough to get it in the statute. So
8 is it an opportunity to really look at this, one way of
9 looking at this very complex component of medications in the
10 life of Medicare beneficiaries?

11 So if it's there, as I said, it's not really
12 readily available as a piece of information to the public
13 when you go on to the Medicare site. And here we have a
14 statutory piece here. So I would go, in the interim, the
15 fact that it is already built in, to at least have all of
16 the plans identify what their MTM program is about. So just
17 as a point of information, that all of the plans be able to
18 say what their process and structure really is.

19 The second part is I fully agree, I think it's a
20 very messy period right now. But what we do know is that
21 many people take multiple medications for these conditions.
22 And whether you hit the \$4,000 mark, and especially if

1 you're in a Kaiser-like plan, that gets kind of buried in
2 there. But people do have a lot of screw up of medications,
3 which tips it into the quality issue that you mentioned,
4 into hospitals.

5 And then what's been, I think a body of evidence
6 is known is that that transitional period post-hospital that
7 people do take medications perhaps incorrectly for a number
8 of reasons or don't adhere to them for a number of reasons.
9 So it just is both a high cost and it is about medication
10 management and counseling. And we don't know about the
11 intervention being the best. But it seems like -- I would
12 just almost do the opposite, by taking a look at the fact
13 that it is in statute and to get something out of statute is
14 quite difficult. So if we have that, what do we do with it
15 in terms of making the most of it?

16 So the targeting I think is real important. And
17 the ability to tie back to what I think we have covered in
18 previous Commission meetings about re-hospitalizations.
19 Rehospitalizations, I think, for benes within 30 days is
20 anywhere from 17 to 20 percent. My recall -- and please I'm
21 going to ask staff to help me be accurate -- but it might be
22 about 60 percent due to medications, medication problems of

1 one sort.

2 So it seems like there are targeted types of
3 things to be able to do it with this. And I would just like
4 to delve into it a little bit more deeply before we let go,
5 that this is not as useful.

6 So one point of information, that if we have it we
7 should let the public know about it. And it should be
8 available in terms of what the plans are offering, since
9 this is already submitted as part of their bid to CMS.

10 Number two, I think the ability to understand the
11 nature of this and the impact of targeting much better.

12 And then an outlier thought completely, and that
13 is if the beneficiaries are now, of course, taking more
14 responsibility for managing or paying more cost and being
15 participants in it, I wonder if, in fact, there might be a
16 consideration of allowing a drug consult privately to be
17 paid and be considered a part of your Part D costs. So in
18 other words, if it has to be a paid for service over and
19 beyond what the plan would offer to really sit down with the
20 pharmacist to go through a full pharmacy regimen.

21 That's an outlier thought, but this is such a big
22 area and medications do weave through the entire

1 epidemiology of what goes on with the quality and the costs
2 and the utilization of hospital care as a result of
3 potential errors.

4 DR. SOKOLOVSKY: Can I just make two clarify
5 remarks here. The \$4,000 is not in statute. That is
6 something that CMS has put there. So what's in statute
7 would allow very flexible definition of what a program
8 should be.

9 The other thing I wanted to mention was that these
10 pharmacists that we've been talking about, who have been
11 doing this for many years, are in fact privately paid by the
12 patient. So that is a mode that's out there.

13 MS. HANSEN: But the question is could that be an
14 allowable cost built into their Part D costs at all?

15 MR. BERTKO: It is.

16 MS. HANSEN: It is already? Thank you.

17 MR. BUTLER: You've got a theme in the remarks so
18 I've been adjusting mine as I've heard the rest. This is a
19 little bit like a solution in search of a problem or a not
20 clearly defined problem. If we're talking about the \$4,000
21 and above expenditures for chronic conditions, which I think
22 is a very appropriate focus, we've highlighted the fact that

1 the caregivers, whether they're clinicians, doctors or
2 others, need to really be much more involved in this. I
3 think we'd all agree with that.

4 I think which is a little less clear is we've made
5 references to medical homes, skilled nursing facilities. I
6 don't think we've clarified enough of the caregivers that
7 we're talking about. For example, I would see a retirement
8 community that has the full continuum of care as an ideal
9 place to partner with because they typically will have the
10 nurse that, even if you're in independent living, often gets
11 involved in the dispensing and monitoring of the drugs. And
12 as you move up the chain to the assisted living and then
13 skilled nursing, it's an ideal environment to kind of say
14 can we make inroads there? Not just in the nursing home
15 piece but in the continuum of care that's offered in the
16 retirement communities. We might get more bang for our
17 buck.

18 And they may not even have the appropriate role in
19 this but I think we need to think about those structures a
20 little bit more.

21 My only other point is that one that says trying
22 to get directly involved in medication reconciliation at the

1 time of discharge -- we've got enough people involved in
2 that. That probably would not be a good intervention if
3 you're trying to do something timely. I just don't think
4 logistically that would work very well.

5 MR. BERTKO: Two quick comments. The first is
6 something that might be easy to follow up on. Through data
7 mining you could look at adherence if you defined a set of
8 maintenance drugs where you expect them to be prescribed and
9 filled every month. My cholesterol medicine fits into that
10 particular one. There we go, Mike, with HIPAA again.

11 A second is, Joan, to point out that there a
12 couple of vendors out there that actually do outreach, push
13 technology to physicians saying our algorithm has shown that
14 you're prescribing this and you should check on it or
15 something like that.

16 I have to say that my limited experience, in the
17 absence of medical homes or other kinds of things, is that
18 physicians don't do much with that. That might be part of
19 the whole incentive structure.

20 So the goal of saying here's something that we
21 should talk to physicians about might be like going outside
22 and yelling down towards the other end of the mall. It

1 happens but it's not very effective. We need to think about
2 that in the context of other changes that we've been talking
3 about.

4 DR. MILSTEIN: A few brief comments. First,
5 people like Jennie who have looked into this, I think would
6 tell us -- and others around the table -- that medication
7 management is potentially very valuable and there's a lot of
8 evidence of patients not understanding and not taking --
9 seriously chronically ill -- not taking their medication.
10 Obviously, in the fee-for-service system where I, as a
11 doctor, don't know what anybody else is prescribing the
12 upside here is potentially large.

13 And I think, therefore, this program is
14 potentially useful in the short term while we're waiting for
15 accountable care organizations and medical homes to evolve.

16 However it's clear, Joan, from looking at your
17 list of what is the information set that CMS is attempting
18 to use to judge the program, including the individual
19 vendors. It's not even close to the information flow you
20 would need to judge the vendors. It's far off. It's crazy.

21 We are being asked to make a recommendation in the
22 absence of any reasonable information base on this program.

1 Would it be possible for us to, within the limits of our
2 capability, to synthesize what people who have been
3 successful in such programs, either inside or outside of
4 Medicare, know about best practices. So at least in the
5 interim we could build into our recommendations known best
6 practices that ought to be requirements of these programs.

7 And I would include on that list of best practices
8 the most likely agent for these programs. Because it
9 strikes me that the plans, for reasons that I think, Joan,
10 you articulated may not be the best agents since every time
11 they succeed in getting a patient to be more adherent in
12 potentially threatens their economics, their business model.

13 DR. SOKOLOVSKY: The one problem is again that the
14 research literature does not clearly define what works. For
15 example, one of the things is that they target different
16 kinds of people. The best literature is on working people
17 who have say diabetes or asthma and no other chronic
18 conditions, and getting those people to understand how to
19 use their drugs. There's fairly good studies that show that
20 that can be very effective but it's a very different kind of
21 population.

22 And then one of the other issues is that all of

1 the people who provide these suggest that they save money by
2 eliminating polypharmacy, by getting people to use more cost
3 effective drugs for the same condition. But the measurement
4 is not probably what you would be happy with. For example,
5 some of it is based on costs that are avoided, but that's
6 not compared to any other group. It's well, there's X
7 percentage of adverse events and they cost so much, and
8 we've eliminated some adverse events so we're saving this
9 money.

10 MR. HACKBARTH: Okay, clearly an important
11 problem, management of patients, especially complex patients
12 on lots of different drugs. But I think we are well short
13 of solutions, in general or in particular, in how to modify
14 this particular program. So more research and information
15 would be helpful.

16 Thank you very much, and we will move on now to
17 our last session before lunch, which is Medicare's statutory
18 to support delivery system reform.

19 MS. RAY: Good morning.

20 The pace of delivery system reform and improved
21 efficiency in Medicare is slow at best. The Commission has
22 made recommendations for changing how the payment system

1 works. In some instances, Medicare cannot implement these
2 strategies because it does not have statutory authority.
3 For example, we have recommended P4P for various provider
4 groups. Medicare does not have the authority to adapt these
5 strategies without a change in the law.

6 In addition, Medicare has had mixed experiences in
7 trying to implement policies to improve the program's
8 inefficiency because the statute is not always clear. Some
9 policy experts have recently suggested that Medicare needs
10 more flexibility in carrying out its mission.

11 The issue that we would like Commissioners to
12 discuss are the pros and cons of giving the Medicare program
13 more flexibility to implement strategies to reform the
14 health care delivery system. In this session we are going
15 to focus on giving Medicare more flexibility to adapt value-
16 based payment policies. Of course, there are other types of
17 policies that we could be looking at as well.

18 To be clear, we are not discussing potential
19 changes to Medicare's governance and structure. The focus
20 of this session is on Medicare's statutory authority to
21 change how the payment system works.

22 Here are some examples of value-based payment

1 policies that either Medicare cannot implement without a
2 change in the statute or where the statute is not clear,
3 including pay-for-performance, competitive bidding,
4 establishing centers of excellence, using prior
5 authorization policies, using shared savings policies,
6 implementing reference pricing -- that is setting the
7 payment for clinically similar services based on the least
8 costly service -- and payment with evidence. This means
9 paying no more for a service unless evidence shows it
10 improves outcomes compared to its alternatives.

11 Some of the challenges that Medicare has faced
12 when trying to adopt value-based policies have come from the
13 courts. Most recently the court has potentially limited
14 Medicare's use of one type of value-based policy reference
15 pricing.

16 In other instances, the challenges come from the
17 statutory language itself. Detailed language is sometimes
18 difficult to carry out and it does not give Medicare much
19 latitude to exercise discretion.

20 I'm now going to talk about four case studies that
21 highlight these and other challenges that Medicare has faced
22 when adopting value-based policies.

1 The first case study concerns Medicare's use of
2 least costly alternative policies. Medicare's contractors
3 have set the payment rate of a service based on the payment
4 rate of a less costly, clinically comparable service. For
5 example, it has used least costly alternative policies for
6 paying for inhalation drugs covered under Part B. Medicare
7 has done so under its statutory authority to cover services
8 that are reasonable and necessary for the diagnosis or
9 treatment of an illness or injury.

10 However, a recent court ruling may affect
11 Medicare's flexibility to carry out LCA policies. The U.S.
12 District Court for the District of Columbia ruled that
13 Medicare can no longer use LCA policies to pay for Part B
14 inhalation drugs. The court concluded that the statute's
15 specific provision that sets the payment rate for Part B
16 drugs based on its average sales price precludes Medicare
17 from using least costly alternative policies under the
18 statute's broader authority of covering services that are
19 reasonable and necessary.

20 So I think the takeaway message from this case
21 study is that Medicare's statutory authority to use least
22 costly alternative policies is not clear and that this court

1 ruling, this recent court ruling, may affect Medicare's
2 flexibility to carry out such policies in the future.

3 The second case study describes Medicare's use of
4 a functional equivalence policy. The functional equivalence
5 policy is similar to the least costly alternative policy but
6 Medicare implements this policy on a national level.
7 Specifically, for two biologics Medicare set the payment
8 rate of these two biologics that are close substitutes based
9 on the least costly product. Medicare adopted this policy
10 in 2003 in the hospital outpatient setting. Similar to the
11 least costly alternative case, Medicare adopted this policy
12 based on the statutory provision of paying for only
13 reasonable and necessary services.

14 Subsequently the BBA, passed in 2003, limited its
15 use. Specifically the Congress prohibited the use of this
16 standard for other drugs and biologics in the hospital
17 outpatient setting. However, the Congress did not preclude
18 the Agency from continuing to use the policy for the two
19 biologics in the hospital outpatient setting or for setting
20 the payment rate the same for other clinically comparable
21 services in other settings.

22 So what have we learned from this case study?

1 One, the statutory authority to use the functional
2 equivalence policy is not clear. And two, legislative
3 guidance can sometimes be conflicting.

4 The third case study is about the inherent
5 reasonableness policy. The statute gives Medicare the
6 authority to deviate from the payment methods specified in
7 the statute if the application results in the payment rate
8 for a service or group of services that is determined to be
9 grossly excessive or deficient, that is not inherently
10 reasonable. The Congress mandated this policy based on the
11 finding that the Secretary lacked adequate authority to make
12 adjustments to ensure that the payment rates were reasonable
13 and equitable.

14 To use its inherent reasonableness authority, CMS
15 would generally go through the rulemaking process and
16 setting forth the factors and the data that contributed to
17 its decision to use this policy. If this policy were to be
18 implemented by Medicare's contractors, then the carriers
19 would contact the affected suppliers.

20 The legislative history behind the inherent
21 reasonableness policy is lengthy. In 1997 the BBA
22 streamlined the process for Medicare to use this authority.

1 Medicare's contractors then proposed to use the authority to
2 set the payment rate of various supplies, including test
3 strips and lances. Following an outpouring of concern from
4 industry groups, CMS suspended the proposed payment
5 reductions. In 1999 the BBRA prohibited Medicare from using
6 this authority until GAO issued a report about the impact of
7 using inherent reasonableness, particularly the contractors
8 using the authority, until Medicare published a notice of
9 final rulemaking that responded to GAO's report and
10 reevaluated the factors used to determine if the payment is
11 too high or too low.

12 GAO issued its report and the final rule was
13 subsequently issued in 2006. So Medicare was without the
14 use of this authority for about seven years. In recent
15 years Medicare has not used its inherent reasonableness
16 authority.

17 So the lessons learned from this case study
18 include the authority granted by the statute is sometimes
19 difficult for Medicare to exercise, and that legislative
20 guidance is sometimes conflicting.

21 The DME competitive bidding program is our last
22 case study. The use of competitive bidding for DME by

1 Medicare has a long history, starting with a demonstration
2 mandated by the BBA. In that demonstration competitive
3 bidding lowered payment rates for selected DME items by
4 between 17 and 22 percent and did not cause access or
5 quality problems.

6 Subsequently, the MMA gave CMS the authority to
7 replace the DME fee schedule with a new competitive bidding
8 program. As we discussed during the September meeting, CMS
9 implemented the first round of the bidding process and
10 announced that it resulted in a 26 percent savings for both
11 the program and beneficiaries. However stakeholders,
12 suppliers, raised concerns about the bidding process.
13 Subsequently MIPPA delayed the new current competitive
14 bidding process because of implementation concerns.

15 At least four lessons are learned here. Medicare
16 needs explicit authority to adopt competitive bidding
17 programs. Statutory requirements are very detailed. The
18 legislative guidance was conflicting. And the influence of
19 stakeholders, the suppliers, impacted on Medicare's ability
20 to adopt these policies.

21 This case study also raises the question of how
22 Medicare can be given the authority to use competitive

1 bidding so that it would lead to a successful and lasting
2 program.

3 This concludes my presentation. To summarize,
4 Medicare's existing authority is sometimes difficult to use
5 to implement value-based payment policies. And in other
6 cases Medicare does not have clear authority.

7 Commissioners may want to discuss the pros and
8 cons of increasing Medicare's flexibility to adopt value-
9 based policies. And specifically, Commissioners may want to
10 discuss an explicit statutory change that would permit
11 Medicare to use value-based policies such as paying
12 providers differently based on their quality or using
13 reference pricing. We would like Commissioners to discuss
14 the advantages and disadvantages.

15 And in addition, we would also appreciate your
16 input about other topics that we should be looking at.

17 MR. HACKBARTH: Okay, round one will be clarifying
18 questions. Let me see hands of people with clarifying
19 questions.

20 DR. CHERNEW: All of this pertains only to the
21 fee-for-service Medicare part, outside of that MA program
22 and all other things, all of the things that they don't have

1 the authority to do could be done by a plan. It's just
2 Medicare in the fee-for-service part?

3 MS. RAY: That's correct.

4 DR. SCANLON: It should also be an issue of
5 Medicare versus -- or not versus, but in dealing with the
6 managed care plans. You can have pay-for-performance for
7 managed care. In fact, there's a MedPAC recommendation to
8 that effect.

9 DR. MILSTEIN: Just for clarification of your
10 answer to Michael, the plans have a certain amount of
11 discretion but isn't it also true that CMS is limited by
12 statute in the flexibility it can give to the Medicare
13 Advantage plans? In other words, it's...

14 MR. HACKBARTH: Give an example, Arnie, of what
15 you think is a limit.

16 DR. MILSTEIN: I don't know whether I can. But
17 presumably, the people that I hear from on the Medicare
18 Advantage plan side say that their ability to be even better
19 than they may otherwise be at value purchasing is
20 significantly limited by Medicare rules.

21 I guess my question, following on your answer to
22 Michael's question, is do we have any reason to believe that

1 Medicare's authority in regulating Medicare Advantage plans
2 is as limited or is as problematic or challenged as what
3 you've described on the fee-for-service side?

4 MS. RAY: I think that's something that we would
5 need further investigation on.

6 DR. MARK MILLER: In my experience, and we've got
7 some managed care folks sitting here so there may be some
8 other views on this. A lot of what I have heard has been
9 the restrictions that are put on them in administering the
10 program, particularly in areas of things like marketing
11 materials and that type of thing as opposed to you must
12 administer the benefit this way. I'm getting some nods
13 there.

14 I think what I would say, if I were Nancy, is this
15 is a good question, we'll look into it deeper...which she
16 did.

17 I think there's two parts to this question that I
18 think I've heard here, which is the legislative authority
19 inside MA plans, and then the point that was raised up over
20 here, which is Medicare's posture relative to the MA plans.

21 DR. CHERNEW: [off mic] Medicare to pay the MA
22 plans.

1 MR. HACKBARTH: So if I were Mark pretending to be
2 Nancy, what I would say is certainly within these areas the
3 case studies were discussed, and what price to pay for
4 particular services and how to identify participating
5 providers, Medicare Advantage plans have broad latitude.
6 That's not to say that there aren't restrictions in other
7 areas. But in the ones covered by these four case studies,
8 they do have broad latitude.

9 Okay, we will go on to round two.

10 MR. EBELER: Thank you for the presentation and
11 chapter. This is very interesting.

12 It seems to me that you start, because of the size
13 of the program, the nature of the program, with strong
14 statutory grounding and framework. And of course, the
15 ability for Congress, anytime it doesn't like what CMS is
16 doing, to undo it. So that's sort of the important
17 statutory given here.

18 You flagged a couple of directions here that are
19 worth talking about for CMS. One is clarification of these
20 potentially conflicting areas, where there is least costly
21 alternative language, there is equivalence language, there
22 is the inherent reasonableness. Just so that Congress

1 clarifies for CMS how to use that language, because that's
2 potentially a valuable tool.

3 Second, it strikes me that there's a difference
4 between thinking about how CMS would change an overall
5 payment policy -- the entire DRG system -- versus the
6 potential clarification for CMS to be able to try some
7 things that are -- is there a path where CMS could try some
8 things as a payer and see how they work, which is helpful to
9 both CMS and the Congress in figuring out future payment
10 directions.

11 It strikes me that those are two potential paths
12 for us to think about going down as we try to clarify this
13 area.

14 DR. SCANLON: I guess I feel like I have a history
15 in this set of issues, having spent about a decade looking
16 at CMS and HCFA and their implementation of some of the
17 statutory authorities, in particular inherent reasonableness
18 and DME competitive bidding.

19 I guess for me the core issue here is, in some
20 respects, the awesome power of government and the need to be
21 able to have some protections from that power. It's kind of
22 like if you had a pet, the safeguards that you would take

1 would be very different if your pet was a tiger versus a
2 house cat. And that is, in some respects, what we've got
3 here. We've brought in the courts and that's one of the
4 sources of redress.

5 The Administrative Procedures Act is another. You
6 can't just implement the statute in any way that you choose.
7 You have to be very transparent about it.

8 And recourse of the Congress is another.

9 All of them I think are important and we need to -
10 - I think to understand it best is put yourself in the
11 position of what would happen if government decided to do
12 something that would devastate your profession. That's kind
13 of what it can potentially come down to.

14 Having said that, the need for a better Medicare,
15 more efficient Medicare program, is profound. But the
16 question is how do we get there? One of the things that I
17 found sort of very striking during those 10 years was that I
18 was both a defender and a critic of HCFA and CMS. The
19 defender was in terms of not that their performance was
20 great but that their task was overwhelming relative to the
21 resources that they had, that they were given an impossible
22 job and therefore how could you expect them to do more with

1 it?

2 I think that that's particularly true in some of
3 things that we're talking about here in terms of reform
4 because the kind of strategic thinking, the kinds of data
5 that you need to be able to design and defend the policies
6 that you want to make sort of in these areas, they're quite
7 significant and we don't have them right now within
8 Medicare's capacity.

9 And when we bring into the discussion we're
10 letting the contractors do this, that compounds the problem.
11 Instead of making it simpler -- you know, physiology is not
12 geographic. And therefore, why are we having each one of
13 the contractors make policy separately, as opposed to
14 concentrating resources and having a much more well informed
15 policy and being able to defend it?

16 I think as a first step, I'd go back to the things
17 that we have recommended in the past in terms of trying to
18 improve CMS's resource capacity because you've got to build
19 confidence before people give you more discretion, more
20 authority. There's too many cases where it's not just the
21 stakeholders that are going up to the Congress and saying
22 this didn't work out right. It's a source like GAO going up

1 to the Congress and saying this was implemented with flaws
2 and you need to think about changes. And you want to reduce
3 those so that there's greater confidence and then there will
4 be more receptivity to providing flexibility.

5 DR. BERTKO: I think we're going to be bookends
6 here. With all deference to Bill's cautions about doing
7 this, we've had a robust discussion over the last couple of
8 months on the urgency of the fiscal status of the Medicare
9 program in general. And so the need for CMS and Medicare to
10 be a better value purchaser, I think, is just overwhelming
11 and we need to move that way. There is, I think, a decent
12 history of demonstrations, perhaps to lead into these rather
13 than jumping into it. And clarifying -- Nancy has done a
14 great job of saying clarification, clarification,
15 clarification. And being able to do that and help CMS be
16 able to better implement the demonstrations and good ideas
17 that have been used around, I think it's really time for
18 that.

19 DR. REISCHAUER: There was a little discussion at
20 the beginning about the authority of Medicare MA plans as
21 opposed to fee-for-service. What I would be more interested
22 in is the extent to which plans serving the non-elderly

1 disabled population use these mechanisms, reference pricing
2 or functional equivalence. Is this something that everybody
3 is doing and we have some kind of basis for what kind of
4 changes would result in terms of relative prices and how
5 much savings we would have? Or is it a situation in which
6 those who are at the other end fear that if Medicare does it
7 then Humana, United Health and everybody else is going to do
8 it, too? So maybe we can learn something from the private
9 sector.

10 DR. KANE: France, England, Germany, Italy,
11 Canada, a whole lot of countries have accepted having the
12 tiger as the house pet. I have to say, I think some of this
13 is just political will. But then some of it could be other
14 things.

15 So I think in thinking about what do you want to
16 recommend fundamentally about Congress, are we just seeing
17 interventions from the past seven or eight years that are a
18 function of a political ideology that doesn't believe in
19 government? Or are we seeing what we would expect to go on
20 forever of the more ambitiously Medicare acts, the more it's
21 going to get more -- the more vulnerable it is to
22 stakeholder interest groups coming in and trying to lobby

1 that out?

2 The latter, I think, is the kind of thing where we
3 really should be saying we need to make a change. But if
4 this is just this swinging political ideology of is
5 government a bad guy or a good guy, I have a feeling --
6 certainly in the last set of eight years I think we've had a
7 real strong sense that the leadership thought government was
8 a bad guy and less is better. That swings back and forth, I
9 think.

10 But what doesn't swing back and forth is interest
11 groups feeling threatened if Medicare becomes more ambitious
12 and wants to do more to contain costs. And it's very hard
13 to do that in a politically vulnerable, politically
14 accountable place. But other governments have figured out
15 how to do it.

16 Then we should, I think, say what can we do to
17 make it easier for Congress to let Medicare do what it needs
18 to do? I don't know. I can't tell from the way you
19 described it whether it's because Medicare has tried to get
20 more ambitious that we've had more Congressional
21 intervention? Or whether it's just been the ideology of the
22 most recent Congress.

1 MS. RAY: I think I would answer that question by
2 saying that, in some instances, the 1965 law has not kept up
3 with what perhaps some may want to do to improve value and
4 efficiency.

5 DR. KANE: That's one perspective. I mean, I
6 think the 1965 law is quite anachronistic myself, but it has
7 been adjusted and changed over time. So I'm not so sure
8 we're still stuck in 1965 still.

9 But are we worried that these interventions by
10 Congress at the level of value-based purchasing is really
11 just a fear of government? Or are we worried that every
12 time we do this you're going to have an ability to create a
13 structure that can resist stakeholders?

14 MR. HACKBARTH: It's an important question, a
15 difficult one to answer. My own perception would be that
16 this isn't particularly ideologically driven but more driven
17 by concern about the impact of particular decisions on
18 constituents. And both Republicans and Democrats can react
19 that way. I don't think it's a big government/small
20 government philosophical issue. That would be my
21 perception.

22 DR. CASTELLANOS: First of all, I think this

1 discussion needs to take place. We need to have a
2 thoughtful discussion. Because there's no question we make
3 certain recommendations that have been very appropriate but
4 perhaps not implemented.

5 I think specifically the LCA has been a
6 significant savings to the Medicare program. However, on
7 the other hand, this recent case was brought up by a
8 patient. And that patient must have had a good reason. And
9 that the patient had to have a reason why he or she filed
10 that case.

11 As a physician, I live under LCA. And a lot of
12 times I have to make clinical decisions based on
13 reimbursement rates that perhaps are not appropriate for the
14 patient. I think that patient has a right to somehow
15 appeal. It's unfortunate that he has to appeal in the court
16 system, but it is a checks and balances system that we live
17 in.

18 MS. BEHROOZI: This might go a little to the point
19 that Bob was making. I just want to say, on behalf of the
20 private plan world that's not the Humanas and the Kaisers
21 and the big players, a lot of the coverage decisions and the
22 payment decisions that are made by the little guys or women

1 are often tracking Medicare. And the thought is that
2 Medicare has made a rational, clinically based, economically
3 base or whatever decision. And it does not immediately leap
4 to mind that the coverage decisions or payment decisions or
5 whatever are the results of political compromise which, the
6 way things are, I am learning more and more, is much of what
7 drives payment decisions.

8 So I think we need to recognize the broad impact
9 of Medicare not being able to make decisions that are
10 justified on a basis other than political compromise.

11 MR. BUTLER: I guess I'm a book on the bookshelf
12 between the two bookends.

13 We've got to create change faster than we do. We
14 have a saying in academic medical centers that a 99-to-one
15 vote means a tie, so it's kind of hard to move things
16 forward. There's some truth to that in some of these kinds
17 of things.

18 I'm having a hard time in defining the continuum.
19 The obvious ones to me are the ones that are not actually
20 quality oriented, that's kind of an obvious price list and
21 we're just not purchasing wisely and somebody is interfering
22 with that and it's just easy cost savings. I suppose DME

1 would fall in that category.

2 Where there gets greater angst is where you're
3 really tying specific quality to the payment and it's not an
4 opposition to it. It's just that, as Bill pointed out, does
5 CMS have the resources, the clinical, the quality competency
6 staff within them to help push that along in a realistic
7 practical way.

8 And is it going to be in sync with what everyone
9 else does? We've talked about synchronization, and there
10 are an awful lot of forums where these kinds of things are
11 coming forward, too. So just the process of making sure it
12 gets rolled out correctly and in sync with what others are
13 doing is probably the anxiety around that end of the
14 continuum.

15 DR. CHERNEW: I'm torn a little bit because I
16 think my personal opinion is it's difficult when you see
17 some of these examples to argue that there shouldn't be more
18 flexibility. And certainly in other discussions we've had,
19 we've seen ways which at least it appears as if the system
20 has not responded in the way you wanted the system to
21 respond for a number of reasons, which one you would pick
22 would depend on how cynical you are.

1 But in any case, what I haven't heard and the
2 reason why I -- it's not clear what the limits on this added
3 flexibility would be. In other words, if the proposal on
4 the table were CMS should be able to use any mechanism
5 however they wanted in any way to do whatever they thought
6 was appropriate for policy, I think we'd say that's just way
7 too much flexibility and there needs to be oversight and a
8 whole series of other things.

9 So right now we have a system where perhaps
10 there's not enough flexibility. Certainly in some of these,
11 particularly I agree price-listy-kind of you're just not
12 purchasing well areas, and would like to move it to allow
13 them to do some of these things at least on the face of it
14 seem pretty clear.

15 But I would like to hear and I'm not sure I've
16 heard what the actual alternative is, as to where we would
17 limit that flexibility and where we think the appropriate
18 authority of say CMS to do what they think the latest buzz
19 is for whatever reason.

20 The first MedPAC meeting I went to was the
21 retreat. And one of the things that struck me is the vast
22 number of demonstration projects that were going on. And

1 they were going on in all the right areas. Many of them
2 didn't have results yet. But none of them had the sort of
3 oh, if we could only do this result...

4 I guess when you're unsure, you should just say
5 thank you, that's all I have to say.

6 MR. HACKBARTH: A couple of thoughts here. I
7 think Bill presented well the concern that many members
8 have, the exercise of this overwhelming power. They should
9 be very concerned about that.

10 However, as our other bookend pointed out, there
11 are real bad consequences of the path that we're on. And
12 so, if we lean too far towards the direction of protecting
13 against the exercise of great and arbitrary power, we are
14 going to buy ourselves some huge problems. The world is not
15 fair in that regard.

16 And so how do we find a path between these two
17 things? One point that occurs to me -- it hasn't been
18 mentioned by other people -- is that to the extent that you
19 limit CMS's ability to act aggressively to pursue higher
20 value, it becomes even more important that you have a
21 Medicare Advantage program that is a focused on efficient
22 delivery of care, which is my big gripe about the current

1 program, is it rewards models that don't enhance efficiency
2 and value.

3 So if we're going to limit Medicare, we really
4 need to create options where people can aggressively pursue
5 higher value and are rewarded for doing so. And we are
6 failing on both ends of that right now. It's a real
7 strategic problem.

8 A second thought is that, as Nancy's presentation
9 pointed out, there is just real confusion in some areas
10 around the legislative authority and there are sort of
11 conflicting signals around CMS going after lowest price for
12 some particular services. And so one path that we can do is
13 just some clarification, make some recommendations for
14 clarifying that authority where it's particularly muddled.

15 A third idea is one that has come up in other
16 contexts, which is broader authority, greater resource
17 commitment to testing new ideas. We've got, as we've noted
18 in previous discussions, we've got a demonstration model
19 that really isn't working for the program. And if we were
20 to invest more heavily and approach that task differently we
21 might be able to generate new ideas that could then go
22 through the legislative mill and be embraced based on data

1 as opposed to the alternative of saying let's just give CMS
2 broad authority to do things that it wants to do. But
3 again, we're not doing that either.

4 So we've got a model right now that sort of fails
5 on multiple fronts. We constrain CMS. We don't have an
6 effective model for developing new approaches and testing
7 them. And we've got a Medicare Advantage program that
8 doesn't provide appropriate incentives for value and
9 efficiency. It's just sort of -- we're struggling on all
10 three fronts.

11 So I'll stop there. Reactions to that, or
12 anything else?

13 DR. SCANLON: I just wanted to make clear that
14 where my bookend was was not a no action. It's the issue of
15 doing things better with some of the authorities we have
16 now. If there are issues of real confusion about particular
17 statutory provisions, raised those, ask the Congress to
18 address those.

19 But to give you -- to use the competitive bidding
20 for DME as an example here, we've talked about that at other
21 meetings. I said that when I was at GAO we were looking at
22 that. We wrote a report that was very positive about that.

1 But the concern in that report and the concern I still have
2 today, is that when CMS did that demo they invested more
3 resources than they would ever be able to, doing this on a
4 national basis or even in a rollout in terms of major
5 metropolitan areas.

6 The question is how much of the positive results
7 that came out of the demo a function of the level of
8 attention that CMS was able to give to that? And how much
9 of that is going to be replicable when you have to cut back
10 that oversight by a dramatic amount.

11 I have no idea about the merits or lack of merits
12 in terms of the objections to the current competitive
13 bidding demonstration or rollout. The issue now is CMS is
14 going to come back and do this again presumably within 18
15 months and their ability at that point to be able to present
16 something that is defensible -- and it's exactly in the
17 terms that you said, Glenn -- which is the issue of
18 beneficiaries are not going to be harmed. That's the core
19 that is constantly being struck in terms of making an
20 argument to the Congress about why something shouldn't be
21 changed. It's because there's going to be a negative impact
22 on beneficiaries.

1 It's the ability to say no, there's not there.
2 Here is both the reasonable case and/or the evidence to show
3 that that's not going to occur is, I think, the power you
4 need to move things forward.

5 Nobody that is trying to protect the beneficiaries
6 is going to be comfortable when there is lot of doubt shed
7 upon an action in terms of what it's going to mean for
8 beneficiaries.

9 DR. CROSSON: Glenn, I just want to lend support
10 to what you said. I think you've pretty much nailed this
11 difficult question for us.

12 I had two takeaways from it in terms of things
13 that we might consider. One I think we've talked about
14 before, and that is the interpretation of the mandate we
15 received to examine the way Medicare Advantage plans are
16 paid. As I've said before, I would urge us when the time is
17 right to interpret that rather broadly and to use it as a
18 tool to perhaps re-sculpt the Medicare Advantage program
19 along the lines that you described.

20 The second one, in terms of what I thought I heard
21 you say, was that perhaps there are some ideas that we could
22 develop -- I'm not sure what the right term is -- perhaps

1 urge a safe harbor of some sort for Medicare demonstration
2 projects beyond what has been provided. That would be up to
3 Congress to model, but urge some sort of safe harbor so that
4 some more aggressive, if that's the right term, more
5 aggressive or more value-based techniques could be employed
6 long enough to determine whether, in fact, they work and
7 can, in fact, protect and preserve beneficiaries. That's
8 probably some work that we could consider looking at.

9 DR. KANE: I agree, I thought you summarized it
10 well. I think, though, the beneficiary harm argument is
11 incredibly important but it can't be done in a vacuum. If
12 you want to talk about potential beneficiary harm of lack of
13 access to a DME supplier, that's one kind of harm. But the
14 other kind of harm is the Part B/Part D cost share premium
15 and potential insolvency of the trust fund that really is a
16 much bigger, to me, harm that we really have to make more
17 paramount than the possibility of some minor harms.

18 Balancing that out is obviously -- that's actually
19 Congress' job, I think. I think the more we can clarify
20 that in our recommendations and in the kinds of policy
21 recommendations that come before us, say there may be some
22 harm here and here's the things we're worried about. But up

1 against the savings that might make this program more
2 solvent and might make it were financially viable and more
3 affordable, I think it's a risk worth taking. I think we
4 just need to keep making that trade-off very evident.

5 DR. CHERNEW: I guess the question I have is is
6 there a discrete number of particular issues like DME and
7 maybe a few others that one could maybe then say the program
8 isn't flexible enough because we need to relax the following
9 three things, and make very specific recommendations about
10 things? Or is it more of a blanket, the program needs to be
11 more flexible going forward as new things arise?

12 As long as it is the former, where we could come
13 up with a handful of things that we would like to see
14 reformed, my gut would be let's look at each of those
15 particular things and then come to some recommendation about
16 whether the program should have the authorization to do X, Y
17 or Z, as opposed to a broader redesign of the program
18 transferring authority.

19 MR. HACKBARTH: You know, I think that focusing on
20 specific things is probably much more likely to be effective
21 -- effective here defined as Congress doing something about
22 it. As opposed to broad grants of authority, let's work on

1 these particular problems, like these pricing issues where I
2 think we might be able to make a compelling case that the
3 current situation is muddled and not particularly effective
4 for the program.

5 Any other comments before we close this one for
6 now? Good job, Nancy, in framing the issue for us. Thank
7 you.

8 We will now have our public comment period. As
9 always, the ground rules are these: please limit your
10 comment to no more than a couple of minutes and begin by
11 identifying yourself and your organization.

12 MS. SCHLOSBERG: Thank you. My name is Claudia
13 Schlosberg. I direct policy and advocacy for the American
14 Society of Consultant Pharmacists.

15 Our pharmacists are consultant pharmacists who
16 work in nursing homes, providing medication reviews.
17 They've been doing it for years. Many of our members are
18 also in the community, providing medication therapy
19 management services to seniors. They are not dispensing
20 pharmacists. They provide medication therapy management.

21 There was so much discussion about important
22 issues this morning, I could probably stand up here for two

1 hours and comment. But let me try to limit it to the
2 discussion on MTM.

3 Medication related problems, particularly in the
4 elderly, are significant. Some estimate that they're
5 costing us \$200 billion a year. They are everything from
6 people not being on the right meds to being on inappropriate
7 meds to not being able to take their meds appropriately.

8 As the government is spending more and more on
9 Medicare Part D, it is quite I think disturbing that three
10 years into the program we really can't say anything about
11 what's going on in MTM. We have the data about the
12 variability but we really know nothing about the outcomes.

13 I heard a little bit in the discussion that since
14 we don't want enough, maybe we need to just walk away from
15 this and we can't go further. I'd like to suggest the
16 opposite. I think we have to do something and we have to
17 look at medication therapy management very, very seriously
18 because the problem is only going to get worse and more
19 expensive, particularly as the baby boom generation ages.

20 When we don't have data -- and I'm not a
21 researcher. But when the data is lacking, the one thing
22 that MedPAC has done and one thing that Congress has done in

1 the past is to mandate that CMS, through demonstrations or
2 through pilots, create programs that could then be studied
3 and analyzed. We know that medication therapy management
4 services work. We know -- and I want to certainly support
5 the comments of commissioners who said we have to have a
6 collaborative process between pharmacists and physicians.
7 Right now pharmacists who dispense see safety edits pop up
8 on their screen all the time. They're not paid to resolve
9 those safety edits, they're paid to dispense medications.

10 We have pharmacists who make recommendations to
11 physicians, and I don't know what the percentage is, but it
12 does happen that physicians don't accept those
13 recommendations.

14 We need to promote the collaborative practice
15 between the pharmacist and the physician. We have to come
16 up with ways to align payment for clinical pharmacy services
17 that are not tied to product dispensing. And we need to
18 make sure that we're supporting those collaborations.

19 If we have to do it outside of D or if we have to
20 create a pilot that looks at paying pharmacists under Part B
21 and being part of a medical home, that's a recommendation
22 that needs to be made. Let's do the comparative

1 effectiveness review. Let's look at Part D services versus
2 other services that we can come up with models that make
3 more sense.

4 But I think we cannot ignore this problem. We
5 know that there are ways to intervene. Our health care
6 system, unfortunately, doesn't support that at this point in
7 time.

8 So thank you.

9 MR. HACKBARTH: Okay, we will reconvene at 1:30.

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

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1 both benefits and risks. There have been efforts by the
2 private sector and the government to regulate these
3 relationships, including laws in several states that require
4 drug manufacturers to report their payments to physicians.

5 We've been considering whether the Federal
6 Government should collect national data on physician-
7 industry relationships, and here we've listed some of the
8 potential benefits of public reporting: First, it could
9 discourage inappropriate arrangements; the media and
10 researchers could use the data to shed light on physician-
11 industry relationships; and payers and plans could use the
12 data to examine whether physicians' practice patterns are
13 influenced by their financial arrangements with the
14 industry.

15 A national database would also have costs and
16 limitations. There would be compliance costs for
17 manufacturers and administrative costs for the government.
18 There is also the concern that public reporting might
19 discourage beneficial arrangements between physicians and
20 industry. And the information may be of limited use to
21 patients because patients usually lack medical expertise and
22 tend to trust their physicians' judgment.

1 Notwithstanding these concerns, there appears to
2 be a growing consensus that the benefits of a national
3 reporting system would outweigh the disadvantages. As I
4 walk through the revised draft recommendations in the next
5 few slides, I will highlight the changes that were made
6 based on the last meeting.

7 Here we have draft recommendation one: the
8 Congress would require all manufacturers and distributors of
9 drugs, biologicals, medical devices, and medical supplies,
10 and their subsidiaries, to report to the Secretary their
11 financial relationships with physicians, physician groups,
12 and other prescribers; pharmacies and pharmacists; health
13 plans, pharmacy benefit managers, and their employees;
14 hospitals and medical schools; organizations that sponsor
15 continuing medical education; patient organizations; and
16 professional organizations.

17 The first change we made to this recommendation
18 was to add distributors in the first sentence to capture
19 payments that might be made by distributors of drugs and
20 devices. We also added several groups to the list of
21 recipients. We added physician groups, pharmacies and
22 pharmacists, and health plans, PBMs, and their employees.

1 Here are the implications for the first
2 recommendation. There would be administrative costs for the
3 government to implement and enforce the reporting law, and
4 we would be asking the Congress to provide sufficient
5 resources to the Secretary to do this. The Medicare
6 expenditure implications are indeterminate. Regarding the
7 beneficiary-provider impacts, although the information may
8 be of limited direct use to beneficiaries, they would
9 benefit indirectly if public reporting leads to more
10 appropriate use of drugs and devices. Hospitals, academic
11 medical centers, and health plans should benefit from a
12 source of information on physicians' financial interests.
13 Manufacturers will incur costs to comply with the reporting
14 law. However, if a uniform Federal law replaces multiple
15 state laws, this should reduce their overall compliance
16 costs. And physicians who receive large payments from
17 manufacturers may receive public scrutiny.

18 The specific design issues for the reporting
19 system are described in the text of your paper, and I will
20 review them in the next few slides. For the sake of
21 brevity, we have left them out of the recommendation itself.

22 Based on the comments at the last meeting, we

1 propose that manufacturers would have to report payments if
2 the total annual value of payments to a recipient exceeds
3 \$100, and this threshold would be adjusted annually for
4 inflation. Once this threshold is reached, all payments or
5 transfers of value to a recipient, regardless of the amount
6 would have to be disclosed. A relatively low aggregate
7 payment threshold would enable the Federal Government to
8 collect data on most payments.

9 In terms of the next issue, we propose that a
10 comprehensive list of relationships should be reported,
11 which are shown on the slide. We propose excluding
12 reporting of discounts and rebates because this information
13 is considered very proprietary, and public reporting of this
14 could make it difficult for purchasers to negotiate price
15 reductions.

16 We would also be excluding free samples from the
17 reporting system under recommendation one, but we do have a
18 separate recommendation on reporting of samples which we'll
19 get to later on.

20 We also propose that companies should report the
21 value, type, and date of each payment; the name, specialty,
22 Medicare billing number if applicable, and address of each

1 recipient; and if the payment is related to the marketing,
2 education, or research of a specific drug or device, the
3 name of that drug or device. The Medicare billing numbers
4 are important for linking the payment information to claims
5 data, but these numbers in our proposal would only be
6 available to researchers through a data use agreement with
7 the Secretary.

8 We also propose that companies would be allowed to
9 delay reporting of payments related to clinical trials until
10 the trial is registered on the NIH website. Companies would
11 be permitted to delay reporting of other payments related to
12 development of a new product until the product is approved
13 or cleared by the FDA, but no later than two years after the
14 payment is made. And this would ensure that payments
15 related to products that are never approved by the FDA are
16 eventually disclosed.

17 We propose that the Federal law should preempt
18 state laws that collect data on the same types of payments
19 and recipients, regardless of the state's dollar threshold
20 for reporting. For example, if a Federal law excluded
21 reporting of discounts and rebates, a state law could
22 require such reporting. We don't think that preemption is a

1 major issue because very few states have reporting laws, and
2 a uniform, comprehensive Federal law would probably
3 discourage additional states from passing their own laws.

4 Next, the Secretary should have the authority to
5 assess civil penalties on manufacturers that violate the
6 law. And, finally, as Nancy suggested last month, the
7 Secretary should monitor the impact of a reporting law on
8 potentially beneficial arrangements between the industry and
9 health care providers. This is to address the concern that
10 such arrangements may decline due to a public reporting law.

11 Here is draft recommendation two: The Congress
12 should direct the Secretary to post the information
13 submitted by manufacturers on a public website in a format
14 that is searchable by manufacturer; recipient's name,
15 location, and specialty, if applicable; type of payment;
16 related drug or device; and year. The goal is to maximize
17 the accessibility and usability of information in the
18 system. We have deleted the Medicare billing number from
19 this version of the recommendation because they would only
20 be available to researchers through a data use agreement.

21 And here we get to the spending and other
22 implications. There would be administrative costs for the

1 government to establish and maintain a public database. The
2 Medicare expenditure implications are indeterminate.
3 Although the information may be of limited direct use to
4 beneficiaries, they would benefit indirectly if public
5 reporting leads to more appropriate use of drugs and
6 devices. Hospitals, academic medical centers, and health
7 plans should benefit from access to information submitted by
8 manufacturers, and physicians who receive large payments
9 from manufacturers may receive public scrutiny.

10 Now we'll turn to the topic of free drug samples.
11 The industry provided free samples with a retail value of
12 over \$18 billion in 2005. Samples offer benefits to many
13 patients. They may allow patients to start treatment
14 sooner. Physicians can use them to test the effectiveness
15 of different drugs before the patient purchases the full
16 prescription. And they're a source of medical for those
17 without health insurance. On the other hand, samples may
18 lead to the use of more expensive drugs instead of cheaper
19 drugs that may be equally effective, and there is some
20 evidence that samples influence physicians' prescribing
21 decisions. Better data on samples would enable researchers
22 to conduct more detailed analyses of their impact on

1 prescribing behavior and overall drug spending.

2 Under the Prescription Drug Marketing Act of 1987,
3 manufacturers and distributors are required to keep
4 information on drug samples distributed to practitioners and
5 pharmacies of hospitals and other health care entities. If
6 the samples are sent by mail or distributed by detailers,
7 the companies must keep written requests from the
8 practitioners and receipts that acknowledge delivery. If
9 the samples are distributed by detailers, manufacturers must
10 also keep an inventory of all the samples that are
11 distributed. This inventory must include the name and
12 address of the recipient, the drug's name, dosage, and
13 quantity, and the date of delivery. If the samples are
14 delivered by mail, there is no similar requirement for an
15 inventory.

16 These records only contain the name of the
17 practitioner who signed for the delivery of the samples
18 rather than the names of all the physicians in the practice
19 who may dispense samples to patients. Although the FDA and
20 other government agencies have the right to request these
21 inventories to ensure that companies are following the law,
22 there is no requirement to report this information to the

1 government on a regular basis.

2 So we asked whether the information on samples
3 could be useful for researchers and speaking here more
4 broadly than the inventories of samples distributed by
5 detailers, but also about the written requests that are
6 required of samples distributed by mail or by detailers.
7 Linking data on the samples to claims data on prescriptions
8 could facilitate research on the impact of samples on
9 prescribing behavior and drug spending. But in order to
10 link data on samples to claims data, the government would
11 need to obtain the names and Medicare billing numbers of all
12 physicians in the practice, not just the practitioner or
13 physician who signed for the samples.

14 Even with this information, it would still be
15 difficult to examine the use of samples by individual
16 physicians because we would not know how many samples each
17 physician used. But the information could be used to
18 analyze the use of samples at the practice level and the
19 geographic level. In addition, collecting information on
20 physician specialty would allow for analyses by specialty.

21 Based on your discussion at the last meeting, we
22 propose the following for draft recommendation three: The

1 Congress should require manufacturers and distributors of
2 drugs to report to the Secretary the following information
3 about drug samples: each recipient's name and business
4 address; if the recipient is a physician practice, the
5 names, specialties, and Medicare billing numbers of each
6 physician in the practice; the name, dosage, and number of
7 units of each sample; and the date of distribution. The
8 Secretary should make this information available to
9 researchers through data use agreements.

10 The reason we're proposing a separate
11 recommendation related to samples rather than including them
12 in recommendation one is: because we would not be requiring
13 manufacturers to report the value of the samples because
14 free samples are provided to a more limited set of
15 recipients than the types of payments in recommendation one;
16 and, finally, because the data on samples would not be on a
17 public website.

18 This recommendation would not apply to free drugs
19 provided by manufacturers under prescription assistance
20 programs to low-income, uninsured patients because the drugs
21 provided under these programs are not considered samples.

22 Here are the implications for recommendation

1 three: There would be administrative costs for the
2 government to establish and maintain a database on free
3 samples. The Medicare expenditure implications are
4 indeterminate. The beneficiaries may indirectly benefit
5 from research evaluating the impact of free samples on
6 physicians' prescribing behavior and overall drug spending.
7 And manufacturers' administrative costs should be minimal
8 because they currently collect much of this information.

9 Now we'll turn to Jeff for the final two
10 recommendations.

11 DR. STENSLAND: Now we're going to shift gears
12 away from talking about drug and device manufacturers to
13 talking about physicians' relationships with other health
14 care entities that bill Medicare.

15 Currently, CMS requires that hospitals and ASCs
16 disclose physician ownership to patients. However, payers
17 and researchers do not have access to this information.
18 These payers and researchers need ownership information in
19 order to evaluate the effects of ownership on referrals,
20 quality, and cost.

21 To make ownership information public, we have the
22 following draft recommendation: The Congress should require

1 all hospitals and other entities that bill Medicare for
2 services to annually report the ownership shares of each
3 physician who directly or indirectly owns an interest in the
4 entity, excluding publicly traded corporations. The
5 Secretary should post this information on a searchable
6 public website.

7 The difference here from last month's draft
8 recommendation is that we are now requiring disclosure by
9 all providers who bill Medicare, not just hospitals and
10 ASCs, and this reflects the discussion you had last month.

11 Because CMS is already collecting most of this
12 information and entering it into its PECOS database, there
13 would be minimal additional costs for CMS to make the data
14 comprehensive and public. While we expect that
15 beneficiaries will rarely change their care decisions to
16 provider disclosures, beneficiaries may indirectly benefit
17 from research on the relationship between physician
18 investment and referrals and outcomes.

19 The Commission has expressed some interest in
20 hospitals' disclosing more than ownership. Disclosures
21 could include physician-hospital relationships, such as
22 equipment leases and medical directorships. The difficulty

1 with broadening the disclosure mandate is the need to
2 balance the desire for transparency with the desire to limit
3 the administrative burden on hospitals, and the question is:
4 What exactly should we require hospitals to disclose?

5 CMS currently plans to collect data on physician-
6 hospital relationships from its own survey of up to 500
7 hospitals. Now, this is a follow-up to an earlier survey
8 they conducted in 2006 as part of the CMS-mandated study of
9 specialty hospitals. In 2006, CMS surveyed hospitals
10 regarding physician ownership, management contracts, and
11 other issues as part of their mandated report. However, a
12 majority of hospitals declined to respond to the 2006
13 voluntary survey. Afterwards, CMS decided to have a follow-
14 up survey, this DFRR, that would report on these types of
15 relationships and be mandatory. The current plan is to have
16 all 290 hospitals that declined to answer the 2006 survey
17 respond to the DFRR and add up to 210 additional hospitals
18 to provide for an adequate sample for statistical inference.

19 Now, it should be noted that roughly 65 of the
20 hospitals that did not return the original survey were
21 specialty hospitals, the subject of the initial
22 investigation. The size of the survey sample may be reduced

1 down from 500 if CMS concludes that it can make accurate
2 inferences with a sample of less than that number of
3 hospitals.

4 Now, the DFRR would be of interest to us because
5 it could inform future decisionmaking on what physician-
6 hospital relationships should be reported by all hospitals.
7 The idea is that if we wait to analyze information from the
8 DFRR, we will be able to do a better job of balancing the
9 desire for disclosure from all hospitals with the desire to
10 keep administrative burden on the hospitals low.

11 Thus, we propose recommending that the Secretary
12 submit a report to Congress on the prevalence of the
13 different types of financial relationships. The draft
14 recommendation reads as follows: The Congress should
15 require the Secretary to submit a report based on the
16 disclosure of financial relationships report of all the
17 types and prevalence of financial relationships between
18 hospitals and physicians. The implications are little for
19 CMS. Because CMS plans to collect the data, the only other
20 cost for the agency would be the cost of the mandated
21 report.

22 So those are the draft recommendations, and now we

1 look forward to your discussion.

2 MR. HACKBARTH: Thank you.

3 Okay, first round, any clarifying questions?

4 DR. CASTELLANOS: I just wanted to clarify on
5 draft recommendation five. I think it's extremely important
6 to have transparency, and the transparency with the
7 physician ownership of the hospital, ASC, or other providers
8 is very evident. However, hospitals also employ physicians,
9 own physicians, and also have arrangements with other
10 facilities. Now, one is going to be publicly reported. The
11 other under the DFRR is going to be reported and then sent
12 to Congress by the Secretary. I want to make sure that the
13 hospital relationships between employment and ownership of
14 hospitals is definitely reported and that data will be
15 available.

16 DR. STENSLAND: I don't think that CMS is
17 currently planning to collect employment information. I
18 think they're trying to balance the administrative burden
19 with the desire to have as much information as possible. We
20 can follow up with them on that. But even if CMS doesn't do
21 it, there's nothing to say that in the future, when we re-
22 evaluate what information should we require from all

1 hospitals, you collectively couldn't decide to have that as
2 one of the things that would mandatorily be reported.

3 DR. CASTELLANOS: That means we will have an
4 opportunity to review this again in a year or so?

5 DR. STENSLAND: I think that was the original plan
6 -- that first we would see what CMS comes up with, and then
7 have our own deliberations on what types of things we think
8 should be reported by all hospitals. First, let's look at
9 the sample of hospitals and see what they're doing and
10 what's prevalent, and then come up with this other decision
11 on what should be reported by everybody.

12 MR. HACKBARTH: So, Ron, we can address this in
13 the text and say, you know, this is an area of interest and
14 something that we may well go back to, and just leave it out
15 of the boldface.

16 DR. CASTELLANOS: Fine. Thank you.

17 DR. KANE: I guess one question was the timing of
18 the report. When is it going to be done? And the other
19 question is: Are we going to only see the report, or would
20 we also be able to take a look at the questions and the data
21 responses? Because it might be that there are maybe -- we
22 may learn that there are better ways to ask some questions

1 from that. So I just wondered how much detail do we get in
2 our report. Is it just what CMS summarizes? Or can we
3 actually see the questions and the responses? And how long
4 will it take?

5 DR. STENSLAND: We have talked to CMS, and they've
6 expressed some willingness to talk to us about maybe how the
7 data would be packaged and presented and how it could be
8 most useful to us. And so we plan to go through with that.
9 I'm not sure where they'll stand on the degree of access we
10 will have to the individual documents, the individual
11 contracts. I'm not even sure I want to see all those
12 individual contracts. But we'll try to work with CMS to
13 have enough access to the information and have it packaged
14 in a way that's useful.

15 The time frame is uncertain in that CMS is still
16 finalizing internally the document. They sent out a few
17 earlier drafts, but they still have to get it finalized
18 internally, and then they have to have OMB approval, which
19 they don't have, and then it would have to go in the field
20 and then it would be analyzed. They have a contractor lined
21 up to analyze the data, but I think you're looking at at
22 least a year, I think, before that information would come

1 back.

2 DR. STUART: I have a question about the language
3 in draft recommendation four. The first sentence says,
4 "Congress should require all hospitals" -- and this is the
5 key piece -- "other entities that bill Medicare for
6 services." Now, the way I would read that in a technical
7 sense, that would only apply to services that are providing
8 under Part A and Part B and would exclude services provided
9 under Part C and D, since those are not billed directly to
10 Medicare. Was that the intent of this?

11 DR. STENSLAND: Yes, I think there was some
12 concern. Right now, when anybody wants to get a billing
13 number from CMS, they've got to fill out an application for
14 a billing number, and as part of that application, they have
15 to say who your officers and directors are and who are all
16 the owners. And so we were going to piggyback off that
17 information, and they could put that into the database, and
18 then it could become public.

19 Right now, if somebody supplies something to a
20 Part C or a Part D plan, they wouldn't have that direct
21 relationship with CMS, and I think it would be much more
22 difficult to go out and find out who they are and get that

1 information from them.

2 DR. STUART: So this was excluded not because it
3 might not be important, but because of the difficulty of
4 actually getting the information?

5 DR. STENSLAND: That was one part. I don't know
6 if we -- the initial examples of the kind of things that we
7 were most concerned about weren't so much directly C or D
8 either.

9 DR. STUART: I'm not challenging this. This is a
10 clarification. I'm trying to understand why this was worded
11 the way that it was.

12 DR. DEAN: I was just wondering if there's a
13 conflict in recommendation one. You said they should report
14 all relationships with health plans and PBMs, but then on
15 page 7, the rest of it said should not report discounts,
16 rebates, et cetera. I would suspect that most of the
17 financial relationships that exist with PBMs are discounts
18 and rebates. So is there a problem with that wording?

19 MR. WINTER: You're right; we intended to exclude
20 -- or the recommendation was to only collect information on
21 other kinds of payments from plans -- from drug companies to
22 plans and PBMs, and there may not be any. So we may have

1 learned that there aren't any, or there may be grants or
2 other kinds of arrangements that we don't know about. And
3 so part of this is we don't know what's really going on
4 there -- at least at the staff level. Maybe Commissioners
5 have insight into that.

6 DR. DEAN: So the discounts and rebates would be
7 the dominant guide here? I mean, they would not report
8 those.

9 MR. WINTER: We would not report that information.

10 DR. DEAN: In a lot of ways, I think that's
11 unfortunate because that's, I think, very important
12 information, although I understand the problems with, the
13 reasons why, you know, you don't want -- or why they don't
14 want to report it. But we know that it affects a lot of
15 decisions about drug selection, and some pretty important
16 decisions get made on that basis. I wish we had access to
17 that data, but maybe we won't. I don't know.

18 DR. STUART: I think it's important to note that
19 actually PBMs do get money on a regular basis from
20 manufacturers for research contracts, and so on the basis of
21 medical school, wanting to understand how a faculty are
22 being paid by drug companies, the same thing would apply to

1 PBMs.

2 MR. GEORGE MILLER: This is probably a follow-up
3 for Ron, but under the reporting under the DFRR, are you
4 also talking about a relationship with physicians who may be
5 employed by a system but assigned to hospitals? Or have you
6 thought that process through?

7 DR. STENSLAND: I'm not sure how that would work
8 out in the DFRR. I haven't seen the detailed instructions
9 on that, but I'm guessing they would say even if the
10 physician is an employee of the system working at the
11 hospital as a director --

12 MR. GEORGE MILLER: But as I understand this, this
13 will go directly to the hospitals, not necessarily the
14 systems. But there are some systems that employ physicians
15 that may be assigned to a hospital and not directly employed
16 by that hospital.

17 DR. STENSLAND: We could bring that up with CMS
18 and ask them how the instructions will deal with that
19 situation.

20 MR. HACKBARTH: Round two, questions, comments?
21 Why don't we just go down the row here, so I have Peter,
22 Tom, Mitra.

1 MR. BUTLER: Just a clarification here, Glenn.
2 Are we going to do one recommendation at a time, or you're
3 looking for comments on the whole thing?

4 MR. HACKBARTH: Good thought.

5 MR. BUTLER: I think it might be better if we --
6 well, you can --

7 MR. HACKBARTH: Yes, why don't we do one at a
8 time, just to focus the discussion. Thanks, Peter.

9 MR. BUTLER: Because I think some of them are
10 pretty difficult.

11 MR. HACKBARTH: Let's start with recommendation
12 one and do --

13 MR. BUTLER: I'll still go first if you want.

14 MR. HACKBARTH: No, you forfeited your place.
15 Okay.

16 MR. BUTLER: I just have one brief comment on --
17 really, it's a predecessor to one. I think this whole paper
18 is very well written, and I think it captures a lot what we
19 want. This sounds like nitpicking, but in the very first
20 paragraph, I think the tone is good and the overall writing
21 of this. But in the very first paragraph, it starts by
22 saying, "Drug and device manufacturers have extensive

1 relationships with physicians, academic medical centers,
2 professional organizations, and health care entities.
3 Although these financial ties often lead to advances in
4 medical research, technology, and patient care, they may
5 also create conflicts among the" -- "between the commercial
6 interests of manufacturers and the physician's obligation to
7 do what is best for their patients."

8 I really think it would be great if the second
9 sentence could say, "These relationships have been critical
10 to the advancement of medical technology" -- recognize their
11 value and then say, "However, they often lead to..." I
12 think it just sets the tone right in the beginning.
13 Otherwise, the whole thing is cast in a negative light, and
14 I think there are various productive relationships that make
15 us world leaders.

16 So a very subtle but suggested recommendation to
17 the wording.

18 MR. HACKBARTH: While we are doing one, why don't
19 we also do two, since one and two are really related.

20 DR. BORMAN: I would just echo first what Peter
21 said about -- I think what he suggests is very important, to
22 put some of the positive here and not have this be

1 potentially in a totally negative light, because it clearly
2 is an emotionally charged subject. Just the word
3 "disclosure" has such meaning in our society anymore, we
4 need to be a little bit careful about that, particularly
5 when we want to engage many of these people as stakeholders
6 in the big issues that lie before us relative to health care
7 delivery reform.

8 Just in terms of the comment and question, I'd
9 like to particularly support the part about the Secretary
10 having a review mechanism to look and see if beneficial
11 arrangements are, in fact, suffering and whether or not we
12 should give some examples in the text of what one or two of
13 those might be. And I'm sure Nancy or I or some other
14 people could work with staff on that.

15 We see so much in the way of unintended
16 consequences, and there certainly are lots of these
17 relationships that play out in the continuing medical
18 education world. And I think, you know, some of what has
19 made us a leader in a lot of fields does relate to the
20 ability to have that kind of increasingly expensive
21 education be financially underwritten to some degree. So I
22 would like to just raise the question of whether we have the

1 room, the capability, and interest in maybe offering --
2 fleshing out that piece of it in the text, or whether staff
3 could just do that, I would advocate for that.

4 DR. DEAN: Just a quick comment on the continuing
5 education issue. At least in a large part of the continuing
6 medical education that currently exists, this already is in
7 place. At least in family medicine, at the approved
8 conferences the speakers are required to divulge any
9 relationships they have with the industry, and they're also
10 required to divulge if they're going to talk about any
11 unapproved or experimental uses for any of the products
12 they're going to talk about. So like I say, some of this is
13 already in place.

14 MS. BEHROOZI: So our methodology here is to say
15 "What I like about this but," right? So what I like about
16 this -- and, actually, this applies to all four --

17 MR. HACKBARTH: [off mic] You can drop the "but."

18 MS. BEHROOZI: Stop stealing my thunder. This
19 applies to all four recommendations. What I like about this
20 is that you have done an amazing job of being really
21 comprehensive in terms of incorporating all the commentary
22 by all the Commissioners, I think, and researching

1 thoroughly what's going on in the field. It's so timely, as
2 Tom says. A lot of things are going on in a lot of
3 different places, and I feel like you have really
4 incorporated everything and made an excellent framework to
5 bring together all of those efforts and offer real
6 leadership and guidance, and I am really impressed. And
7 there is no "but," so there.

8 [Laughter.]

9 DR. KANE: I was going to go on to three and five,
10 I think. I was going to pass.

11 MR. HACKBARTH: We're still focused on one and
12 two.

13 DR. KANE: Except to say I support one and two.

14 MR. HACKBARTH: All right. Thank you.

15 One and two, Mike?

16 DR. CHERNEW: Very quickly, I'm also supportive of
17 the recommendations and think it's very well done. The only
18 question I was going to have is: In general, in much of the
19 things that we've seen here, you've gotten a lot of feedback
20 from people that are not around the table here but outside,
21 and you've spoken with a lot of -- I'd be interested I
22 knowing if you've received a lot of general push back about

1 aspects of the administrative costs and reporting
2 requirements from folks that are not around the table.

3 MR. WINTER: In terms of the administrative costs,
4 what I have read and heard from stakeholders, particularly
5 manufacturers, is that the big issue is preemption; that if
6 you're going to require us to report this to the Federal
7 Government, then don't force us -- or make sure we don't
8 have to also report all this information to 51 or 50
9 different states. Even though there are only five right
10 now, plus D.C., other states have been considering this kind
11 of legislation. And so their concern is if you can have
12 just one Federal uniform requirement system, that might make
13 it easier. Or certainly if you're going to do that, don't
14 make it harder on us by also making us comply with all the
15 different state laws.

16 DR. CHERNEW: Let me respond to that. So you
17 perceive this as sort of a middle ground and that you
18 preempt -- you force states that are less stringent in this
19 to come up to this, but you don't preempt states that are -

20 MR. WINTER: No. What we're saying is we're not -
21 - states would not be able to have systems that are similar
22 to the Federal system. So it's not that states would have

1 systems that are equivalent to it. It's that they wouldn't
2 be collecting this information because the Federal
3 Government is already collecting it. And if they wanted to
4 go and collect additional kinds of relationships, then they
5 could do that.

6 DR. CHERNEW: If they had a \$50 threshold, that
7 would be a different threshold.

8 MR. WINTER: Our proposal is to preempt that law
9 as well, even if they have a lower threshold, because we've
10 already set a low threshold for aggregate payments, and
11 there's no threshold for each individual payment. If it's
12 \$1 -- once you get past \$100, if it's \$1, you report it.

13 DR. CHERNEW: So this effectively -- I'm sorry. I
14 don't understand. So this effectively does preempt -

15 DR. MARK MILLER: Yes.

16 DR. CHERNEW: Okay.

17 DR. STENSLAND: It wouldn't preempt if there was
18 different types of information they wanted to collect. Like
19 if Massachusetts wanted to know about relationships with
20 health economists and drug companies, they could do that.

21 MR. WINTER: And states that collect information
22 on discounts and rebates would be able to continue doing so,

1 and there are two state laws that do that.

2 DR. CROSSON: I'd just like to say I support the
3 first two recommendations. I think it's about time. I've,
4 you know, been distressed over some 20 or so years, as an
5 infectious disease physician, by the apparent influence that
6 some -- not all -- pharmaceutical companies have not just on
7 individual prescribing practices but on the pattern of use
8 by whole hospitals in terms of new antibiotics, for example;
9 but even more so, the influence over the research base, the
10 practical research base that physicians and other clinicians
11 use in determining what is appropriate treatment. This is
12 not a solution for all of that, and I don't in any way
13 discount what Peter had to say. I think that, yes, I mean,
14 to a large degree, the collaboration between pharma and the
15 industry in this country has produced top-quality health
16 care for Americans. But I think there is a dark side to
17 this, which I experienced early on as a clinician, that I
18 think is unfair, and I think it differentiates among
19 physicians, between those who are willing to accept this
20 sort of gratuity and those who aren't. And I think it's
21 time that it began to cease, and this sort of disclosure is
22 a beginning of that sort of work.

1 MR. HACKBARTH: Any more on one and two?

2 DR. CASTELLANOS: I'm just wondering if there's
3 going to be any provision to be able for these entities to
4 review, correct, or explain any of these decisions before it
5 becomes public.

6 MR. WINTER: What we talked about in the text is
7 that if a recipient -- recipients would have the right to
8 challenge the accuracy of information that's been reported
9 by a manufacturer, and manufacturers would have to
10 investigate and correct any errors in a timely way.

11 DR. CASTELLANOS: Thank you.

12 MR. HACKBARTH: Let's move to recommendation
13 three.

14 DR. KANE: Just a little background, we debated
15 earlier whether this should be a public domain or a
16 researcher-only database, and I think we've come to this
17 consensus that probably it makes more sense, at least for
18 now, to have it only available to researchers through data
19 use agreements. But part of my concern in accepting that as
20 a recommendation is that the definition of researchers not
21 be overly restrictive, that there be a timeliness
22 expectation in terms of both making the agreements, you

1 know, signing these agreements and delivering the data, and
2 that the definition of researcher would include those who
3 want to use the data for practical purposes such as counter-
4 detailing, going to beneficiaries using the physicians and
5 actually trying to deal with, you know, what's going on
6 based on their analysis of the data.

7 So I would like to be sure that we have, if not in
8 the recommendation then in the supporting text, a concern
9 that the data use agreements not be overly restrictive and
10 that they foster the use of this data by commercial
11 entities, plans, and others who want to use this not just to
12 publish something but to actually intervene in the way drug
13 samples are being used.

14 MR. BERTKO: Now I only need to second Nancy's
15 comments. So if that would go into the text and explicitly
16 say that, I'm happy.

17 DR. STUART: I think you could just remove the "to
18 researchers" and then put it in the text.

19 DR. KANE: Although I think you'd still need to
20 modify what a data use agreement is, because that could be
21 another way of restricting access.

22 DR. MARK MILLER: That's what I heard Bruce

1 saying, is to take the actor out of the sample -- sorry. I
2 had a sample earlier today. Take the actor out of the
3 recommendation and in the text make a statement that we
4 expect this is broad availability if people can sign data
5 use agreements and talk about the purposes.

6 DR. STUART: And I agree with John that we want to
7 also have language in there that indicates that the data use
8 agreements are not going to be difficult to get through.

9 MR. HACKBARTH: Any objection to deletion, Bruce's
10 proposal to delete "researchers" from that last sentence?

11 [No response.]

12 MR. HACKBARTH: Okay.

13 DR. DEAN: I'm a little bothered by this one. I
14 totally agree that the distribution of samples affects
15 prescribing behavior and that that is a concern, and I
16 certainly share that concern. I am just uneasy that we're
17 going to be able to get the kind of data through this
18 mechanism that we need or that it's likely to affect any of
19 the kind of behavior changes that we're interested in, I
20 guess especially the statement that if the recipient is a
21 physician practice, the named specialties and Medicare
22 billing numbers of each physician in the practice need to be

1 collected. Well, the larger the practice is, the more
2 difficult it's going to be to get all that information; and,
3 secondly, the less valuable it is because within that group
4 you're going to have huge variations in terms of the
5 behavior of individual physicians. And I think I'm afraid
6 that it's just going to be a blend that is going to be less
7 and less meaningful. Even in a small practice, I can tell
8 you that the very small practice that I'm in, there are big
9 differences in the way that these samples get used, even
10 though they will be attributed to whoever happens to be
11 there at the time when the representative comes through.

12 So I'm just concerns that, yes, this data is
13 potentially important, but I think it's going to be very
14 difficult to interpret.

15 MR. HACKBARTH: So do you have a proposal for
16 modification?

17 DR. DEAN: I just think this whole route of
18 transparency is not the way to go, but I don't really have a
19 good suggestion, no. And I'm not in any way against
20 transparency in general. It's just I'm not sure for this
21 particular issue that it gets at the concern.

22 DR. CHERNEW: I think this might be related. I'm

1 not sure. I am concerned/curious about the feasibility of,
2 I guess, the second bullet point, which is if the recipient
3 is a physician practice, the named specialties and Medicare
4 billing numbers of each physician in the practice would be
5 provided. And I'm concerned about that because for large
6 physician practices, with perhaps residents or other people
7 circling in and out and maybe changing over time,
8 administratively that is more complex to do. Maybe Peter
9 has some sense of how that might work at Rush. I don't
10 know. But it strikes me that that might be a challenge to
11 present, and it might be that, in fact, if you just
12 presented the name of the physician practice, that would be
13 sufficient anyway for doing the analysis.

14 DR. REISCHAUER: [off mic] In a single number.

15 DR. CHERNEW: In a single number. Now, you might
16 have to worry about how you would tie in different
17 physicians to that practice so I understand there's
18 complexities. But I can envision going to one office which
19 is part of a much broader practice and asking for the names
20 of all the people that worked there then, and that data is
21 not kept for the other practices at that one site, and they
22 have to go -- so it might be possible, so I wouldn't argue

1 but I would be -- it struck me in the settings where I was
2 familiar with that that might be complex information to get
3 and report for the people who are giving the samples.

4 MR. HACKBARTH: The effort was to get at one of
5 Tom's points in the earlier discussions. Physician A may
6 be, you know, standing there and signed a piece of paper,
7 and if you just have that physician having received these
8 samples, the implicit message is, well, this one physician
9 is using it all. So the effort was to say, well, there may
10 be multiple physicians, in fact, using these samples. You
11 know, you have raised a legitimate question about the
12 practicality of that. Do you have a proposal?

13 DR. CHERNEW: I don't know if my proposal is any
14 more practical. I envisioned a world in which you would
15 say, you know, John's medical practice or St. Good Health
16 Medical Group, and then all of the people who are in there
17 would be implicitly included. So you wouldn't say, you
18 know, Tom Dean. You would say -- I could look here and find
19 the name of the practices. But apart from that, you would
20 just say the practice name and have a number, instead of --
21 that just struck me as easier than having to make sure that
22 someone reported all the names of all the people who worked

1 in the practice at the time.

2 MR. HACKBARTH: Any thoughts on that?

3 MR. WINTER: The way it's currently being
4 collected, the information, you have the name of the
5 practitioner is collected by the manufacturer, and not the
6 name of the practice. I'm not sure if practices are sort of
7 -- I guess they're formal legal names. So that would have
8 to be, I guess, a change to what's currently being
9 collected.

10 If it's being delivered to a pharmacy at a
11 hospital, then the name of that entity is collected, but not
12 if it's a physician practice. Then in that case it's just
13 the practitioner.

14 DR. CHERNEW: But if it was delivered to a
15 pharmacy at the hospital, would they have to report the
16 names of all the physicians and all of their specialties and
17 all their billing numbers at the hospital?

18 MR. WINTER: Not under this recommendation.
19 That's why we have the qualifier "if the recipient is a
20 physician practice."

21 DR. CHERNEW: But if you were Harvard Vanguard or
22 something...

1 DR. REISCHAUER: But what would you do with this
2 information? I mean, if you have a hundred physicians'
3 names and numbers and then a lot of stuff that's been given
4 to them, I mean, you can't relate it to individual people
5 anyway.

6 MR. HACKBARTH: But if you have just one physician
7 name and a hundred physicians using the samples, you've got
8 the same problem, which is part of Tom's general
9 reservation. So I don't think this makes it worse. It may
10 make it modestly better, although at some administrative
11 cost.

12 DR. REISCHAUER: It's more complex and equally
13 unusable. Right?

14 MR. BERTKO: I think it could still be useful in
15 the sense that if you're looking for counter-detailing, a
16 PBM or a PDP would know who the paid scripts were for, and
17 they could look backwards and see where the samples went and
18 generated the paid scripts and know that that's the time to
19 do the counter-detailing. So it would be kind of a
20 retrospective look at these things, and it would be useful.

21

22 DR. CASTELLANOS: It's a clarification. In a

1 large group, there's only one billing number for every
2 physician. Every physician has the same number, so there's
3 not going to be any clarification on the number, who
4 prescribed it.

5 DR. STUART: I had the same request or the same
6 issue. It seems to me that Medicare could do that, and
7 maybe the onus should be on Medicare, that the manufacturer
8 gives information about the individual who receives the
9 samples, and then we use the billing number and the
10 individual ID numbers to flesh that out in terms of the
11 organization.

12 MR. WINTER: I've actually done some work on
13 trying to aggregate physicians into practices, and there's
14 no sort of precise way of doing that. We've been using the
15 tax ID as a proxy for a practice, but we've heard that's not
16 always accurate. And so CMS could do that, use the tax ID
17 as a proxy, and group them together, but that may not always
18 -- may not be accurate in every case.

19 DR. CROSSON: We're still on number three?

20 MR. HACKBARTH: We are, right. But we need to
21 move on. Is it on this particular issue of the second
22 bullet that Mike raised?

1 DR. CROSSON: Yes, it is.

2 MR. HACKBARTH: Okay.

3 DR. CROSSON: Well, I just wanted to say I support
4 the recommendation. It's important to note that this is a
5 very different issue than we were dealing with in
6 recommendations one and two, which is a conflict of
7 interest. This is an issue of the impact of samples on the
8 cost of pharmaceuticals for beneficiaries and for the
9 Medicare program. This is a very early effort. This is an
10 effort to try to get some rough data about the relationship
11 between the use of samples and the cost by geography and
12 perhaps by practice.

13 I have to say, after listening to Tom and Mike, I
14 am a bit concerned about the second bullet point myself
15 because, just thinking about our own situation, it would be
16 difficult administratively and probably not provide any
17 useful data. So I wonder whether we either strike that and
18 in putting together the text we come up with a better
19 recommendation rather than doing it on the fly here, when
20 the recommendation would be probably that the practice be
21 identified in some way.

22 DR. MARK MILLER: Ariel, is that the first bullet?

1 Is that the practice?

2 MR. WINTER: The recipient's name and business
3 address?

4 DR. MARK MILLER: Yes. Would that be the practice
5 in the instance that the sample was given to a practice?

6 MR. WINTER: In terms of the information that's
7 currently collected, it would be a practitioner or the
8 practice. It would not be the name of the practice itself.
9 So we could ask them to collect -- we could ask Congress to
10 require them to collect the name of the practice, but that
11 would be additional information. And maybe that's where
12 you'd want to go.

13 DR. CROSSON: That is what I think the
14 recommendation should be, that if the recipient is a
15 physician practice, then the name of the practice be
16 collected, and strike the rest of it.

17 MR. WINTER: What about the billing number?
18 Because the billing number is really key for being able to
19 link to claims data. So would you want the billing number
20 of the practitioner assigned for the samples?

21 DR. CROSSON: Well, that was my concern about
22 trying to manufacture this on the fly.

1 MR. EBELER: Jay, as I hear you, you're saying if
2 you drop bullet point two, the technical definition that we
3 might want to articulate, underneath one we could put in
4 text, but not in the recommendation.

5 DR. CROSSON: Yes, that was my initial suggestion.

6 DR. KANE: Is there a difference between a billing
7 number and an ID number? Because Ron's point is that a
8 practice is a single billing number that accounts for
9 multiple ID numbers of physicians. But if you just get the
10 practice's billing number, that's the billing number through
11 which multiple physicians bill in that practice. And so all
12 you really need is the billing number.

13 DR. MARK MILLER: Actually, in the data it kind of
14 goes both ways, is the problem. It may be true in your
15 practice, but there are also practices where it kind of goes
16 the other way.

17 But here is what I'm hearing, and I'm trying to
18 work with Jay: We basically drop the second bullet, and we
19 spend time in the text defining what the first bullet refers
20 to in an individual physician's circumstance and in a
21 physician practice circumstance. And I think we understand
22 the concerns that are raised by the Commissioners here, and

1 we'll address those in the text. And then, of course, you
2 guys can review the text. But for purposes of getting
3 through today on the vote, I think what we can do is take
4 the detail out in the second -- take the second bullet out
5 which has that detail and navigate it in the text. I think
6 that's where you were headed anyway.

7 MR. HACKBARTH: Right. Any objection to that
8 proposal?

9 [No response.]

10 MR. HACKBARTH: Hearing none -

11 MR. WINTER: And just to be clear, we'd be
12 dropping "billing number" from the recommendation itself,
13 from the language of the recommendation.

14 DR. MARK MILLER: The second bullet.

15 MR. WINTER: Yes.

16 MR. HACKBARTH: Anything else on recommendation
17 three? Yes, Tom?

18 DR. DEAN: My concern is I think we already know
19 we have a problem. The question is how to address it, and I
20 would prefer to go to something more direct, like something
21 along the line of the counter-detailing that John has
22 brought up. I don't know exactly how you do that. I mean,

1 that's obviously a much bigger undertaking, but I guess I'm
2 just not sure that this is going to help us to address the
3 problem.

4 MR. HACKBARTH: That's a discussion for another
5 day. So we are now finished with questions and comments on
6 number three. Let me see hands for number four, and I guess
7 we ought to do five together, they're sort of related, four
8 and five.

9 MR. BUTLER: First, I'm supportive of both
10 recommendations four and five as stated, no changes in the
11 wording. My comments relate to recommendation five in the
12 narrative, and I would suggest two specific things be
13 included in the narrative.

14 The first is there are loose references to this
15 applying to perhaps more than just the cost and quality of
16 Medicare services. There's some that would like to use this
17 as a compliance database, as a Stark database. I think that
18 those kinds of violations should be handled elsewhere and
19 are not part of the scope of this. This is all about our
20 responsibility as MedPAC Commissioners to worry about the
21 cost and quality of services to Medicare. So I think that
22 distinction should be made.

1 The second relates to how you kind of practically
2 gather the data through the DFRR. I'll make the general
3 comment that in my mind 500 hospitals, and having read and
4 tried to apply the survey to our own institution, the amount
5 of information being requested is way more than is
6 necessary. I realize that I think the horse is out of the
7 barn a little bit on this so that the ability to make some
8 of those modifications may be limited, and I also understand
9 maybe CMS is already trying to address some of the
10 administrative burden.

11 Now, as significant as the administrative burden
12 is, I actually am more concerned about the ability for the
13 CMS staff to practically use the mounds of paper that will
14 come in and convert it to some findings that we can look at
15 and really make a difference in terms of recommendations,
16 which I am very much interested in doing, because I do think
17 in general the cost of the Medicare programs are largely, as
18 I think we've shown before, due to volume kinds of issues,
19 and some of these relationships are the very ones that, you
20 know, incentivize inappropriate or unnecessary volume, and
21 we need to get to that.

22 My specific suggestion then in the language would

1 be to create, call it a technical advisory committee that
2 would help work with CMS in terms of perhaps not the survey
3 itself but the receipt of the data and how it could best be
4 digested in a practical, efficient fashion to get to the
5 results. This would address the kinds of things, for
6 example, that George brought up and say, okay, what happens
7 if you get data from a system and a hospital level? That
8 would be very hard for CMS to kind of sort through on their
9 own, and there are multiple questions like that. So I think
10 some advisory committee would be useful to kind of expedite
11 and create the most productive set of results we could get.

12 MR. HACKBARTH: Just to make sure I got it right,
13 Peter, you're saying put that in the text.

14 MR. BUTLER: Both of my comments in the text --
15 the compliance issue and the technical advisory, yes. The
16 recommendation as stated, fine.

17 MR. HACKBARTH: Thank you.

18 DR. KANE: I basically agree with both four and
19 five. I just wanted a point of clarification. When you say
20 "all hospitals and other entities that bill Medicare for
21 services," do you want to have the ownership of all
22 physician practices, even if it's the primary base from

1 which the physician sees patients, or do you want to have
2 only those things which are ancillary to? And in a comment
3 that I wondered if you really wanted to know the ownership
4 of every LP out there of physician practice. I wasn't sure
5 that was the intent. Maybe it's just too hard to define the
6 border between the physician's primary practice and
7 something they own separately to which they refer patients.
8 But if it isn't too hard, I would say let's go for trying to
9 define the line there.

10 DR. STENSLAND: Right now any limited partnership,
11 physician limited partnership that applies for a Medicare
12 billing number has to list all of the partners already, and
13 then that goes into the database that CMS has. So that's
14 already happening. So the amount of extra work it would
15 take then to put that on this database is minimal. I think
16 we could go either way in the text of saying physicians
17 should be in or physicians should be out.

18 The one example I can think of in my own
19 experience of talking to folks is I was talking with
20 somebody who said -- you know, his practice was bought and
21 he said, "Well, when I owned the practice and I got the
22 ancillary revenue, well, maybe I did order more ancillaries

1 than I do now when I don't own the practice." So,
2 conceivably, there could be some use of this information if
3 a researcher wanted to say, "Is there a difference in
4 imaging ordering between people who own their practice which
5 has an imagine machine and people who just work at the
6 practice but don't have the imaging machine?"

7 DR. KANE: I was thinking of that, also. So maybe
8 we want that. But then should we also then have a list of
9 what services they can bill for within that practice, or are
10 you just going to use the claims data to figure that out?

11 DR. STENSLAND: Just claims.

12 DR. KANE: Then you need to have the ID numbers --
13 I mean the billing numbers. This is going to be on a public
14 website. How are you going to get from that to the claims
15 data to know what they're billing for?

16 MR. WINTER: I believe we contemplated that they
17 also would be reporting the billing numbers, and that would
18 be available to researchers through a data use agreement.
19 I'm not sure if that's in the text or not, but that was our
20 intent, because currently they do report the billing numbers
21 of all physician owners. It's just not public.

22 DR. KANE: Do you want to make it public?

1 MR. WINTER: No, no. We're saying not.
2 Consistent with number one and number three, it would not be
3 public. It would be available to researchers. But the
4 public database could have, would probably have the names at
5 least.

6 DR. KANE: So do you want to clarify that people
7 who want to get access to this data and the ID numbers would
8 have to go through another data use agreement? Or is that
9 just a given? Should we clarify that this is going to be
10 data that you can't just go to a website and figure out
11 much? Because you don't know what services are within that
12 entity. You can only find that out by the claims data.

13 DR. MARK MILLER: Actually, I think there is value
14 in just understanding kind of, you know, entity ownership.
15 There is value to that, even in a public data set. I think
16 some of the issues that you're raising, the way I
17 contemplated resolving those issues, which all came out of a
18 conversation in the last meeting and was driven, I think, by
19 a number of people but certainly Karen, is we should not be
20 posting physician IDs on websites. And so what I would say
21 is as a blanket statement in our discussion here, that
22 information is collected but only available through the DUA

1 process. But on the public website, you know, the notion of
2 the entity and the owners and their ownerships would be
3 available. And then if you wanted to do claims data
4 analysis, you would have to go through the process of
5 getting the ideas and linking the claims.

6 DR. KANE: It might just be worth clarifying that
7 in the text.

8 MR. WINTER: It is in the text right now. It's on
9 page 35. But if you think it's not clear enough, we'll work
10 on that some more.

11 MR. HACKBARTH: Yes, Jay?

12 DR. CROSSON: I support both of the
13 recommendations. I just have a comment with respect to the
14 tone and the text, and it has to do with the fact that if
15 you were to pick up previous work that we've done on
16 physician-hospital relationships and physician-hospital
17 integration and read that separate from this one, you might
18 decide that there was a bit of a schizoid point of view on
19 the Commission, which there isn't. Because, in fact, I
20 think while we're dealing with this set of issues,
21 transparency and concern about inappropriate relationships,
22 we also have been discussing at another time the fact that

1 if we're going to move to more delivery system integration,
2 we probably need to encourage certain types of physician-
3 hospital integration through gain sharing or shared savings
4 or whatever we want to call it.

5 So my only suggestion is that somewhere in this
6 chapter, because these stand alone often, we refer to the
7 other work and make some distinctions here between what
8 we're trying to do here and other work that we've done.

9 MR. HACKBARTH: The stance that I'd like to see us
10 take on this overall set of recommendations is that this is
11 about transparency. It's not about condemnation of these
12 agreements. If we knew that they were all uniformly bad,
13 then we ought to propose that they be eliminated. But as
14 Peter and some of the other comments illustrated, there is
15 some real complexity here. So this set of recommendations
16 is about transparency, and that's point number one.

17 Point number two is I very much agree with your
18 comment, Jay, that there are certain types of relationships
19 that we want to foster, and there are other types of
20 relationships which may be counterproductive, and the nuance
21 is very important here; and I think it would be good to
22 discuss that in the text. But I don't want that point to

1 imply that all this is bad, because I think we get into
2 trouble if we say it's all stuff that we want to get rid of.

3 I think that's our last comment, and we're ready
4 to vote. And as we go through these, Ariel or Jeff, please
5 remind me if we've agreed to any modifications of these so
6 we can just remind people of that.

7 I think number one is as written. I don't think
8 we agreed to any modifications, so on recommendation number
9 one, all opposed to recommendation one? All in favor? Any
10 abstentions?

11 Okay. Let's go to number two. I think number two
12 is as worded, no modifications. All opposed to number two?
13 All in favor? Any abstentions?

14 Okay. Number three. And on number three, as I
15 recall, we said we would delete bullet two. All opposed to
16 number three? All in favor? Any abstentions?

17 Number four. All opposed to number four? All in
18 favor? Abstentions?

19 And number five. All opposed to number five? In
20 favor? Abstentions?

21 Okay. Good work.

22 DR. CROSSON: A point of clarification. On number

1 three -- could we bring back number three? I thought we had
2 made -- did we not strike "researchers" in the last
3 sentence?

4 MR. HACKBARTH: Oh, yes. Thank you, Jay. So
5 let's put it up just so the audience knows. Good catch. So
6 in the last sentence of number three, we also agreed to
7 delete "researchers." Delete the "to" also, yes.

8 Okay. Thanks.

9 MR. HACKBARTH: Okay. All right. Our next item
10 is the Medicare hospice benefit, which we discussed at some
11 length last spring and now we're moving to the next step of
12 that analysis, which is what, if anything, should we do
13 about our findings. And Jim, why don't you lead the way.

14 DR. MATHEWS: Thank you. Good afternoon. As
15 Glenn just mentioned, the work that we are about to present
16 builds on work that we began last year, throughout the
17 course of the last 18 months or so. I would say up front
18 that some of the material in here does assume this prior
19 knowledge, but for purposes of keeping the presentation to a
20 manageable length, we have had to kind of cut right to the
21 chase in some of our analyses. But if there are any things
22 that are unclear or if you need the background that's not in

1 the paper, we'd be happy to take that on question.

2 MR. HACKBARTH: Could I just make an editorial
3 observation? I looked at the title for the session,
4 "Critical Evaluation of the Medicare Hospice Benefit." I
5 think you're using "critical" in the sense of analytic,
6 careful evaluation --

7 DR. MATHEWS: That is correct.

8 MR. HACKBARTH: Yes. Okay.

9 DR. MATHEWS: Before we begin, I would like to
10 acknowledge the work that Zach Gaumer and Hannah Miller put
11 into getting us to this point today

12 Our presentation today will consist of a couple of
13 distinct parts. First, we'll provide some brief background
14 information on the hospice benefit, building on, again as I
15 said, analyses that we started last year.

16 Second, we'll discuss several policy areas that
17 the Commission identified last year as needing additional
18 analysis and policy development with a goal of reaching the
19 draft recommendations that we'll present today. These fall
20 into three general categories. First is payment system
21 reform. Second is the need for greater accountability
22 within the hospice benefit. And third are additional data

1 needs that would help policy makers better manage and modify
2 the benefit going forward.

3 There are two fundamental principles that we would
4 like you to keep in mind as we walk through today's
5 presentation. First, hospice provides an alternative form
6 of care for beneficiaries who do not desire aggressive
7 conventional treatment at the end of life. It is a
8 voluntary benefit. Beneficiaries must explicitly elect
9 hospice. In order to do so, the beneficiary needs
10 certification of likely death within six months. In
11 electing hospice, beneficiaries forego curative treatment
12 for their curative conditions.

13 The second tenet that we have up on the slide here
14 is that the benefit was -- in addition to giving
15 beneficiaries this choice about their end-of-life care, the
16 hospice benefit was implemented with the presumption that it
17 would be less expensive than conventional end-of-life
18 treatment and would result in lower Medicare spending. Our
19 work over the course of the last 18 months has suggested
20 that Medicare's payment system, however, contains an
21 incentive for providers for long stays in hospice. This
22 incentive potentially undermines the presumption that

1 hospice would indeed be less costly than conventional
2 treatment.

3 As I mentioned a moment ago, in our recent
4 analyses, we identified these three areas of Commission
5 interest with respect to the work that we'll present today.

6 To lay the groundwork for these issues, we'll
7 first discuss a few trends and statistics. Everyone is
8 probably aware that since 2000, Medicare's hospice benefit
9 has grown considerably. Roughly 900,000 beneficiaries were
10 in hospice in 2006, an increase of almost 80 percent since
11 2000. This growth represents in part a growing awareness of
12 the benefit and an increasing acceptance of hospice as an
13 end-of-life alternative for the Medicare population.

14 Growth in spending was even more significant,
15 reaching \$9.2 billion in 2006, more than triple the 2000
16 spending level. Medicare spending for hospice will exceed
17 \$10 billion in 2007, more than the program spends on
18 inpatient rehabilitation hospitals, critical access
19 hospitals, long-term care hospitals, comprehensive
20 outpatient rehab facilities, or ambulatory surgical centers.
21 So it's no longer a niche benefit within the Medicare
22 program. Additionally, hospice spending is expected to grow

1 faster than most other components of Medicare over the
2 course of the next ten years.

3 To accommodate the increase in beneficiaries' use
4 of hospice, the number of hospice providers has also grown.
5 Currently, nearly 3,300 hospices participate in Medicare, up
6 by 1,000 providers in the last seven years. The majority of
7 the growth in hospices since 2000 has come from entry of
8 for-profit hospices into the market, which is the yellow
9 line on the left-hand side of the slide here.

10 The number of for-profit hospices grew by nearly
11 230 percent over this time, or about 12.5 percent annually,
12 while the number of non-profits remained flat. Much of the
13 new entrants were small, independent hospices and many
14 operate in areas of the country with considerable market
15 saturation, as we had discussed last year.

16 Over the same period, there were pronounced
17 changes in hospice length of stay, which you see on the
18 right-hand chart. The median length of stay for a hospice
19 was nearly unchanged, at a little over two weeks. Stays
20 below the median were very short and also didn't change much
21 between 2000 and 2005. Length of stay above the median, by
22 contrast, changed significantly. It got much longer,

1 especially at the 90th percentile and above. As we
2 discussed last year, very long stays in hospice can result
3 in higher Medicare spending than would have been incurred
4 had the patient not elected hospice. Thus, very long
5 patient stays undermine one of the statutory principles of
6 the benefit.

7 Some of the increase in length of stay reflects
8 changes in the hospice patient population. Some diagnoses
9 typically have longer length of stay than others. However,
10 diagnosis does not explain all of the increase in length of
11 stay. There are some hospices that have longer lengths of
12 stay for all of their diagnoses.

13 There are many explanations for these differences
14 and we can talk about them during the Q&A. Some of them are
15 articulated in your chapter, in the draft chapter. But one
16 of the most compelling is financial. At the extreme, some
17 hospices may be operating a business model based on
18 extending length of stay in hospice to maximize
19 profitability. The consequence of this approach, however,
20 is that hospices that pursue such an approach are likely to
21 exceed Medicare's payment limit, the hospice cap.

22 Last year, we showed that there was a pronounced

1 relationship between length of stay and profitability, as
2 shown on this slide. We arrayed hospices by length of stay
3 decile and calculated margins for each length of stay group.
4 In all years we looked at, we found an almost linear
5 relationship. Hospices with the longest stays were the most
6 profitable and hospices with extremely short stays were
7 actually unprofitable. While it's not shown on this slide,
8 our preliminary analysis of 2006 data indicates that this
9 trend holds almost exactly for 2006, as well.

10 Here's a graphical illustration of why longer
11 stays are more profitable. As discussed in your paper,
12 Medicare payments are generally flat through the course of
13 an episode. Variations in the level of care, such as the
14 use of inpatient respite care or continuous home care, do
15 have an effect, but most hospice care is routine home care.
16 Routine home care is paid at a fixed rate per day for each
17 beneficiary who is enrolled in hospice, regardless of
18 whether the beneficiary receives a service on any given day,
19 so a relatively flat stream of payments across the episode.

20 Hospices' costs, on the other hand, follow a U-
21 shaped curve. Hospices have higher costs at the beginning
22 of the episode associated with the intake of the patient and

1 higher costs at the end of the episode associated with the
2 higher level of activity that hospices perform at the time
3 of the patient's death. The intervening period is generally
4 less costly. So the hospice's profits related to the
5 episode relative to Medicare payment and their own costs are
6 shown in the green area of these charts. By extending the
7 length of stay, as you see on the right, hospices can
8 increase their profitability.

9 Arguably, the payment system should better,
10 although not necessarily completely, reflect the normal
11 curve of hospices' costs throughout the episode to reduce
12 the incentives for extremely long stays. Still using a per
13 diem construct, a relatively high rate of payment could be
14 set in the earlier months of a hospice episode, cognizant of
15 the benefits to all parties, the patient, the Medicare
16 program, and indeed the hospices themselves, that accrue
17 with appropriate lengths of stay. Payments could be
18 constructed so that they decline over time, and in order to
19 provide incentives for hospices to closely monitor patient
20 length of stay, could even be calibrated so that they
21 approximate or even dip below hospices' costs at a given
22 point in the episode. Payments could then be structured to

1 provide a higher payment reflecting hospices' greater level
2 of effort at the time of the patient's death. We'll come
3 back to this point in a moment.

4 We modeled a new payment system using such an
5 approach. We calculated payments under the current system
6 and simulated what payments would be under a system where
7 per diem payments were stepped down over the course of the
8 episode using the weights shown here, or relative payment
9 amounts shown here. For purposes of this model, we
10 simulated moving to the new system in a budget-neutral
11 manner. Thus, we set payments for each of these weights to
12 ensure that aggregate payments under the new approach were
13 equal to aggregate payments under the current system.

14 We want to point out very explicitly here that
15 this model does not yet reflect the additional payment that
16 would be made to hospices at the time of the patient's
17 death, reflecting that higher level of effort. We will
18 continue to work on our model here and bring this back to
19 you the next time we present on hospice.

20 DR. MARK MILLER: Jim, could I also just get you
21 to remind people that these payments, even though they step
22 down, would continue throughout the stay of the patient.

1 DR. MATHEWS: That is correct. Once they reached
2 a certain level, the payments would continue as long as the
3 patient was enrolled in hospice.

4 The new system would redistribute payments among
5 groups of hospices basically as a function of length of
6 stay. It would shift payments from hospices with very long
7 stays to those with shorter stays. Since length of stay is
8 rather correlated with hospice type, this redistribution
9 results in differential impacts among the various categories
10 of providers that we typically analyze.

11 Among the specific highlights, payments to for-
12 profit and freestanding hospices, which are highly
13 correlated groups, would be reduced by about three percent,
14 respectively. Payments to non-profits would increase by
15 about two percent, and payments to provider-based hospices
16 would increase by 11 percent. Payments to rural hospices
17 under the new system would increase by about five percent
18 relative to current policy.

19 I do want to be clear on this point, though, that
20 the policy doesn't favor one provider type over another but
21 is completely a function of length of stay. And so to the
22 extent length of stay is correlated with specific provider

1 types, that is what accounts for these impacts, and again,
2 we can discuss that more completely if you would like during
3 the Q&A.

4 Again, I also want to be clear that these impacts
5 do not yet reflect the payment adjustments that would be
6 made at the end of the episode with the patient's death.
7 Such an adjustment we anticipate would be financed by
8 reducing the base payment amounts under the new system,
9 possibly by around five percent. It would also have the
10 effect of magnifying the redistributive effects of this
11 stepped-down payment system that you see here.

12 Lastly, we are in the process of estimating the
13 impacts of the new payment system on the number of hospices
14 that would exceed Medicare's payment limit. Tentatively, we
15 estimate that the number of hospices exceeding the cap would
16 be reduced by a third from the nearly 300 that we estimate
17 for 2006 to just under 200 under the new system.

18 We believe there are several merits to the
19 approach that we have outlined here. First, it reinforces
20 hospice as an end-of-life benefit and incorporates
21 incentives to ensure that hospices provide the optimal
22 balance of benefits to Medicare beneficiaries and the

1 program itself. It also better matches hospices' actual
2 cost curve in the course of an episode, and it does include
3 payment adjustments to make hospices more sensitive to the
4 impacts of long lengths of stay. It will also likely, as I
5 just mentioned, reduce the number of hospices exceeding the
6 cap.

7 Additionally, it provides higher reimbursement for
8 patients with very short stays in hospice under the current
9 system, which are in the aggregate unprofitable. As a
10 result, this payment system revision may provide an
11 incentive for hospices to take greater efforts to
12 appropriately lengthen the stays for very short stay
13 patients.

14 Given the Commission's prior discussions, the
15 first recommendation appears on this slide. The Congress
16 should change the current Medicare payment system for
17 hospice to reduce payments per day as the length of the
18 episode increases. The revised payment system should
19 include a payment adjustment to reflect hospices' higher
20 costs associated with patient death at the end of the
21 episode.

22 We have made a first cut at implications of this

1 draft recommendation and for those that follow. The formal
2 assessments will need to come from the Congressional Budget
3 Office, however, and we anticipate having these for you once
4 the recommendations are final. We believe that this
5 recommendation will not have significant spending
6 implications in the first year due to the goal of
7 implementing it in a budget-neutral manner.

8 The effects on patients are likely to be mixed.
9 Some beneficiaries with conditions likely to have short
10 stays in hospice may be able to receive more hospice care,
11 but there would likely be fewer beneficiaries with long
12 hospice stays.

13 The proposal would have significant impacts on
14 providers with redistribution of Medicare payments, as
15 indicated earlier.

16 We will now move on to the second policy area that
17 we flagged in the spring, the need for greater
18 accountability, which Kim will discuss.

19 MS. NEUMAN: We're next going to look at the
20 accountability safeguards currently in place under the
21 hospice benefit and whether there's a need for additional
22 safeguards, for example, in the areas of certification and

1 recertification of patients' hospice eligibility and
2 Medicare program oversight. We will first look at the
3 hospice patients with very long lengths of stay and then we
4 will consider special issues related to nursing home
5 referrals to hospices.

6 First, the long-stay patients. Length of stay in
7 hospice is increasing, particularly for patients with the
8 longest stays. The top ten percent of beneficiaries in
9 hospice had a length of stay of at least 212 days in 2005.
10 That's up roughly 50 percent from the level in 2000.

11 Patients can have long lengths of stay for several
12 reasons. First, there is uncertainty in predicting life
13 expectancy. This means there will always be a certain
14 percentage of patients that live longer than expected and
15 have long hospice stays.

16 Second, some patients may be admitted to hospice
17 too early or not discharged when their prognosis improves.
18 MedPAC's work in the June 2008 report showed that there were
19 certain hospices that had longer lengths of stay across
20 every diagnosis. This suggests that some hospices may be
21 pursuing a business model that focuses on long-stay
22 patients, potentially spurred by the profit incentives

1 associated with long stays under the current payment system
2 which Jim just discussed.

3 We asked an expert panel of hospice providers we
4 convened in October to give us their perspective on very
5 long hospice stays. Before we talk about the expert panel's
6 feedback, I am going to walk through the current hospice
7 eligibility process.

8 To enroll in hospice, two physicians, the
9 beneficiary's personal physician and a hospice physician,
10 must certify that the beneficiary's prognosis is terminal.
11 As Jim mentioned, terminal is defined as a life expectancy
12 of six months or less if the disease runs its normal course.
13 After initial enrollment, the beneficiary's continued
14 eligibility for hospice must be recertified at 90 days, 180
15 days, and every 60 days thereafter. Recertifications only
16 require the signature of a hospice physician.

17 The Medicare claims processing contractors have
18 devised Local Coverage Determinations called LCDs that
19 provide guidelines for determining if a prognosis is
20 terminal. If a beneficiary does not meet that criteria, the
21 beneficiary may still be eligible for hospice if a physician
22 certifies the prognosis is terminal based on their medical

1 judgment concerning aspects of the patient's condition not
2 considered by the LCD.

3 Last month, we convened an expert panel of eight
4 hospice administrators, medical directors, and nurses. The
5 panelists came from both nonprofit and for-profit hospices
6 and from a wide range of geographic areas. A medical
7 director from a Medicare claims processing contractor also
8 participated.

9 We asked the panelists about the reasons for
10 increasingly long stays. The panelists cited a number of
11 factors, for example, uncertainty in predicting life
12 expectancy and changes in the mix of hospice patients in
13 terms of the types of diseases they have. At the same time,
14 panelists indicated that some long stays are due to a lack
15 of compliance with Medicare eligibility criteria among some
16 hospices. Panelists uniformly asserted that many hospices
17 comply with Medicare eligibility criteria. However, they
18 also indicated that some do not.

19 Panelists cited a number of reasons for non-
20 compliance among some hospices. A lack of physician
21 engagement in the certification and recertification process
22 was one factor cited. For example, we heard that some

1 physicians delegate responsibility for recertifications to
2 non-physician staff and just sign off on the paperwork. And
3 at the extreme, some hospices reportedly prohibit physicians
4 from visiting patients for recertification purposes. In
5 addition, inadequate charting and a lack of physician or
6 staff training can reportedly lead to some patients being
7 certified or recertified for hospice when they may not truly
8 qualify.

9 Finally, some panelists pointed to financial
10 incentives associated with long-stay patients and cited
11 examples of questionable practices among some providers in
12 their communities. For example, we heard anecdotal reports
13 of some hospices never discharging patients for improved
14 prognosis, enrolling patients who had been turned away or
15 discharged by other hospices, disregarding the eligibility
16 guidelines in the Medicare Local Coverage Determinations,
17 aggressively marketing to individuals likely to have long
18 lengths of stay, like nursing home patients, or marketing
19 hospice to patients without mentioning the terminal illness
20 requirement.

21 Consensus emerged among panelists about the need
22 for more accountability and greater oversight with regard to

1 long-stay patients. Panelists offered several suggestions.
2 First, some panelists suggested that Medicare could require
3 a physician or an advanced practice nurse to personally
4 visit the patient to assess continued eligibility at the
5 180-day recertification and every second recertification
6 thereafter, that is, every 120 days thereafter. This type
7 of requirement would result in more direct physician
8 engagement in the recertification process. Given the strong
9 financial incentives for long stays, however, there may be
10 compelling reasons to require a visit at each
11 recertification beyond 180 days, that is, every 60 days.

12 A second suggestion offered was that all
13 certifications and recertifications could be required to
14 include a brief narrative statement from the physician about
15 the clinical basis for the terminal prognosis. Panelists
16 felt such a requirement would focus more attention on
17 accountability and spur more physician engagement in the
18 certification and recertification process.

19 Third, a suggestion was made for CMS to increase
20 its medical review of long-stay patients, focusing on
21 providers with exceptionally high lengths of stay.
22 Panelists felt that the existing LCDs, or Local Coverage

1 Determinations, were reasonably effective in identifying
2 patients appropriate for hospice, but that a perceived lack
3 of enforcement of the existing guidelines was leading some
4 hospices to enroll individuals of questionable eligibility.

5 In addition to these suggestions, the expert panel
6 discussion also highlighted special issues with regard to
7 hospice referrals from nursing homes. Both nursing
8 facilities and hospices have incentives to enroll nursing
9 home patients in hospice. For example, nursing facilities
10 may seek cost savings from having a second entity partly
11 responsible for the patient's care. Nursing facilities may
12 also gain an additional stream of revenue if they contract
13 to provide certain services on behalf of the hospice.

14 Hospice providers also have incentives to admit
15 nursing facility patients. First, hospice providers are
16 likely to realize cost savings by providing care to several
17 beneficiaries in one nursing facility rather than traveling
18 to individual homes. Hospices may also see less demand for
19 their services since the patients have access to nursing
20 facility staff.

21 Second, for dual-eligible beneficiaries, the
22 Medicare payment for nursing facility room and board --

1 excuse me, the Medicaid payment for nursing facility room
2 and board is made to the hospice, who is then required to
3 compensate the nursing facility for room and board at a rate
4 no less than 95 percent of the Medicaid rate.

5 Third, nursing facilities may be a source of long-
6 stay patients for hospices, a group that typically requires
7 fewer visits per week and tends to be profitable, as Jim
8 discussed.

9 Medical directors of nursing facilities typically
10 serve as residents' primary care physician and as such are
11 likely to be the physician who refers a resident to hospice
12 and certifies that the prognosis is terminal. As a result,
13 nursing facility medical directors can be at the center of
14 potential conflicts of interest concerning referrals to
15 hospice.

16 In addition to the general financial incentives to
17 refer nursing facility patients to hospice discussed
18 previously, there are certain circumstances where the
19 potential conflict of interest may be enhanced. First,
20 there may be added financial incentives for referrals to
21 hospice when the nursing facility and hospice have joint
22 ownership.

1 Second, the conflict of interest is further
2 enhanced in situations where hospices put nursing facility
3 medical directors on retainer or make other financial
4 arrangements to compensate the medical director for serving
5 as a referral source for the hospice provider. Some of our
6 expert panel members provided anecdotal information
7 indicating that such conflicts of interest do exist among
8 some providers.

9 Based on the Commission's guidance and prior
10 discussions of hospice for the June 2008 report, there's a
11 two-part draft recommendation for consideration. The first
12 part focuses on enhanced accountability for long-stay
13 patients in general, and the second part focuses additional
14 attention on nursing home referrals to hospice and hospice
15 marketing practices.

16 The first part of the draft recommendation reads,
17 "The Congress should direct the Secretary to: Require that
18 a hospice physician or advanced practice nurse personally
19 visit the patient to determine continued eligibility at 180
20 days and at each subsequent recertification and attest that
21 such visits took place; require that certifications and
22 recertifications include a brief narrative describing the

1 clinical basis for the patient's prognosis; and require that
2 all stays in excess of 180 days be reviewed by the
3 applicable medical director of the Medicare claims
4 processing contractor for hospices with an average length of
5 stay greater than 120 days."

6 Given the concerns the Commission has previously
7 expressed about the adequacy of CMS resources to administer
8 and oversee the program, the text of the report would
9 potentially include the following draft language. "The
10 Congress should provide CMS with the resources necessary to
11 enforce existing policies applicable to the hospice benefit
12 and any new policies adopted on the basis of recommendations
13 herein."

14 The implications of this draft recommendation,
15 which are pending feedback from CBO, are: In terms of
16 spending, the direct spending effects are indeterminate, but
17 the draft recommendation would require additional CMS
18 administrative resources. In terms of beneficiary and
19 provider impacts, the draft recommendation would reduce the
20 likelihood that a beneficiary ineligible for hospice would
21 receive hospice care. There is a potential positive impact
22 for hospice-eligible beneficiaries by promoting increased

1 physician engagement. Finally, cost to providers would vary
2 following disproportionately on hospices with long lengths
3 of stay, and there would be minimal burden associated with
4 the requirement for a narrative explanation of prognosis in
5 certifications and recertifications.

6 Turning to the second part of the draft
7 recommendation, it reads, "The Secretary should direct the
8 OIG to investigate the prevalence of financial relationships
9 between hospices and nursing facilities that may represent a
10 conflict of interest and influence admissions to hospice,
11 differences in patterns of nursing home referrals to
12 hospice, and the appropriateness of hospice marketing
13 materials."

14 The implications of this draft recommendation are,
15 with regard to spending, there would be no direct Medicare
16 spending implications but it would require OIG
17 administrative resources. In terms of beneficiaries and
18 providers, there would be no direct or immediate impact.

19 And with that, I'll turn it back over to Jim.

20 DR. MATHEWS: Finally, last year, we also
21 identified the need for additional data in order to better
22 understand and manage the Medicare hospice benefit.

1 Administrative data are currently collected via both
2 Medicare cost reports and from hospice claims, but
3 improvements and enhancements can be made to both of these
4 instruments. We will talk about claims first.

5 Historically, hospices have had only to indicate
6 the number of days of each type of service they were billing
7 for a given beneficiary on their claims. In 2008, CMS began
8 requiring hospices to report additional information on
9 claims, notably the specific type of personnel who provided
10 a visit, such as physicians, nurses, or home health aides.
11 We believe that there is tremendous value to CMS collecting
12 both this information as well as additional information via
13 hospice claims.

14 In particular, CMS should collect information on
15 all practitioners who provide visits. The agency should
16 also collect information on the duration of visits, similar
17 to the requirements on home health agencies, who report
18 visit times in 15-minute increments. It's worth noting that
19 at least one of the major hospice industry associations has
20 also recommended that CMS collect this information. There
21 is more detail in your paper on this point. A
22 recommendation in this area would be particularly timely, as

1 CMS is developing the next phase of its hospice data
2 collection effort as we speak.

3 So draft recommendation three reads, "As a
4 condition of payment, the Secretary should require that
5 hospices report information on all visits provided to the
6 patient on hospice claims, including length of visit."

7 The preliminary implications of this draft
8 recommendation are shown here. As was the case with our --
9 we do not see immediate direct spending implications,
10 although CMS would incur some administrative costs in
11 revising hospice claims. We also do not anticipate any
12 immediate implications for beneficiaries, but there could be
13 some beneficial long-term effects. Lastly, hospices would
14 likely incur some costs in adapting to these claims
15 requirements and in ensuring staff are adequately trained to
16 log and report visit time increments according to Medicare's
17 requirements.

18 The second component of our analysis of data needs
19 dealt with hospice cost reports. The content of existing
20 cost report data could be improved and new data could be
21 collected via the cost reports. During the course of our
22 work, we identified a number of data quality issues with

1 cost reports. These are described in detail in your paper,
2 but generally consisted of missing information, inconsistent
3 or contradictory information, or information that was simply
4 wrong.

5 We also identified information that either was
6 collected only on some providers' cost reports, for example,
7 only on free-standing hospices' cost reports, or was not
8 present on the cost report at all. In particular, we
9 identified four types of information that cost reports
10 should include: Consistent information on Medicare payments
11 across all hospice types; information on visits consistent
12 with CMS's collection of this information from hospice
13 claims; uniform reporting of days of care; and other
14 revenues, such as charitable contributions, that may help
15 provide a fuller picture of hospices' overall financial
16 performance.

17 In light of your confirmation last year that more
18 data is needed, draft recommendation four reads, "The
19 Secretary should change cost reports to reflect new data
20 collection on hospice claims, add new data fields to capture
21 the full range of hospice revenues in order to provide a
22 more accurate picture of hospices' financial performance,

1 and increase the accuracy of cost report data through audits
2 or other processes so that these data can be used in
3 setting, adjusting, or rebasing payments, as warranted."

4 The preliminary spending implications of this
5 recommendation are shown here. We do not see immediate
6 direct spending implications, although CMS would incur some
7 administrative costs in revising cost reports and
8 establishing more stringent review and audit criteria.
9 Similarly, there are no short-term implications for Medicare
10 beneficiaries, but there could be long-term effects if these
11 data are subsequently used to improve the accuracy of
12 hospice payments. We anticipate that hospices would incur
13 some costs in adapting to the new cost reporting
14 requirements, both in terms of upgrading and integrating
15 claims and cost reporting software and in ensuring staff are
16 adequately trained in these new elements.

17 To summarize, then, we hope these draft
18 recommendations on payment system reform, accountability,
19 and data needs are consistent with the expectations you may
20 have had at the end of the last analytic cycle. At this
21 point, we will look forward to your discussion and stand by
22 to address any questions you may have.

1 MR. HACKBARTH: Good job, Jim and Kim. These are
2 draft recommendations, so no votes today. Depending on how
3 this discussion goes, possibly in December, or will we do it
4 in January?

5 DR. MARK MILLER: I've got to think through the
6 schedule a little bit more. We have a heavy load in
7 December when we come to the update, so this may move to
8 January for the return on this.

9 MR. HACKBARTH: All right. I need hands for
10 clarifying questions, and Bruce, why don't you lead off.

11 DR. STUART: This was a superlative job. I
12 learned more about hospice reading this chapter than I knew
13 before this, so I want to commend you on that. Now we know
14 after you have presented it that the "critical" in the title
15 actually refers to something more than just analytical, and
16 that actually --

17 DR. MARK MILLER: For the record, no it doesn't.

18 [Laughter.]

19 DR. STUART: The question I have is -- and the
20 chapter goes into this a little bit -- by assuming budget
21 neutrality, what you are in essence doing is you're
22 transferring some funds from longer stays to shorter stays,

1 and when we saw that chart on margins by length of stay, I
2 mean, it seems to me that that is not unreasonable.

3 However, it also appears that these longer stays,
4 the difficulty here is not just overpayment. There are some
5 really, there is some bad behavior going on here. And so
6 the question is, why would you want to have this completely
7 budget neutral, or is it necessary to be completely budget
8 neutral? Couldn't you save some money in this area?

9 MR. HACKBARTH: Why don't we come back to that?
10 That's a little bit more than clarifying.

11 [Laughter.]

12 MS. BEHROOZI: At the risk of also sounding a
13 little bit like a statement, it really is a question. Who
14 is minding this candy store? Kim, on page 18, you talked
15 about the eligibility requirements and Local Coverage
16 Determinations. Is it just the Medicare claims processors
17 who are responsible for enforcing that the eligibility
18 requirements are met?

19 MS. NEUMAN: Right, so the --

20 MS. BEHROOZI: And to whom are they accountable?

21 MS. NEUMAN: So the physician has to certify the
22 patient's eligibility and then the certification is kept in

1 the medical record and it is only requested upon audit. So
2 the way --

3 MS. BEHROOZI: And who audits?

4 MS. NEUMAN: The Medicare claims processing
5 contractors would audit and the amount of audit would depend
6 on the level of their resources.

7 MS. BEHROOZI: So who audits the medical claims
8 processors auditing or whatever, that they are doing what
9 they are supposed to be doing?

10 MS. NEUMAN: They're CMS's contractors, so they
11 are CMS's hands in the field, so they would oversee them.

12 MS. BEHROOZI: Okay, and on page 19 and in the
13 paper, you talked about the suggestion that I think came
14 from hospice operators themselves that the certification
15 include a narrative. So then my question is, if it doesn't
16 include some clinical evidence, what does it require now,
17 just a single term of diagnosis and checking the box that
18 the person is terminal?

19 MS. NEUMAN: So they need to say that the
20 prognosis is terminal. It needs a physician's signature.
21 And then if the file was audited, they would send the
22 medical record and the medical record would need to support

1 the clinician's certification that the prognosis is
2 terminal.

3 MS. BEHROOZI: Okay. So the certification itself
4 just has to have the prognosis and the signature?

5 MS. NEUMAN: Yes.

6 MS. BEHROOZI: Thank you.

7 DR. MARK MILLER: Overlaying this, and Kim, just
8 make sure I'm right here, overlaying this is pretty much CMS
9 doesn't have a lot of resources to do any of this, and so --

10 MS. NEUMAN: Right.

11 DR. MARK MILLER: -- our take-away from the
12 medical directors that we talked to in the hospice, for-
13 profit, nonprofit hospices that we put together was they
14 didn't think much of this was going on, if any, and it was
15 quite striking that they were asking for more oversight,
16 which --

17 DR. CASTELLANOS: Jim, Kim, great job, I really
18 thought you did. Jim, this is really a clarification on a
19 subject you brought up last year. It was not mentioned in
20 the meeting briefs or today's discussion. You mentioned a
21 little bit about caps last year and you said a very high
22 percentage of those caps occurred under one of the Medicare

1 fiscal intermediaries. And my question to you is, does this
2 still exist, and if it doesn't, great. If it still exists,
3 have you looked at it?

4 DR. MATHEWS: We have done a preliminary
5 assessment of the number of hospices that will exceed the
6 cap in 2006. I believe it's discussed in your paper. With
7 respect to the distribution by intermediary, yes, the
8 pattern we observed last year does still hold in 2006, that
9 80 percent of the cap assessments are attributable to one
10 fiscal intermediary.

11 Again, I would stress, as we did last year, that
12 that distribution does not appear to reflect anything that
13 that fiscal intermediary is doing differently by way of
14 assessing the caps, calculating cap overpayments, but rather
15 reflects the length of stay distribution of the hospices in
16 the geographic areas covered by that fiscal intermediary.
17 It does not look like that fiscal intermediary is doing
18 anything different.

19 DR. KANE: On your page ten of your -- so if we
20 are to suggest that this type of payment system should be
21 perhaps implemented, have you already figured out how much
22 they should be and how they be stepped down? I mean, how do

1 you know the schedule and the amount? What's the basis upon
2 which you would come up with that model, or is the model
3 already come up with? Where is that coming from?

4 DR. MATHEWS: This borders between a clarifying
5 question and a very substantive question, but to try and
6 briefly -

7 DR. KANE: It's a clarification of --

8 DR. MATHEWS: To briefly answer your question,
9 this is one potential way that you could step down payments.
10 It is not necessarily the definitive way. We came up with
11 this schematic here based on the distribution of current
12 length of stay, average payment for hospice patient, what
13 the current cap amount is, what payments would look like at
14 180 days under the current payment system, and try to change
15 payments under the new system relative to current system in
16 order to shift length of stay away from the long-stay
17 patients.

18 DR. KANE: So it's not a cost model. It's sort of
19 a revenue model?

20 DR. MATHEWS: That's correct.

21 DR. KANE: Okay. That was my question.

22 DR. MATHEWS: Other ways of doing this would be to

1 base the distribution on a hospice's provision of visits, as
2 reflected in the claims data that CMS is currently
3 collecting.

4 DR. CHERNEW: On this topic, did you have any
5 assumption about any sort of behavioral response when you
6 got budget neutrality? In other words, if you put this in
7 and there's a change in distributions of things, was there
8 any adjustment made, or you assumed the exact same --

9 DR. MATHEWS: That's correct. We've made no
10 behavioral adjustments here.

11 DR. CHERNEW: My second clarifying question is,
12 when a physician goes to recertify somebody per the
13 recertification, I think it was 2(a), I'm not sure, one of
14 those, the recommendation was, who pays? Do they bill
15 separately for that extra visit or is that billed in some
16 other bundle or by some other organization, that
17 recertification activity?

18 MS. NEUMAN: If a physician visits a patient just
19 for recertification purposes, the payment is considered to
20 be part of the per diem payment that they get and there's no
21 extra payment.

22 DR. MARK MILLER: The hospice pays the physician

1 for a recertification visit if that's the only thing that
2 the physician does during that visit.

3 DR. CHERNEW: I'm just trying to figure out how
4 the cost of that extra set of activities is being borne.

5 DR. MARK MILLER: I think the other way to say it
6 is that was assumed in the payments that are going out to
7 the hospice. And in this panel that we had, there were
8 several hospices, or there were some medical directors who
9 said when a patient begins to have a very lengthy stay, the
10 physician may actually go and say, I want to see this
11 patient and see what's going on, and they pay for that out
12 of the hospice payments that they get, because this is the
13 medical director of the hospice making the visit in this
14 particular instance. Other hospices, as Kim was saying, is
15 that there are policies where they don't do that and the
16 question is, is it clinically they don't need to, or is it
17 because of the payments, the issue that you're raising.

18 DR. CHERNEW: [off mic] Right. I was actually
19 mostly concerned if we made them do a lot more than the
20 accountability thing, is there a real cost of that? And how
21 would that...

22 DR. SCANLON: There was a procedure set up for

1 recertification, which there was a payment to physicians,
2 and I'm not sure if it only applied to home health, and it
3 didn't necessarily involve a visit, but it was for basically
4 signing the form, reviewing the form and signing it. And
5 the question is whether or not it applies to any context
6 other than home health. This was set up maybe around the
7 year 2000.

8 DR. MARK MILLER: I think what Bill is referring
9 to, and I'm also looking for Evan here, is the attestation -
10 - no, okay. Then speak up, please.

11 MR. CHRISTMAN: [off mic] I think your
12 recollection is correct, Bill. There is a physician billing
13 for certifying a home health admission. I believe it's only
14 for home health, though. I don't believe it's for hospice.

15 MS. HANSEN: This is just a question on the point
16 of the medical directors potentially having a conflict of
17 interest factor, and I just wondered, since we had a whole
18 recommendation on Medicare and physician relationships
19 whether this potentially falls into just a disclosable
20 relationship. So that is one question.

21 And the second question is related, too. With
22 these long length of stays, do people just stay on ad

1 infinitum, or if they really go beyond the caps, what
2 happens to the patient?

3 MS. NEUMAN: On the second part of your question,
4 they can continue onward. There is no finite limit. As
5 long as the physician continues to certify them as being
6 terminal, they can continue in the benefit indefinitely.

7 DR. MATHEWS: On that point, for example, when we
8 did our analysis last year where we compared patients in
9 2000 to 2005 and looked at the difference in their
10 characteristics, in the course of doing diagnostics on those
11 data files, we found slightly over 1,000 patients who had
12 uninterrupted hospice stays that spanned from 2000 to 2005.

13 MR. GEORGE MILLER: If you could turn to slide 11,
14 please, and just to clarify and question, if I am a rural
15 provider-based not-for-profit entity, do I get five plus 11
16 plus two percent, or do I --

17 [Laughter.]

18 MR. GEORGE MILLER: Or if I'm a provider-based
19 for-profit, do I get to subtract three from 11 percent?
20 Have you thought that through or --

21 DR. MATHEWS: We'll see if we can break down those
22 impacts at that level of detail, but --

1 DR. MARK MILLER: But they are not simply added to
2 it.

3 DR. MATHEWS: They are not.

4 DR. MARK MILLER: Right. You would have to run
5 the analysis with the interactions of the characteristics to
6 come up with that number, but people should not be looking
7 at those numbers and accumulating them. They aren't added
8 to --

9 MR. GEORGE MILLER: But do I get to choose which
10 is --

11 DR. MARK MILLER: I completely misunderstood your
12 question.

13 [Laughter.]

14 DR. MATHEWS: We're not setting up a new business
15 model here.

16 MR. GEORGE MILLER: The second part of my
17 qualifying question, if you could help me understand the
18 for-profit entities. I was very stricken -- and this is an
19 excellent report and I loved reading it -- could you give me
20 a profile of what a for-profit entity looks like? The
21 reason I'm asking, I've heard anecdotal stories competing
22 with ours in my home town that there are a lot of ma-and-pas

1 out there who are not clinicians who own hospices. So do
2 you have a profile of what --

3 DR. MATHEWS: It's varied. They range from
4 individually-owned for-profit enterprises, you know,
5 locally-owned, to large publicly traded corporations that
6 have multiple sites across the country. So I don't think
7 you can broadly characterize what the for-profit slice of
8 the hospice community looks like.

9 MR. GEORGE MILLER: Okay.

10 DR. MARK MILLER: They don't tend to be smaller?

11 DR. MATHEWS: The for-profit cap hospices are
12 distinctly smaller --

13 DR. MARK MILLER: That's what I'm thinking.

14 DR. MATHEWS: -- than hospices that do not exceed
15 the cap. But I don't think we could characterize all for-
16 profits that way.

17 DR. CROSSON: Yes, I just had a question on the
18 data portion. I was surprised when we first started talking
19 about the hospice benefit or the hospice issue to realize
20 that, in fact, hospices were not reporting the actual care
21 that was being delivered. It struck me as odd compared with
22 other parts of the Medicare program and still does. I

1 wondered, in the new claims reporting information, because I
2 couldn't tell from the text, to what degree of granularity
3 is that issue resolved. Is that going to actually enable
4 someone to tell on any given visit what sorts of services
5 were provided to an individual?

6 DR. MATHEWS: No. The current data collection
7 effort only requests that hospices provide information on
8 the type of practitioner who provided the visit, so, for
9 example, physician, nurse, home health aide. It does not
10 break down in any more detail what services that
11 practitioner provided nor does it provide information on the
12 duration of the service. So a physician visit or a nurse
13 visit is the same as a nurse visit under the current
14 collection effort, and that's one of the reasons that led us
15 to suggest that CMS also begin to include information on
16 visit duration.

17 DR. CROSSON: But the suggestion does not include
18 that information about what kind of services was provided be
19 provided?

20 DR. MATHEWS: That's correct.

21 DR. MILSTEIN: Managing lengths of stay, as you've
22 pointed out, involves a fair number of moving parts and

1 players. This may have been in the background materials and
2 I missed it. Has MedPAC previously considered the pros and
3 cons of a fixed-price approach to this benefit, which is
4 obviously a very different way of managing length-of-stay
5 abuse, if we think it's common?

6 DR. MATHEWS: By a fixed-price approach, do you
7 mean a single payment for the beneficiary who elects
8 hospice? I think we might have mentioned it briefly in
9 passing in the set-up for describing the step-down payment
10 system revision that we've presented here, but we have not
11 developed that extensively.

12 MR. BUTLER: The data in the chapter shows that
13 the growth in the last seven years has been all on the for-
14 profit side and it's been flat on the nonprofit side and
15 that non-profits represent now about a third of all the
16 hospices. I think that's what it says.

17 My question, though, is on this slide. You have
18 the nonprofit and provider-based, which I assume is almost
19 exclusively a subset of the nonprofit. Probably most are
20 nonprofit on the provider-based. So my question is, how
21 many are provider-based as a percentage of the total and do
22 you know anything about the trends in the last seven years

1 of the provider-based hospices, because I don't think I saw
2 that in the -- I assume those are mostly hospital-sponsored.

3 DR. MATHEWS: Let's see what I have here. Just a
4 point of clarification. I think the way we have
5 characterized the distribution by ownership is that slightly
6 over 50 percent are for-profits. The remainder are the non-
7 profits, the government, and then there are a small subset
8 of sort of mixed ownership type, county and nonprofit
9 collaborations, that sort of thing. There are charts where
10 we don't show --

11 MR. BUTLER: It doesn't add up to the total.
12 That's why I --

13 DR. MATHEWS: Yes. We don't show the government
14 providers. So that's how we would characterize that
15 distribution.

16 With respect to the percent who are provider-
17 based, probably a third to 40 percent tops. So I'll say 30
18 to 40 percent --

19 MR. BUTLER: Of the nonprofit, and they're almost
20 all nonprofit.

21 DR. MATHEWS: The majority are probably nonprofit.
22 I would not say all. There are some for-profit provider-

1 based hospices. The provider can be a hospital or a home
2 health agency are the predominant parent provider types.
3 There are a handful of skilled nursing facility-based
4 hospices, literally nine or ten that are in our most
5 analytic file.

6 DR. REISCHAUER: This really is a clarification.
7 On eight, where you have your illustrations of costs and
8 revenues from length of stay, it suggests that it's less
9 costly when somebody dies after 12 months than after six
10 months. Does that come out of your data or is that just --

11 DR. MATHEWS: This is purely an illustration.

12 MR. EBELER: Just to follow up on Peter's
13 question, if we're going to clarify the data on number of
14 hospices, it might be also useful to include a column on the
15 number of beneficiaries served by those categories, because
16 if we're talking about entities with different sizes, we
17 just need to understand both denominator of hospices and
18 denominator of beneficiaries served, I think.

19 MR. HACKBARTH: Are you ready, Jim? I'm going to
20 set Bruce free here.

21 DR. STUART: I've already asked my question.

22 MR. HACKBARTH: You're just waiting for the

1 answer. Why don't you go ahead and restate it, Bruce.

2 DR. STUART: The question, in brief, is why did
3 you assume budget neutrality for this analysis?

4 DR. MATHEWS: We thought it would be the best
5 starting place for the Commission to begin its
6 deliberations.

7 DR. MARK MILLER: Just to follow up on that,
8 something that Mike said earlier is that we don't have a
9 sense of the behavioral impacts and there could be changes
10 over time from that. And also, the way we've been
11 proceeding for the last year is kind of what's this benefit
12 and what's going on and it hadn't come up as an objective in
13 and of itself, but also to integrate it at some point in
14 time into our standard kind of financial analysis and update
15 type of analysis. And so, really, the direction to Jim up
16 to this point has been we should be looking at the
17 underlying payment structure of the benefit and haven't
18 really taken on the kind of total expenditure thing. But
19 it's a completely legitimate question.

20 DR. STUART: Well, I think there are two parts to
21 this question, and Mike raised one of them, and that is have
22 you factored in behavioral responses to these suggestions,

1 and the fact that obviously at some point you are going to
2 want to do that. So that gets to the accuracy of the
3 estimate. But that still doesn't get to the issue of why
4 you are assuming that this should be budget neutral as
5 opposed to generating savings from what appear to be bad
6 actors.

7 MR. HACKBARTH: Most of the time, if not all the
8 time that Medicare has moved to a new payment system, it
9 does so on a budget neutral basis, not to sanctify the
10 existing level of spending, but really as a practical
11 consideration. If you say, well, we are going to do a new
12 payment system and that step one, we're going to reduce
13 expenditures by some significant percentage, you've made it
14 politically, practically, more difficult to get the new
15 payment system adopted. Not only do you have the people who
16 would lose under the redistribution, you are also shrinking
17 the size of the pie, which just means that many more
18 potential votes against you. Of course, on the other side
19 of the coin, you don't want to add to the expenditure
20 problems that we have already got.

21 So it is common to start with budget neutrality
22 and then over time you may get dynamic effects that reduce

1 expenditures or you may want to make system refinements that
2 reduce expenditures.

3 DR. STUART: I'd like to hear what Bill has to say
4 about this, since he's our institutional historian, because
5 it goes back to the home health issue, it seems to me, in
6 1997. Clearly then, there was an assumption that the
7 payment levels were just simply too high and you had to get
8 them down.

9 DR. SCANLON: There's no question about that, but
10 at the same time, when you do do something other than budget
11 neutrality, you take on for yourself an analytic
12 responsibility to demonstrate that your cut is going to be
13 something that is acceptable. And the logic that's been
14 used in terms of adopting some of these new payment systems
15 with budget neutrality is we're not experiencing a problem
16 now, so therefore we're not going to be experiencing a
17 problem if we spend the same amount of money in a better
18 way. And so you kind of take that one analytic task that
19 you have off the table.

20 In all of these things about changing systems
21 dramatically, you're faced with this problem that you have
22 no data on the world that you're creating, and so it becomes

1 -- your analytic task is very hard and your ability to
2 convince people is very hard. So it is this issue of trying
3 to reassure people who are ultimately responsible, namely
4 the policy makers, that you're not going to cause harm. I
5 mean, it's again this issue, can we make improvements over
6 time as opposed to instantaneously and where we increase the
7 risk when we do try to do it instantaneously.

8 DR. SCANLON: I just want to say, this is an
9 excellent sort of report and I'm fully supportive of the
10 recommendations. I think that particularly the
11 reimbursement recommendation, the idea of this new structure
12 is, I believe, very much in the right direction and reflects
13 the fact that we have a payment system that is, what, it's
14 close to 25 years old and was based upon a benefit that was
15 very different. This reflects, in some respects, the new
16 structure of the benefit.

17 Having said that, I think Nancy's point is very
18 important, that the structure for the reimbursement system
19 or the payment system may be correct, but we really do have
20 to worry about the parameters. And one of the things to
21 think about is whether or not we want to say that if it
22 comes down to it, the existing data are non-adequate to

1 provide good estimates of the parameters that we want here,
2 that there should be a data collection effort, some sort of
3 short-term, very intensive that allows us to move forward.

4 We did this with respect to SNF payments. We
5 don't rely on administrative data to set the SNF payment
6 system. We have to do special data collection and we should
7 think about it sort of in this context, as well.

8 In terms of the recertification, I'm behind that,
9 as well. The issue for me would be, and Jim, I agree with
10 you that even though we have a geographic concentration of
11 the cap issue, it's probably not the contractors and not
12 related to the contractor. But I would prefer that we have
13 something other than Local Coverage Decisions being enforced
14 and that really we should have national standards for what
15 constitutes appropriate hospice care, because in this whole
16 issue, there's two parts of the local coverage versus
17 national coverage decisions.

18 One is the efficiency thing. Why have every
19 contractor reinvent the wheel and go through the evidence
20 and come up with a decision as to what's going to be
21 covered?

22 The second aspect of it is the equity, the fact

1 that you can be in one State and get coverage under Medicare
2 for something, and be in another and have it denied. That
3 just is not appropriate sort of in a national program.

4 On the IG study, I don't know if your panel raised
5 this at all as an issue, but residential long-term care has
6 changed dramatically sort of over the last 15 to 20 years,
7 to the point now where we have about a million people living
8 assisted living. I guess they're some of the same types of
9 issues. There's not really in many instances a big
10 difference between a nursing home and an assisted living
11 facility and whether we should be looking at the same kinds
12 of questions for hospice and assisted living facilities as
13 we are looking for hospices and nursing homes is something
14 to think about.

15 The last thing, which is not sort of among the
16 things we're doing now, is a different kind of
17 certification, and that's survey and certification, and
18 that's the issue of are the people that are coming into this
19 program capable of being hospices? This is something I have
20 heard sort of in a variety of contexts. We don't spend much
21 time looking at whether the organizations can comply with
22 the conditions of participation and do so on a continuing

1 basis, and that is another part of this. I mean, we've got
2 to make sure that we have capable providers. I've even
3 heard this from the hospice industry itself, saying we
4 really would like to be looked at a little more frequently
5 than we are now. Sometimes it's five to ten years between
6 surveys.

7 MR. HACKBARTH: We're in round two now, just for
8 those who are keeping score.

9 DR. CHERNEW: I have two sort of broad points to
10 make about this. The first one is, loosely, it's not clear
11 to me what the optimal length of stay is given that we have
12 to think about this in the broad care for the people, not
13 just always hospice and assisted living and home care and
14 nursing home care. If the person is not in the hospice over
15 a long period of time, they're somewhere else, maybe just in
16 the community, but it's not clear to me necessarily. I do
17 believe there's something wrong with the payments or the
18 margins, but it's not clear to me inherently what the right
19 level of hospice care we want in general would be.

20 For example, if we make these payment changes,
21 we're going to have a bunch of behavioral responses. I'm
22 not sure what they all are. And if I knew what they all

1 were, then I'd have to ask, are they good? Are they good in
2 terms of financially or are they good in terms of clinical
3 quality? And so I'm not sure yet that I know once we make a
4 change what the ramifications would be. All I really know
5 is right now, the incentives don't seem to be right, but
6 that doesn't mean that the outcomes we're going to get
7 broadly for the beneficiaries are going to be better if we
8 go to some other way because it interacts with a whole bunch
9 of other services that we're sort of not dealing with here.

10 The second comment that I have, and this is just
11 sort of an intuitive sense, is I believe that more
12 accountability is important and some of the things that it
13 sounds like happen are really appalling. All of that said,
14 I think there's potentially a lot of administrative costs in
15 some of the accountability things that we conceivably could
16 force people to do in terms of data and stuff and sometimes
17 I believe, and I'm not sure I believe it in this case, is if
18 we got the payment right or got the payment better, that
19 could mitigate a lot of the need for micromanaging various
20 things that went on.

21 For example, if we had the right payment, I would
22 be willing to spend a lot less resources on verifying people

1 very frequently if we had the right incentives in the first
2 place.

3 MR. HACKBARTH: That would be true, Mike, if you
4 had a bundled payment and moved away from per day, for
5 instance.

6 DR. CHERNEW: Right. For example, if we had a
7 bundled payment, I wouldn't need people to be certified.
8 There might be other things I would worry about. I might
9 worry about quality. So there's a whole series of things
10 that one would want, but there's interaction between the
11 payment and the information one wants, and so what we know
12 now is the stuff isn't happening. We have a bad payment
13 system and a bunch of bad things going on. But once we fix
14 one, it's not clear the other one is going to need to be
15 fixed in the same way.

16 MR. HACKBARTH: So the model presented here is
17 continue with the per day payment system, change the level
18 at different points in this day. So long as you have a per
19 day system, you're going to need some checks on the
20 appropriateness of the stays.

21 DR. CHERNEW: Not if you lowered the payment low
22 enough for some of the per days.

1 DR. MARK MILLER: You should say that with the
2 microphone on, well, just so everybody hears it.

3 There's also one thing I want to clarify, just in
4 case it's crept into people's minds. On the accountability
5 recommendations, two of them are sort of clinical. The
6 physician ought to see the person at some set points in time
7 and ought to document reasons. The real oversight one, the
8 one that you're referring to, it had two pieces. It is
9 stays that are beyond six months in hospices that have high
10 lengths of stay, on average. So it's not hitting the entire
11 distribution. Just in case anybody else is unclear on that,
12 it is designed to be at the right-hand tail of the
13 distribution and the long stays in that tail, if you see
14 what I'm trying to get at. But it still will incur costs.

15 DR. SCANLON: Theoretically, I think, Mike, you're
16 exactly on target, I mean, this whole issue that if we could
17 do a good job in setting the payment rates, we wouldn't need
18 to be as concerned about some of this accountability. But
19 if you look at the distribution on page six between the 90th
20 percentile and the tenth percentile in terms of length of
21 stay and you combine that with what every clinician says
22 about sort of the difficulty of making a prognostic

1 prediction about sort of death, we are talking about sort of
2 an incredibly challenging task here and it's not something -
3 - right now, we're limited to mostly diagnostic information,
4 and I'm not even sure if you asked clinicians what else they
5 would want on the menu in terms of saying variables that are
6 going to influence this they could come up with a list that
7 had much explanatory power at all. So we really probably
8 need to stay in this context because it's the one that's
9 feasible for the intermediate term. Daily payments, right.

10 DR. REISCHAUER: Can I just say something about
11 what Mike said? Changing the payment system shouldn't
12 change the demand for the service. It might change the
13 number of suppliers out there wanting the service. If you
14 do this in such a way so there is a normal margin, you know,
15 normal being defined with the appropriate care, you
16 shouldn't worry about what you're worrying about, I don't
17 think.

18 DR. CHERNEW: [off mic][inaudible.]

19 DR. REISCHAUER: Whatever you were worrying about.
20 [Laughter.]

21 DR. CHERNEW: I worry about a lot. Yes, if you
22 get the payment right, then there's less to worry about.

1 DR. REISCHAUER: People who are saying at this
2 point, I think the right thing is to give up on aggressive
3 care and go into palliative care, and that's in a way a
4 personal decision for each family, it will sort of average
5 differently for Alzheimer's folks than from cancer folks
6 from other folks like that. As you said, there is no right
7 average length of stay, probably no right one even for all
8 cancer patients. And so it's really are we letting people
9 avail themselves of this option and is there an appropriate
10 supply of these services available? It seems there's more
11 than appropriate right now and there might be some marketing
12 going on which in the end is inappropriate.

13 MR. EBELER: Thank you for all the work. I mean,
14 these three directions you've laid out here are very much on
15 track, getting the payment right, getting some of the
16 clinical criteria right, and getting more data.

17 I tend to agree with Bill that it is worth
18 thinking about national standards for what are the clinical
19 issues here rather than all those being local. And on the
20 supply question, at least until these policies are put in
21 place, I do wonder if it's worthwhile thinking about
22 moratoria in certain communities as these things crop up.

1 The supply impact of these changes would not occur for
2 several years, at best, and it's just worth thinking about.

3 The two things I want us to think about longer
4 term, the budget neutrality question has two features in the
5 case of hospice, the one that Bruce mentioned, and I think
6 the way you've laid this out is the more traditional way to
7 do it in Medicare. But the second one is the policy
8 question, is hospice saving or costing Medicare money, and I
9 don't think we're going to be able to address that in this
10 chapter. I don't expect to. But I think long-term, we
11 still need to look at that.

12 The second, again, is something to mention toward
13 the end of this, not as a recommendation. This is an effort
14 to fix the current hospice benefit as it's been designed and
15 as we've known it. I think we had a discussion maybe two
16 meetings ago on this issue of at some point sort of thinking
17 longer term about what a different end-of-life benefit may
18 look like. Again, I don't think we have a clue what to
19 recommend in that area, but I just think at the same time we
20 pursue these three very appropriate vectors for the fix, we
21 keep those longer-term issues on the plate for the future.

22 DR. CROSSON: Thank you. I want to compliment the

1 work, also. I like and support the payment changes and the
2 recertification recommendation.

3 I have, as some others have mentioned, a
4 predilection towards prospective payment and the idea of a
5 case rate here seems to me perfectly reasonable, one to
6 pursue if we're going to stick with a fee-for-service
7 system. I still have a question about why we don't have
8 information about what types of service are being rendered.
9 It would seem to me somewhat odd and potentially
10 manipulatable.

11 So it's possible that, in keeping with what Mike
12 said, that we might not be recommending that because it is a
13 lot of administrative burden to do that, I would imagine,
14 and maybe the services that are rendered don't vary that
15 much from visit to visit, from provider to provider, which
16 would be one reason to not capture the data and apply that
17 sort of burden.

18 Another one might be our assumption that the
19 payment change recommendation, since it goes down in the
20 middle of that curve to about five percent of the peak,
21 might render this information less valuable because the
22 payment change itself is going to be enough to change the

1 dynamics. But I don't know that we've had that discussion,
2 and so I was wondering whether in terms of the
3 recommendation for more data it was actively discussed and
4 rejected or not.

5 DR. MARK MILLER: I'm going to take the first pass
6 at this, and I think my fundamental answer is I'm not sure.
7 When we were talking about the claims data and getting the
8 visits and the lengths of the visit, we're thinking that a
9 lot of what goes on here in terms of service is the kinds of
10 visits that are rendered during the stay, or during the
11 hospice episode.

12 I guess what I'm a little confused in, and Jim, if
13 you have a sense of what he's asking, then you should jump
14 right in, is what are the kinds of services or types of care
15 are we thinking about here?

16 DR. MATHEWS: So you would be interested in
17 knowing, for example, if a registered nurse goes to visit a
18 hospice patient in their home, what service that person is
19 doing. Are they administering narcotics to alleviate pain?
20 Are they doing dressing changes for pressure sores? If a
21 home health aide goes into that patient's home, are they
22 bathing the patient? Are they providing assistance with

1 activities of daily living? Is the hospice providing
2 relevant durable medical equipment in the course of a visit?
3 That's what you're asking, if I understand you correctly.

4 DR. CROSSON: That's the question, because, of
5 course, in most of the rest of Medicare, we have that
6 information. At least in fee-for-service, we're billing for
7 things that we do or things we provide and the like. In
8 this particular case, we don't do that. Now, it may be, as
9 I said, again, that there's enough uniformity here and lack
10 of ability to manipulate the level of service that it's
11 irrelevant, but I'm just asking the question. If we're
12 going to ask for more data, have we thought about and
13 rejected that type of information for some reason?

14 DR. MARK MILLER: One other thing I would ask,
15 Jim, and again, I may be way off point, and it seems to be
16 the whole day I've been off point, so I'm going to go ahead
17 and be off point again. There was a discussion at one point
18 in time based on some data that you had from a given
19 provider about differences in treatment between types of
20 patients with different diagnoses, cancer versus -- and I
21 vaguely, and maybe a couple of other people are vaguely
22 recalling, there wasn't a lot of difference. Is that a

1 correct recollection?

2 DR. MATHEWS: Yes. To clarify, what we were
3 looking at there were claims or encounter-level data from a
4 national chain provider who stepped up and volunteered this
5 information for our use, and we were able to conduct our own
6 independent analyses of utilization across a hospice episode
7 by different patient types. We did see that the mix of
8 visits changed over time, that with very long stays, the mix
9 of visits shifted more towards home health types of
10 personnel and less towards skilled personnel, and that
11 change in the mix of visits was irrespective of patient
12 diagnosis. If you were a cancer patient at 160 days, your
13 mix of visits was similar to an Alzheimer's patient at 160
14 days.

15 The problem is that data does not contain the
16 level of detail that you are interested in, that it was
17 purely a visit by a given practitioner that began at one
18 point in time during the day and lasted for 90 minutes,
19 lasted for 40 minutes. So it did provide who provided the
20 visit and how long the visit lasted, but did not provide any
21 information as to the content of the visit, what that person
22 actually did with the patient.

1 DR. MARK MILLER: So in answer to your question, I
2 don't think we have actively rejected this. I think
3 probably the right thing to do at this point is to kind of
4 go back, let us churn on it a little bit, and come back to
5 you.

6 DR. MATHEWS: But just to be clear in terms of
7 guidance, I mean, is this something -- never mind.

8 MR. HACKBARTH: Jim, do you want to just quickly
9 address Jay's first point about why not a per case system?
10 Arnie has raised that and Mike sort of alluded to it.
11 You've proposed a new payment approach but continue to use
12 per day as the structure.

13 DR. MARK MILLER: Do you want to do it or do you
14 want me to? I think that the reason that we did this is
15 given -- and some of it occurred over here, and I can't
16 remember exactly who the actors were, but it was on this
17 side of the table. I think it was Bill.

18 This is a very difficult -- and I want to be
19 really clear -- this has been a very difficult area to
20 analyze. It's highly emotional and very complicated.
21 Despite the fact that we focused on some of the things that
22 the expert panel has told us at the extremes, also what went

1 on in the panel is the difficulty in predicting how long
2 somebody is going to need is just -- it's incredibly
3 difficult. This notion of could clinicians even tell you,
4 if I had all this information, could I get better at it, it
5 still remains very much an art and not a science.

6 And so I think what drove us in this direction is
7 if you start moving towards capitated payments, you need a
8 couple of things. You need to have a sense of how big that
9 is and if it varies by characteristic, whether it's
10 diagnosis or ADLs or some other characteristics of the
11 patient, and we didn't feel that we had the wherewithal to
12 do that and some concern that at least the per diem leaves
13 you a little bit of latitude if you're dead wrong that the
14 hospice -- oh, wow.

15 [Laughter.]

16 DR. MARK MILLER: My resignation will be tendered
17 at this time.

18 DR. REISCHAUER: But it sets up exactly the wrong
19 incentive, which is to go get people just before they're
20 about to expire.

21 DR. MARK MILLER: Right, and that was the other
22 point I was trying to come to. The other thing that we're

1 trying to do with this is we really do think that there is
2 this -- and now I'm going to really slow down and think
3 about what I'm saying -- there is a spike in cost, and
4 anybody who's been through this process with their family
5 knows this, when it comes to the end of the episode and the
6 end of the person's life. And we also thought that it was
7 really important that we have that incentive at the back end
8 so that there isn't this very strong incentive to say, okay,
9 great. Let's just get short-stay patients.

10 Because the other thing which we don't often have
11 time to go through in detail is back to the length of stay
12 stuff, which is right there, is the perplexing thing about
13 this is that it's the right tail that's growing and the rest
14 of it isn't, and we don't want to push really short stays.
15 We want to curtail the very extreme right-hand tail and
16 we're thinking that with that adjustment for the end of
17 life, we can give something better of an incentive along
18 those lines.

19 But the capitation stuff just kind of -- there's a
20 fair amount of information there that you feel like you need
21 and a fair amount of variance in people's ability to predict
22 what somebody is going to need.

1 DR. MATHEWS: On that point, given the fact that
2 if you did have a capitated payment system and wanted to
3 adjustment payments by a diagnosis in order to reflect the
4 patient's likely use of case, given the fact that diagnosis
5 can be strongly correlated with length of stay, you
6 basically get a capitated payment system that varies as a
7 function of length of stay.

8 DR. SCANLON: And the one last thing, which is
9 that setting the rate right doesn't mean that you've
10 established that you're going to have the product that you
11 thought you were going to get. You have to be able to
12 monitor the product that you're buying, and in this case,
13 this is exactly like home health. We don't have a
14 definition of what is appropriate care for an episode, and
15 so we would be at a total disadvantage in terms of trying to
16 say, we paid you this. You didn't deliver.

17 DR. KANE: Well, I guess I'm going to -- since the
18 payment issue has already been on the table, but I do
19 support Bill's suggestion that under draft recommendation
20 one, that we make some modifications on what kind of the
21 basis of the payment system should be and that it should be
22 driven by cost and as much data as we can get on what the

1 content of those visits is before we come up with that
2 payment system, and it shouldn't just be how would I
3 reallocate the payments that we're currently giving to get
4 the right length of -- some more normal length of stay, that
5 it should have some decent cost data in it.

6 So the only other question I had or topic that I
7 really don't even know how we would go about it but I just
8 wanted to hear what people had to say was do we need to look
9 at some of the incentives that go beyond just the providers'
10 incentives to the incentives of the families and the
11 incentives maybe even of the beneficiaries themselves,
12 because a lot of the people that are going into hospice
13 have, particularly when you look at the Alzheimer's and the
14 mental -- I mean, there were some pretty difficult diagnoses
15 here, organic psychosis, dementia -- and a lot of those
16 people, when they are not in hospice, if they are not in a
17 nursing home, they're trying to cope on their own or out of
18 pocket.

19 Obviously, when you get into hospice, you do at
20 least get a support system, and I think that's a good thing
21 on the one hand. On the other hand, that's not Medicare's
22 intent, I have a feeling. So should we be also trying to

1 understand the decision to go into hospice on the part of
2 the beneficiary a little better? There is a financial
3 incentive for many of them to go ahead and do that, or by
4 their families, who are often the guardians by the time they
5 do it.

6 I think we need to understand better why people
7 choose it and what's going into that thought process and
8 does it need a little modifying if, in fact, it is being
9 used as a substitute for custodial care for people who are
10 just difficult to take care of -- not that I want to deny
11 them care, but maybe the hospice benefit isn't the right one
12 and this isn't the place to put it. So I feel like we
13 haven't talked much about the beneficiaries and their
14 choices at this point and I think it would help to address
15 that in thinking about who is going in and why.

16 DR. CASTELLANOS: Just a couple of points. I
17 think we talked about payment. We talked about
18 recertification, which I totally agree with.

19 One of the things that I'm a little concerned
20 about is the data. We're just looking at the medical data,
21 but hospice is a better benefit than that. There's a
22 benefit for the patient with massage therapy, music therapy,

1 respite service for the family, and it doesn't end with
2 life. There's benefits after life with a support group, a
3 bereavement process. I mean, it's not just a finite period
4 and finite care. So I think if we could expand the data, I
5 think we'd be all a little bit surprised about how much they
6 provide, and it is different end-of-life care than the
7 normal end-of-life care.

8 One of the things that bothered me when I read
9 this, and I guess from a personal viewpoint, people elect to
10 go into here. As I said, it's a benefit for the
11 beneficiary, but it's a significant benefit to the family
12 and the surrounding family, the community, and society. The
13 better they do, and they really feel very, very welcome and
14 very, very appreciative of the care they get, and a lot of
15 these people give donations. Why are we requiring hospice
16 to report the donations? Is there any other Medicare
17 service where we kind of collect the data of donations to
18 that society? Maybe there is. Well, then maybe it is
19 appropriate, but to me, the donations are going to show that
20 that's the best group.

21 And one last point about outliers. I couldn't say
22 it better than anybody else. You know, everybody doesn't

1 follow the normal curve, and just because you're an outlier
2 doesn't mean you live in Florida and you're a criminal.

3 [Laughter.]

4 MS. BEHROOZI: Thanks. This was really great
5 work, and Kim, as you know, I was focusing a lot on the
6 accountability stuff. I appreciate in draft recommendation
7 2(a) on page 22 that you were taking into account the
8 recommendations of hospice providers whom you spoke to and
9 at the sort of extreme end, at the outlier end when the
10 cases exceed 180 days and they're in a hospice that
11 routinely has long lengths of stay, that would be a good way
12 to get to the ones, those that have routine excessive
13 lengths of stay.

14 But you talked in the paper about abuse and you
15 mentioned it in your presentation, at the going in it, where
16 hospices are certifying as eligible patients who have been
17 discharged by other hospices for failure to meet eligibility
18 criteria in the first place. So I would be a little
19 concerned if we are talking about abuse. I mean, that's
20 very clear in the paper that we're not talking about people
21 not making good judgments or it's not about the families
22 making choices to offload their care needs because the chart

1 that shows what some of these diagnoses are show that it's
2 institutionalized patients, nursing home patients that more
3 often have those long length of stay kind of diagnoses, like
4 Alzheimer's and whatever.

5 I don't know exactly what I would recommend as a
6 way to kind of get at that, to make sure that the initial
7 certification is really appropriately rendered without
8 gaming in mind, frankly. I mean, it looks like if there --
9 now gaming the system, we don't want to let them game it up
10 to 180 days, either. I mean, that's a lot of money that
11 Medicare would be paying that if you do a budget neutral
12 adjustment in the payment, you might not end up with
13 savings, but if you keep people out of the hospice payment
14 stream to begin with who shouldn't be there, that might
15 result in absolute savings. So, like I said, I'm not sure
16 what I would recommend, but I would suggest trying to figure
17 out how to stop the abuse at the front end.

18 MS. NEUMAN: Just one comment. I think the second
19 piece of the recommendation that requires certifications to
20 include a brief narrative describing the clinical basis is
21 intended to create greater accountability so that a
22 physician would have to say, I believe this person is

1 terminal because of X, Y, and Z, in a very brief way, and I
2 think our panel felt that that would help some in terms of
3 focusing accountability. But again, if somebody is truly
4 trying to game the system, that wouldn't necessarily go all
5 the way.

6 MS. BEHROOZI: I actually also forgot to mention
7 this, that one of the areas of great concern relating to our
8 earlier discussion is in the area of conflicts of interest
9 and common ownership and kickbacks, frankly, to medical
10 directors for referrals and things like that. So I
11 understand that that would be a sort of a front-end kind of
12 safeguard, but easily circumvented, it seems.

13 DR. MARK MILLER: The only thing I would say is
14 also remember the payment. A piece of the payment is linked
15 to the end of life, and if you're really consistently --
16 again, at the extreme, because I don't want to characterize
17 an entire industry -- at the extreme just ignoring
18 eligibility requirements and bringing people in who are in
19 for long periods of time, under a revised payment system,
20 there would be a block of payments that you would not see,
21 or at least not in a timely manner.

22 DR. MATHEWS: If I could also add something on

1 this point, you might recall, and it pertains to the
2 discussion of whether or not we should develop national
3 coverage decisions, the implication of what you are saying,
4 if you were saying we should control eligibility better on
5 the front end, last year we discussed this a little bit and
6 it relates to the difficulty in prognosticating the end of
7 life for a specific patient. If you have the criteria
8 relatively loose, you will admit a larger share of patients
9 who do not die within six months. However, if you make the
10 criteria too tight, you will exclude people from the benefit
11 who will die within six months, and so that's the balance
12 that the FIs who developed the coverage determinations and
13 the hospice medical directors themselves are walking in
14 trying to apply those criteria and it's a balance that we
15 need to be cognizant of, as well. Nonetheless, we'll see
16 what we can think up by way of items that could address your
17 concerns.

18 MR. BUTLER: The first comment, on the
19 recommendations directionally, I think are all very good,
20 given my limited knowledge of some of the technicalities.
21 But I also would support the per diem or some manipulation
22 of it as opposed to a case rate, and I'll explain why in a

1 minute. So I think you're right on target where you're
2 headed.

3 Now to make my other two points, I'll use my two
4 experiences with hospices to do it. One, a community
5 hospital, a community teaching hospital with a very strong
6 relationship with a large nonprofit hospice. The reason I
7 found this a little bit heartbreaking is that I worked for
8 two or three years with an exceptional medical director,
9 exceptional integration and education of the medical staff,
10 including rotations for the internal medicine residents to
11 be exposed to the palliative care concept, to take it beyond
12 hospice to treat some of the very diagnoses that are being,
13 quote, "abused," and tremendous education for students and
14 residents at a very early time that minimally invasive
15 treatment to handle pain of all kind in an aging population
16 is a good thing, and it started to have an impact on the
17 culture of the hospital. And so when you see that it is
18 having unintended effects in others, it kind of casts a
19 shadow on all of the non-cancer diagnosis advancements we've
20 made in hospice care and I hope we don't lose that.

21 For that reason, too, I think the case payment, no
22 matter how you manipulate it, I'm skeptical, because that

1 very invitation to kind of let the normal doctor let go or
2 at least partner might be inhibited and you don't want to do
3 that. So that's point one.

4 The second experience is where we sold a hospice
5 and it was one of those provider-based. It was not making
6 money. We were having trouble with it, and that was part of
7 my question before, because now we let it go and it is kind
8 of the same pattern as we looked at in psych or in skilled
9 nursing or others where you see growth and you see growth in
10 for-profit freestanding pieces of our continuum. At the
11 same time, we talk on that side about -- we watch that go on
12 and we talk about episode of care and bundling and
13 accountable health care organizations, so we see a
14 disaggregation over here of what we are trying to aggregate
15 over here. Where it becomes very real for somebody like me
16 is as we've got our electronic health record and we are
17 literally making decisions today about how we scan in and
18 what we need to scan in from these other continuum of the
19 care so we have the whole picture instead of just a piece of
20 the picture.

21 So that's just a general observation as we watch
22 the trends in these things. How do we try to reintegrate

1 what we disintegrated in some respects while recognizing
2 that some institutions, like hospitals, aren't always the
3 best to run some of these entities because it's not a core
4 competency, but it's a real dilemma that we're in that if
5 we're really going to get around treatment of the fragile
6 elderly patient, we have to find a way to make sure we're
7 continually reinforcing collaboration and partnership as
8 opposed to silos that are kind of tough to reconnect once
9 you've disconnected them.

10 DR. BORMAN: First, I would say that I generally
11 support the direction that we're going in this very fine
12 analysis, which even as a Plain Jane general surgeon, I
13 think I understood, which is scary.

14 I would wonder where we view this work fitting in
15 terms of is this a piece generally of evaluating different
16 parts of the payment system, almost like a piece of the
17 update process or related to that, or do we see this more
18 interdigitating with some of the sustainability issues about
19 looming problems and things we have to do better. I guess I
20 need a little bit better sense for that. I'm not sure it's
21 appropriate, and the answer to that would help me a little
22 bit about knowing whether surrounding this stuff, or maybe

1 it's somewhere else in the context after something, that we
2 need to comment about -- just reiterate the percentage of
3 expense that happens in the last year of life, some of our
4 thoughts about how sensitive an issue this is, the cultural
5 pieces that we all understand and that we want to be very
6 up-front about, but that as a fiduciary and professional
7 obligation of this Commission we have to look at it, and a
8 sense of where this fits into our evolving notions about
9 delivery systems and where some of these dialogues should
10 happen.

11 Hospice, presumably, follows on some conversations
12 between -- or that include patients and families and
13 providers, and certainly the issue of medical home and all
14 those kinds of things will wrap up into this a bit. Some of
15 the conversations, or some of those activities might, in
16 fact, ultimately impact are the right people being
17 considered for hospice and do we have a benefit that meets
18 those kinds of needs in that delivery system that we think
19 we're working toward.

20 And so I have a feeling it kind of doesn't belong
21 here, but I guess I am asking where that contextual piece
22 belongs and would we refer to it from here? Would we have a

1 cross-reference from that part to here? Just kind of how
2 does that background and context stuff relate to this very
3 specific evaluation of a benefit and some recommendations
4 about where we go with it. A rhetorical question.

5 DR. MARK MILLER: All right. Then maybe I'll take
6 the first shot at it. When I think about some of the things
7 that we do, there's kind of, particularly for December, for
8 example, we're going to be talking about ongoing payment
9 systems, what do we think about what the payment rates
10 should be. But we also have had conversations within
11 administering given Medicare systems about the guts of the
12 system and kind of the underlying equities and whether
13 distortions are occurring. A real good recent one was the
14 skilled nursing facility, where we felt non-therapy
15 ancillary is way out of whack, needed to bring that back.

16 I see this more in that category. We're sort of
17 stepping into this, because we had to educate ourselves over
18 the last year, which you were also part of, and now we're up
19 to can we get kind of the underlying dynamics of this
20 correct. It would be later, but again, to Bruce's point,
21 no, not later, to talk about, well, what is the proper
22 amount to be paid here. I would see that as kind of coming

1 later.

2 In terms of sustainability, this, like many other
3 things, and I know this frustrates some people out in the
4 more general policy world, when something is going really
5 fast and going up, it tends to attract attention and this,
6 like other types of service, was one of those. I mean, to
7 Bruce's point on the payment, is when you have supply
8 increasing at this rate, it certainly raises the question of
9 whether your payment rates are inadequate.

10 So in my mind, the context of this is, like a lot
11 of things, kind of hit the sustainability radar, but it's
12 really more about sort of the patterns we are observing here
13 that struck us as a payment system badly out of whack, which
14 some of that came up again over here. That's the context
15 that that, in my mind, is in.

16 MR. HACKBARTH: Yes. To me, it's how do we
17 achieve -- improve the accuracy and equity in the payment
18 system with an eye towards the original goals of this
19 program, which to me were twofold. One is to provide a
20 humane, compassionate alternative for patients, and the
21 second was potentially to reduce Medicare expenditures if
22 that alternative didn't rely as much on heroic measures.

1 And so those are sort of the beacons for our effort to
2 revise the payment system and improve its accuracy, if you
3 will.

4 DR. MATHEWS: If I could add a couple of things on
5 this point, and they are more related to the relationship of
6 hospice to larger delivery system reform issues, and I'll
7 pick up on two things that Peter mentioned. One, going back
8 to the slide on length of stay, we talked a little bit about
9 the short-stay patients. Very short stays in hospice tend
10 to reflect very late referral in the course of the patient's
11 terminal disease trajectory and it usually indicates that
12 the referral to hospice has occurred after a period of
13 intensive, say, Part A interventions at the end of life. So
14 in those situations, arguably, the patient hasn't gotten the
15 benefit of everything that hospice has to offer, nor has the
16 program gotten the benefit in terms of hospice's potential
17 to result in lower expenditures at the end of life.

18 Now, the reasons for those short stays are
19 several-fold and they're fairly complex. At a very crass
20 level, I mean, the Part A provider has an incentive to hang
21 onto a patient and do as much as they can for that patient
22 before discharging them to hospice. There are also

1 individuals' sort of mindsets regarding hospice, and these
2 occur both at the patient level where the patient is not
3 willing to concede that the end is near, and it also goes
4 back to that it invokes medical education, where the
5 physician is trained not to give up, to do everything they
6 can to preserve the patient's life.

7 And so to the extent you can involve hospice in
8 medical education programs the way that Peter just
9 mentioned, and this was a theme that some of our panelists
10 mentioned, as well, if you can change the medical
11 community's mindset in a way to recognize the value of
12 hospice to the patient and the program, you could see
13 hospice as sort of an integral and proactive part of
14 delivery system reform.

15 DR. BORMAN: Just a follow-up comment. It sounds
16 like this piece is particularly sort of more nuts and bolts
17 and that's fine, and as I've said, I support the direction
18 that we're going. When we were talking a while back to some
19 degree, if I recall right, it was in the context of medical
20 home and coordination of care, I'd just like to take this
21 opportunity on this subject to say that I think somewhat
22 related to this -- this being a downstream effect, that we

1 really do need to think about a piece of coordination of
2 care is some conversation about advanced directives and
3 thoughts. Thinking about this reminds me of that and I'd
4 like us not to lose track of that, because I think hospice
5 and a whole host of things are the downstream of not paying
6 attention to that when the decision is less pressured.

7 As a surgeon, I have the opportunity to have these
8 kinds of discussions routinely under pressured
9 circumstances, at two in the morning about somebody has
10 asked me to come comment on an operation on somebody that's
11 essentially moribund. Those are very difficult
12 conversations to have and frequently it uncovers that
13 there's been very little thought generally about what Great
14 Aunt Minnie would want, and it becomes less about what Great
15 Aunt Minnie would want than about what the relatives' values
16 are and their guilt about the fact that they didn't visit
17 with Great Aunt Minnie. So having seen that this clearly is
18 in more of a nuts and bolts context, then I would make the
19 pitch that we not lose that other contextual piece in our
20 other work.

21 MS. HANSEN: Well, by now, I think many of the
22 points are made and I will definitely pick up on Karen's

1 point, but I have three short ones.

2 One is I just want to build on what Bill has
3 brought up and other people have said about some universal
4 national way to define the program. And in addition,
5 besides the nursing home facilities is to consider the
6 assisted living, but there's also a tremendous number of
7 people living in residential care facilities, and that's a
8 whole another group of people if we are going to be looking
9 at populations in terms of their characteristics and where
10 they potentially pass away and the need of hospice care.

11 The other thing is relative to -- I just want to
12 acknowledge, really, the leadership of the group of focus
13 individuals who came together to ask for some greater
14 accountability about the program, and that is a leadership
15 role rather than saying, no, don't look at us. We really
16 have heard, I gather, that people are saying, let's make
17 sure that we are producing quality for patients and families
18 but also for Medicare.

19 One of the things that, just kind of thinking
20 about just the description of the types of programs, I know
21 one of the signature pieces that hospice programs have
22 traditionally had was that of the volunteer program that was

1 accompanying it that was deeply done with volunteers as part
2 of their workforce who had to actually get education and
3 training for 100 hours. I just wonder if that's part of the
4 profile now of hospices as we start to see today, just so
5 that we get an understanding, much as Ron has pointed out
6 that traditionally hospice provides care for family members
7 for a year afterwards. So are those services still part of
8 what hospice as we know it and define today, whether it's
9 operated by a not-for-profit or a for-profit, truly offer?

10 The last point I have is relative to Karen's last
11 point, and Jack, your earlier point about just where does
12 this fit in the total cost of saving money or being a part
13 of the Medicare side of it. I just wonder, that since
14 hospice historically had been so modestly used for years,
15 but at the same time we have so many Medicare expenditures
16 in the last six months of life for people as a whole, I
17 wonder if we look at this from a continuum standpoint if
18 hospice was an appropriate resource and used much earlier,
19 whether there's any research or modeling that can be looked
20 at as to what the dollars are that are expended.

21 And there's a bit of an illusion that this is
22 where providers may not want to let go of people while

1 they're in acute care because of all the added, quote,
2 services and billing that comes with it, but it's oftentimes
3 because advance directives were not really done, and whether
4 that whole kind of continuum of looking at it from the
5 Medicare beneficiary, what the impact to Medicare dollars
6 expended might be arrayed a little bit more fully.

7 So I just don't remember what Medicare spends on
8 the last six months of life, but that always seems to be a
9 big number and we could begin to try to attach that somewhat
10 as a context piece to why the hospice program is not only a
11 compassionate program and humane program, but it may have
12 some Medicare levers of savings if used appropriately.

13 MR. GEORGE MILLER: Thank you. And Jennie teed up
14 what I was going to say a little bit about what Peter talked
15 about, the integration of care. At a hospital in Illinois,
16 we hired part-time a palliative care physician who part-time
17 was the director of the hospice program and she worked with
18 us to review patients in the ICU and the CCU to see and
19 determine if it was appropriate for them to be there versus
20 should they move to a palliative care with a full
21 integration. And over time, we were able to, and I realize
22 this is anecdotal, but we were able to lower costs because

1 of her intervention. So I think hospice has a very good
2 place and is part of the full integration of care and it's a
3 very good program.

4 The other side of it, though, to Ron's point, it
5 appears to be from the data in this report there are some
6 abuses and we've certainly got to address those abuses from
7 the fringe. I want to ask the question on the third
8 recommendation in 2(a), have we considered and looked at the
9 Joint Commission as part of the process? Less than six
10 months ago, I went through a Joint Commission audit and they
11 asked some of the same questions of us that you alluded to
12 that were not being asked by the FI here.

13 I'm wondering if you had stratified that. If
14 someone had a Joint Commission certification, did they have
15 the same type of problems that your report seems to
16 indicate, because they would deal with appropriateness of
17 care. They would make sure that the medical records by the
18 physician and had certification, all those things were being
19 done. I don't know if, of all of the programs you looked
20 at, if there was a demarcation line if a hospice program was
21 Joint Commission certified and they did not have the same
22 type of issues and problems.

1 DR. MATHEWS: We have not looked at that
2 particular characteristic --

3 MR. GEORGE MILLER: You have not.

4 DR. MATHEWS: -- but it is something we can
5 pursue and get back to you with.

6 MR. GEORGE MILLER: Okay. Thank you.

7 DR. CHERNEW: Thank you. This has been a
8 fascinating discussion and I think it's a troubling one
9 because there are so many different angles, but I guess
10 where that leaves me is the academic side of me feels like
11 saying that I'm not comfortable with a lot of the
12 recommendations until there's a more detailed behavioral
13 component to the policy analysis. In other words, I'm just
14 not sure how whatever we would ultimately recommend, what
15 would that do, not just on the hospice side, but on the
16 other things that aren't hospice. What would that do to the
17 acute care? What would that do to all the other things?

18 The sort of more managerial side says, given
19 what's presented, I'd hate to hold hostage improvement in
20 policy for want of sort of the perfect policy, and so I do
21 think that I'm sympathetic to potentially doing something.

22 So I guess where I would come out to reconcile

1 those two sides, given this whole debate, is perhaps a
2 little better discussion of what if. If we were to do
3 something like this, and if the length of stay were to drop
4 back to where it was in 2002, these people wouldn't be
5 getting hospice care, or they were getting shorter hospice
6 care. That means they would be spending X months longer
7 prior to admission to hospice and that would suggest things
8 would be just as good, they'd get two more admissions in
9 that period, their family -- I'm not sure what the "what if"
10 is. But I would be thrilled but I doubt it's possible to
11 have a really analytic answer to the policy analysis
12 behavioral response question, but at least some sense of how
13 the world would change apart from paying less for the exact
14 same services, in fact, in this case, paying the same for
15 the same services, just differently, would be really useful
16 for me as we move on to recommendations with some teeth.

17 MR. HACKBARTH: Okay. I think it is going to be
18 difficult to have an analytic answer to that question, but I
19 agree wholeheartedly that that's a logical question, an
20 appropriate question for Congress to ask in considering this
21 sort of a change. So I think we need to take a stab at it
22 as best we can.

1 Okay. Good discussion, and obviously more on this
2 later.

3 Our last item for today is improving payment
4 accuracy for imaging.

5 MR. WINTER: Good afternoon. I'll be talking
6 about payment accuracy for imaging services in the physician
7 fee schedule. This is one of the topics that came up during
8 the expert panel that we had on imaging at the September
9 meeting. Much of the material I cover today has appeared in
10 prior MedPAC reports and comment letters on proposed rules.
11 We plan to discuss this issue in the physician update
12 chapter for the March report. I want to thank Nancy Ray and
13 Hannah Miller for their help with this work.

14 Just some background to start off with. There has
15 been impressive technological progress in imaging which has
16 increased its importance for diagnosis and treatment and
17 expanded the availability of imaging services in free-
18 standing centers and physician offices. However, the rapid
19 growth of imaging services within Medicare, geographic
20 differences in imaging use, and variations in the quality of
21 providers have raised concerns about whether imaging is
22 sometimes used inappropriately. Over the last few years,

1 the Commission has focused on improving both the quality and
2 payment accuracy for imaging services.

3 This slide reviews or describes Medicare's
4 physician fee schedule. The payment for service is based on
5 its relative value units, or RVUs, and there are three types
6 of RVUs: practice expense, physician work, and professional
7 liability insurance. Practice expense accounts for almost
8 half of spending on physician services. It includes direct
9 costs, which are non-physician clinical staff; medical
10 equipment and medical supplies; and indirect costs, which
11 are administrative staff, office rents, and other expenses.

12 In 2007, CMS made important changes to the
13 practice expense method and data which affected payments for
14 many services. This was a budget-neutral change. It
15 shifted RVUs from imaging services and major procedures to
16 other procedures, tests, and evaluation and management
17 services. Despite the impacts, we believe that there are
18 opportunities to further improve payment accuracy for
19 imaging.

20 So let's review for a moment why payment accuracy
21 is important. Inaccurate payments can distort the market
22 for physician services. Overvalued services may be over

1 provided because they are more profitable. Some providers
2 may not furnish undervalued services, which may threaten
3 access to care and affect the supply of physicians. Other
4 providers may increase the volume of under-valued services
5 to maintain their overall level of payments. In addition,
6 when services are misvalued, Medicare is paying too much for
7 some services and not enough for others, which means it's
8 not spending taxpayers' and beneficiaries' money wisely.

9 On the topic of payment accuracy, it's important
10 to remember that the Commission made several recommendations
11 in 2006 for CMS to strengthen the process by which it values
12 physician services, such as creating an expert panel to help
13 identify overvalued services and to review recommendations
14 from the RUC.

15 Although CMS has not created this expert panel,
16 they have recently taken some steps to identify potentially
17 misvalued codes. For example, in the physician fee schedule
18 final rule that was issued last week, CMS announced that it
19 has sent a list of about 100 codes that experienced rapid
20 volume growth to the RUC for review.

21 Here we see how the physician fee schedule pays
22 for imaging services. There are two portions to an imaging

1 service: the technical component, which is performing the
2 study, and the professional component, which is interpreting
3 the study and writing the report.

4 Medical equipment accounts for a significant
5 portion of the practice expense payment for the technical
6 component of advanced imaging services. By this I mean CT,
7 MRI, and nuclear medicine.

8 Now we're going to focus on how CMS estimates the
9 cost of medical equipment for a service. The cost of the
10 equipment for a service equals its estimated cost per minute
11 times the number of minutes it is used for that service. To
12 determine the cost per minute, CMS uses a formula to spread
13 the machine's purchase price over the number of minutes it
14 is projected to be used during its useful life, taking into
15 account the cost of capital and maintenance costs. In this
16 formula, CMS assumes that all equipment is used at 50
17 percent of the time that a practice is open for business.
18 CMS uses this number for all equipment because it was unable
19 to obtain data on use rates for specific equipment.

20 If equipment is actually operated more frequently,
21 the cost per service declined. This is because the fixed
22 cost of the machine is spread across more units of service.

1 In 2006, MedPAC's sponsored a survey by NORC of
2 imaging providers in six markets. The survey found that MRI
3 and CT machines were used more than 50 percent of the time
4 that providers were open for business per week. As you can
5 see on the chart, providers in these markets used their MRI
6 machines about 90 percent of the time they were open for
7 business on average, and that's the red bar at the far left.
8 The median use rate was 100 percent, which is the green bar.
9 On average, CT machines were used 73 percent of the time
10 that providers were open for business with the median of 75
11 percent, and those are the two bars at the right. Although
12 the survey results were not nationally representative, they
13 are representative of MRI and CT providers in the six
14 markets that were surveyed.

15 These results raised questions about whether CMS
16 underestimates how frequently providers use MRI and CT
17 machines. In addition, Medicare's use rate could be
18 encouraging lower-volume providers to purchase expensive
19 machines. CMS acknowledges that its 50-percent assumption
20 is not accurate for all types of equipment, but says that it
21 lacks sufficient evidence to justify an alternative rate.

22 Here we'll look at two options for updating the

1 equipment use rate for expensive machines. First, you could
2 base the rate on empirical evidence from a survey of
3 providers, and the AMA is fielding a national survey on
4 physician practice costs, which includes questions about the
5 use of high-cost equipment. However, if the survey shows
6 that providers are operating these machines infrequently, do
7 we want Medicare's payment rates to be based on a low-
8 volume, inefficient level of use?

9 Another option would be to set a standard based on
10 an expectation of efficiency; in other words, providers who
11 purchase costly imaging machines would be expected to use
12 them at close to full capacity, with some allowance for down
13 time for maintenance and patient cancellations. In fact,
14 the NORC survey found that several providers operate their
15 MRI machines more than 90 percent of the time. In this
16 approach, Medicare would be encouraging efficient, high-
17 volume use of expensive equipment through its payment rates.
18 We would also be discouraging low-volume providers from
19 purchasing these machines, which may reduce excess capacity.

20 This principle could be applied to machines that
21 cost more than \$1 million, such as MRI, CT, and PET
22 machines; or even extended to machines that cost more than

1 \$500,000, which would include the cameras that are used for
2 nuclear medicine procedures.

3 We contracted with NORC to estimate the impact of
4 increasing the equipment use rate for imaging machines on
5 practice expense RVUs. This model assumes that the changes
6 would be budget neutral -- that is, dollars from imaging
7 services would be redistributed to other services. It does
8 not account for the effect of the outpatient PPS cap
9 mandated by the Deficit Reduction Act, which I will get into
10 more later.

11 In addition, the baseline assumes that CMS has
12 fully phased in the changes to practice expense RVUs that it
13 began making in 2007. In reality, CMS is phasing in these
14 changes over 4 years.

15 So if you look at the table, you'll see that if
16 CMS were to increase the equipment use rate to 75 percent
17 for MRI and CT machines, practice expense RVUs for imaging
18 would decline by about 6 percent, while other categories of
19 services would increase. About \$600 million per year would
20 be redistributed from imaging to other services. If CMS
21 were to increase the equipment use rate to 90 percent,
22 imaging practice expense RVUs would decline by about 8

1 percent. About \$900 million a year would be shifted from
2 imaging to other services.

3 We also modeled increasing the use rate for the
4 cameras used for nuclear medicine procedures. This would
5 redistribute an additional \$100 million a year from imaging
6 to other services under either the 75-percent or 90-percent
7 rate.

8 Now I'm going to switch gears to discuss how CMS
9 estimates the number of minutes equipment is used for a
10 service. Here, again, we see the formula for calculating
11 equipment cost per service. It's a function of the cost per
12 minute times the number of minutes it's used for that
13 service. CMS bases its estimate of the number of minutes
14 imaging equipment is used for a service on the amount of
15 time it takes a radiology technician to perform the study.
16 These time estimates were recommended by a practice expense
17 Committee established by the RUC, and this committee
18 developed the time estimates for most MRI and CT services in
19 2002 and 2003.

20 Recent advances in CT technology, such as the
21 development of 64-slice CT scanners, have made it possible
22 to scan patients faster. Similarly, the introduction of

1 more powerful MRI machines has reportedly reduced imaging
2 times and increased patient throughput. Even providers who
3 are still using older machines could be performing more
4 studies in less time as they become more familiar with the
5 procedures and the equipment, and this is the process of
6 learning by doing.

7 The time estimates used by CMS for MRI and CT
8 studies may not reflect reductions in scanning time, which
9 could result in overstating the equipment and radiology
10 technician costs. CMS could request that the RUC review the
11 time estimates for these services to ensure that they are up
12 to date.

13 As I mentioned earlier, CMS recently sent a list
14 of about 100 codes that experienced rapid volume growth to
15 the RUC for review. There were 13 CT codes and one MRI code
16 on this list. But there are many more codes that use these
17 machines, and these other codes might also merit review.

18 Up to now, we've talked about two changes that CMS
19 could make to the practice expense RVUs for imaging. If CMS
20 were to make these changes, their impact would be affected
21 by a policy from the Deficit Reduction Act that caps the fee
22 schedule rates for the technical component of imaging

1 studies at the rates paid under the outpatient PPS. In
2 other words, Medicare will not pay more for an imaging study
3 performed in a physician's office than it pays in a hospital
4 outpatient department.

5 Before this policy was adopted, physician fee
6 schedule rates were higher than outpatient rates for many
7 imagine codes. This provision reduces the fee schedule
8 amounts for these services and returns the savings to the
9 Part B trust fund; in other words, the policy is not budget
10 neutral.

11 A recent GAO study found that about two-thirds of
12 advanced imaging tests were affected by this cap and were,
13 therefore, paid at the outpatient rate in 2007. Thus,
14 reducing practice expense RVUs for advanced imaging studies
15 or revising the equipment use rate and the time estimates is
16 unlikely to affect the payments for many of these services
17 in the short term. This is because the payment rates for
18 many imaging codes would be reduced anyway by the outpatient
19 cap.

20 Despite the presence of the outpatient cap, it may
21 still be worthwhile for CMS to improve the accuracy of the
22 physician fee schedule and to encourage efficient use of

1 expensive imaging machines. In addition, the impact of the
2 outpatient cap will decline over time if outpatient rates
3 increase faster than physician fee schedule rates for
4 imaging services.

5 One final issue to keep in mind is that savings
6 from the outpatient cap are returned to the trust fund
7 rather than being shifted to other physician services.
8 However, when CMS changes how it calculates practice expense
9 RVUs, these changes are budget neutral. So, for example, if
10 CMS were to increase the equipment use rate, dollars from
11 imaging RVUs would be redistributed to other physician
12 services. In this case, the outpatient cap would have less
13 of an impact because fee schedule rates would already be
14 lower. This would reduce savings for the trust fund, but it
15 would expand the pool of dollars for physician fee schedule
16 services.

17 I will finish up with some questions for you to
18 consider. Should Medicare's equipment use rate for costly
19 imaging machines be based on an efficiency standard? Should
20 the time estimates for MRI and CT studies be updated? And,
21 finally, are there other practice expenses used that we
22 should consider?

1 MR. HACKBARTH: Okay. Let me see hands for
2 clarifying questions. Nancy and then Jack.

3 DR. KANE: For the outpatient cap, what is the
4 assumption in the outpatient rate about machine time, or is
5 there one?

6 MR. WINTER: It's based on data on charges and
7 costs from possible outpatient departments. So whatever
8 their charges are reduced to their costs at the department
9 level, that's the basis for the outpatient rates. So if
10 they're using them efficiently -- whether they're using them
11 efficiently or not, that's what the rates are based on.

12 DR. KANE: But they must have some volume that
13 they divide that cost into? Or, you know, where do you get
14 the rate? What's that? So there is some real volume
15 standard built into the hospital rate because you're using
16 the total cost into the real volume. So, in effect, that's
17 at least some way to get it down to the level of -- okay.
18 That was my question.

19 MR. WINTER: It could be that hospitals are using
20 them very frequently or not very frequently. We don't know.
21 Per machine. Per machine, sort of new overall.

22 MR. EBELER: Ariel, I'm sure that you've answered

1 this before. The assumption of 50 percent of the time that
2 the practice is open, what's the assumption about the amount
3 of time that the practice is open?

4 MR. WINTER: CMS assumes that the practice is open
5 50 hours per week, and that was based on data from the AMA
6 and the MGMA. In our survey, we did ask --

7 MR. EBELER: That's including at an imaging
8 center, that it would be open 50 hours per week?

9 MR. WINTER: Basing that across all practices and
10 providers in the physician fee schedule. When we did our
11 survey, we found that, on average imaging providers -- MRI
12 and CT providers, at least, were open more hours than that
13 per week.

14 DR. CHERNEW: I didn't catch -- and it's probably
15 my fault -- why the percent time thing is actually budget
16 neutral.

17 MR. WINTER: When CMS makes any changes to the
18 practice expense RVUs or other RVUs -- work RVUs -- any
19 savings or any money that's freed up from, let's say,
20 reducing RVUs for some services are redistributed across
21 other services. It's a statutory requirement that any
22 changes be used for budget control.

1 DR. CHERNEW: If we found any of the ones with
2 over -- if we found that any RVU was overpaid and said that
3 should go down, by statute it would be redistributed across
4 other things.

5 MR. WINTER: Correct.

6 MR. HACKBARTH: Ariel, in the physician fee
7 schedule, generally what we're trying to do is work with
8 empirical estimates of relative costs. Now, the data aren't
9 always great for making those estimates, but it's
10 empirically driven. At least that's been my understanding.
11 Here what we're considering is using a normative standard,
12 thus departing from what has been the practice in the past.
13 That normative standard would be consistent with the idea of
14 an efficient provider, and it's appealing in that regard.
15 But could you address what the implications might be of
16 departing from empirical estimates and starting to use
17 normative estimates? We're changing the fundamental rules
18 of the system.

19 MR. WINTER: That's a good point, and the idea
20 behind the system is to estimate relative resource use for a
21 typical service. This would be using the -- trying to
22 encourage efficiency through the RVU process rather than

1 through the conversion factor or some other mechanism in the
2 payment system. And you could think about extending this to
3 other types of equipment perhaps or other types of services
4 where you'd want to encourage more efficiency through
5 setting the RVUs differently rather than through some other
6 factor.

7 I'm sorry I can't go beyond that. We can try to
8 go back and think about other implications, though.

9 DR. SCANLON: This is partly in response to what
10 you just said, because it seems to me that the NORC data
11 provide us an opportunity to make changes based upon
12 empirical data or suggest that if we have more empirical
13 data, we would want to be making changes that would move
14 towards lower fees and potentially more efficiency.

15 Having an efficiency standard by itself I always
16 find problematic because it's very hard to know what is
17 truly efficient. So I guess I'd like the idea that we
18 potentially can gain by having more data and paying
19 attention to it.

20 Having said that, and earlier arguing for
21 something on a national basis, let me now argue for
22 something on a geographic basis, which is the fact that one

1 of the key criteria in setting payment rates and getting
2 them right is to maintain access for Medicare beneficiaries.
3 And in something like this with equipment, there's a real
4 issue in terms of density and sort of then the market that
5 you're talking about.

6 And so just to pick two states at random,
7 providing MRIs in Montana and Iowa might be different than
8 providing them in New York or Pennsylvania. You just have
9 sort of lower density there, and the machines are not going
10 to be operated to the same extent. And you could say, well,
11 we'd like them to be operated -- you know, we'd like people
12 to travel more. But we're talking about distances there
13 that may be really problematic for people to swallow.

14 So we have a precedent here, which is ambulance
15 payment in Medicare, where we take into account sort of the
16 density of the community, and I think it's the kind of thing
17 where we may want to think here, too, you know, we have a
18 weight adjustment in the fee schedule; do we need to have a
19 density adjustment if we're going to make some kind of
20 aggressive adjustment of utilization?

21 DR. REISCHAUER: You know, that's true for high-
22 level hospital care. It's true for specialist care. It's

1 true for everything in Medicare. You know, so why would you
2 want to necessarily adjust imaging when we don't adjust all
3 these other things?

4 DR. SCANLON: Well, we have already made some
5 adjustments, but it's in the other direction. And I guess
6 I'd rather do that in terms of this fee schedule than to
7 start down the path which we have with the critical access
8 hospitals and put everybody back on a cost basis. I don't
9 want to do something that wipes out sort of MRIs in these
10 areas and then have to backtrack and say, okay, here's going
11 to be our new strategy for dealing with this. I'd rather
12 have one system that brings in adjustments that are
13 legitimate. Okay? It costs more to deliver that service in
14 a sparsely populated area.

15 MR. BERTKO: I'm going to speak as one of those
16 people who live in a corner of a sparsely populated state, a
17 sparsely populated end of it. If you're going to go to that
18 kind of geographic variation, I mean, it's normal for people
19 in my end of Arizona to drive 70 miles to go to Wal-Mart. I
20 don't think you need to have an MRI every 20 miles apart.

21 MR. GEORGE MILLER: If you happen to bleed and
22 they need a CT, you don't want to drive an hour.

1 MR. BERTKO: We have helicopters for that.

2 MR. GEORGE MILLER: I just can't imagine the
3 former President of the National Rural Health Association
4 would be thrilled to hear that statement. I'm just sorry,
5 it -- you wouldn't limit a fireman because there are small
6 fires and say you can't get a fire truck, if that's a good
7 analogy.

8 MR. BERTKO: It's not.

9 MR. GEORGE MILLER: Okay. Well, you don't pay a
10 fireman by the fire then.

11 MR. BERTKO: If you had an accident in Arizona in
12 the four corners, you wouldn't want to be treated by a
13 facility there because they wouldn't see many of them.
14 You'd want to be helicoptered into Flagstaff where they've
15 got the big machine.

16 MR. GEORGE MILLER: Okay, but you at least would
17 want the CT done at that facility so it would be already
18 done --

19 MR. BERTKO: In Flagstaff, not in the four
20 corners.

21 MR. GEORGE MILLER: Okay.

22 MR. BERTKO: There ain't nothing there.

1 MR. GEORGE MILLER: Well, I would be concerned
2 about the statement we would discourage low-volume providers
3 from purchasing costly equipment. That still could be a
4 rural hospital that has the capability of providing
5 diagnostic testing to determine whether that person needs to
6 be flown to Flagstaff. We shouldn't make policy to
7 determine --

8 MR. HACKBARTH: Yes. Important points are being
9 made here about different geographic circumstances. To me,
10 it's always -- you need to think carefully about where you
11 want to make those adjustments. I always have sort of a
12 negative reaction when, well, there's special circumstances,
13 therefore, we shouldn't change it for anybody because it
14 doesn't accommodate the special circumstances of a low-
15 volume rural provider.

16 I think the appropriate policy response is you
17 make a sensible change for everybody, and then if you need
18 to make special adjustments for providers in particular
19 circumstances, you do that.

20 So, for example, in a case of hospital payment,
21 we've looked at low-volume adjustments. There are certain
22 circumstances where providers are just not going to have

1 high volume. Their costs per unit are, therefore, going to
2 be higher. And so we deal with it at that point.

3 I'd really be reluctant to --

4 DR. SCANLON: We're talking about just two paths
5 to the same end, and, you know, the idea of -- I think we
6 are. You know, it's the issue of sort of where are the
7 parameters in this process. It's not the question of the
8 structure. And it's not sort of trying to have an MRI every
9 20 miles. It's maybe having an MRI every 150 miles or
10 something like that, because maybe 50-percent utilization is
11 the right level for a sparsely populated area and 150-
12 percent is the right level for a very dense area, because,
13 you know, this assumption of 50 hours a week may be
14 incredibly conservative in some areas. I've been in places
15 where they run two shifts. That's 80 hours a week.

16 This is the issue of are we -- when we talk about
17 right prices, how much do we want to invest in calibrating
18 these prices to be truly right, because the low-volume
19 adjustment is exactly the same idea. It's just using a
20 different --

21 MR. HACKBARTH: Yes, well, let's get some other
22 people involved. I agree that they are two different

1 approaches for getting to a similar end, but I think there
2 may be some policy reasons to prefer one approach over the
3 other.

4 DR. CHERNEW: The question I was going to ask --
5 maybe it's a little off base. It wasn't clear to me that
6 full use is always efficient use. It might using the
7 machine efficiently, but it doesn't mean that the actual use
8 of the machine is always efficient. And so somehow one has
9 to think through the issue of what the payment rate is in
10 conjunction not just with what it costs to provide a
11 particular care, but how we get the incentives to provide
12 the right care. And I think that's really a challenge in
13 some of these high-fixed-cost, low-marginal-cost services
14 where the pricing, if you pick just one price and you try
15 and get that price to get an average cost, by definition
16 you're going to be overpricing the marginal use and
17 encouraging inefficient care. And so I'm not sure what to
18 do about that.

19 DR. MARK MILLER: [off mic] That's where we are
20 now.

21 DR. CHERNEW: I understand. The challenge,
22 though, if you lower is to be closer to the marginal cost,

1 then you think you've gotten it right at some level. But
2 now you have a disincentive to invest in places where you
3 think there might be a fixed cost. So there would be some
4 other --

5 DR. MARK MILLER: [off mic] And then I think that
6 gets back to should it be executed through a price or some
7 other exception.

8 DR. CHERNEW: Exactly.

9 DR. CASTELLANOS: Let's get back to payment
10 accuracy. I think we all want to get the payment closer to
11 the cost. I don't think there's any question we want to do
12 that. And I appreciate MedPAC's survey on six markets, but
13 these are large communities. We all recognize that CMS
14 went to AMA, and there's a national survey that's in
15 progress right now involving every specialty all over the
16 United States. And I would certainly be -- we talked about
17 data. I would certainly like to get that data, which is
18 going to be a better database than just six individual large
19 communities. I'm not sure when that data is going to be
20 available.

21 As far as cost per minute, I have a CT scan. It's
22 one slice. I don't have a 64-slice, and I can't afford a

1 64-slice. So, you know, I think you have to be a little bit
2 reasonable about cost per minute.

3 I think you need to see where we stand today, and
4 if you look at the data, we saw a little bit of it last
5 month on that last presentation where we did look at
6 imaging, and imaging was flat as opposed to every other cost
7 in the medical community. And the utilization rate for 2007
8 is still high, but it's down 5 percent from the year prior
9 to that.

10 DR. CASTELLANOS: Yes, but it's down. Okay? And
11 we can also see there's a site of service change and the
12 high x-ray things -- the MRI and the CT scan -- they're
13 going to back into the hospital. If you look at the data,
14 there's a site of service change.

15 So health policy so far has worked, and I
16 congratulate us for doing what we did, because we did the
17 right thing. But let's get the data first before we jump at
18 some assumptions.

19 MR. EBELER: I think your first question here in
20 some ways is the policy framework we've been grappling with
21 in other areas, whether we should be starting to norm
22 payment not on averages but on some definition of efficiency

1 and effectiveness. Our problem has typically been, geez,
2 how do you do that? It strikes me that this is an area
3 where in the short term there may be a way to do that. It
4 seems to me the suggestion you've come up with is a metric
5 that lets us get an overpayment a little more accurate.

6 It strikes me as a valuable direction. You
7 clearly need to adapt to communities in some ways that need
8 access to a fixed capital item that don't have that type of
9 volume. But I don't think we want to make national policy
10 for other areas based on those exceptions. It seems to me
11 you make the policy and then make sure you deal with those
12 low-volume areas.

13 So it strikes me that the policy vector for the
14 Commission is, as we head down this path, are we going to
15 try to slowly norm where we can against a more efficient and
16 effective provider? This is very appealing to me on that
17 score, so I like this direction and would almost push
18 harder. You flag it a little bit in the paper. Are there
19 other areas in which one might consider such a direction? I
20 think that's the hard discussion.

21 Again, I'm not saying that there's a magic here
22 that this fixes everything in health care, but the bullet

1 point one is the long-term policy question for the
2 Commission that I think is very valuable and worth pursuing
3 in this area.

4 DR. KANE: Well, I guess one question I have is:
5 Are we trying to talk about this in a generic way or just
6 for CT and MRI? Because I have several colleagues in the
7 radiation/oncology area who are very concerned about people
8 rushing out and buying proton something that sound like they
9 cost gazillions of dollars. And I guess my concern is, you
10 know, I don't think there is a right price -- I mean, I
11 think there is a point where it's really got to be on a
12 different basis than the per unit use.

13 When I listen to us talking about what's the right
14 rate, on the one hand, if you set it too high, people want
15 to use it too much because it's more profitable. And if you
16 set it too low, people want to use it too much because then
17 they regain their -- I mean, there is no -- there's a volume
18 incentive either way. And I think there's also an incentive
19 to purchase equipment because you can leverage your time
20 using ancillary equipment.

21 To me, the only way really to talk about
22 efficiency in this whole realm is to really try to talk

1 about standards of care or -- I mean, the only way you can
2 really get at it is bundling it for appropriate use within
3 the episode, and all the other talk about it is really just
4 -- I think we're spinning our wheels. I like it that using
5 the hospital facility rate cut the rates on two-thirds of --
6 I don't know if it was the six sites or not. But, okay, so
7 we have a standard. The hospitals are doing it. They're
8 probably a little more incentivized because they have other
9 ways to make money. Maybe we should just stick with the
10 hospital payment rate for a while. But, really, I'm very
11 worried about the incentive to go out and just buy those
12 huge pieces of equipment, and then, no matter what, you've
13 got an incentive to use it all you can because you've bought
14 it.

15 So the volume incentive here is scary, and there's
16 no way to stop it on a per unit price. The only way to stop
17 it is to bundle it into an episode or a visit for an
18 appropriate use, and maybe the best thing is the hospital
19 because they have -- they're probably a little more likely
20 to be using it the right amount of time only because they
21 have other competing ways to make money.

22 I think this is really kind of a conversation that

1 can just go in circles for days and not really resolve the
2 major problem, which is we're probably going to -- we
3 probably have too much equipment out there, probably
4 misallocated, too. And maybe we really need to go back and
5 say should there be, God forbid, certificate of need or
6 planning or some way to say, you know, let's have the right
7 -- let's try to get at the right number of units of
8 machinery out there and then we can talk about what the
9 right amount to pay for that unit is. But as long as it's
10 wide open to go buy as much equipment as you want and then
11 have as much volume as you want, there is no efficient
12 price.

13 DR. REISCHAUER: There, of course, is a huge
14 problem with looking at what is because what is is the
15 result of a flawed payment system that's wildly overpaid and
16 paved the country with these machines. And I'm where Bill
17 is, that I think you can say, you know, in metropolitan
18 areas of a million or more people, we're going to assume 80
19 hours a week for these machines, and that's the way it's
20 going to be. I think the hospitals probably -- you know,
21 we're paying too much for them, too. But it would be a huge
22 mistake to do surveys and look at what exists now, except

1 maybe in rural areas, you know, because it's the product of
2 a flawed payment system.

3 DR. DEAN: I would just echo the concerns Nancy
4 raised. It struck me when I read this chapter that there's
5 just no way to figure this correctly for the reasons that
6 Bill raised and the reasons that Nancy raised. We just put
7 in a CT scan in an extremely small hospital where in a lot
8 of ways it doesn't make sense, but in actual fact what we
9 paid for it was a third of the amount that's listed here as
10 the cost for a CT machine. And so the type of machine you
11 buy, you know, how often you use it, there's just enough
12 variables in there, I don't think there's any way to get an
13 administered price that's going to fit all the situations.

14 So somehow I think that decision has got to be
15 made on a broader level, and, you know, probably that means
16 bundling. It doesn't make sense in this particular
17 situation.

18 MR. HACKBARTH: Surely it's difficult, but it is
19 being made, it's adherent in the payment system we've got.
20 And so we can accept the one we have or we can modify it.

21 DR. DEAN: What you said a minute ago, you know,
22 maybe is a good counter. The idea that you should set a

1 base rate that is an ideal rate in the most efficiently used
2 piece of equipment, and then maybe make adjustments for some
3 of these other things like low utilization. I don't know.
4 But it's obviously very complicated because there's so many
5 things that affect it.

6 MS. BEHROOZI: It struck me, listening to Nancy
7 and going back to a comment that Mike made, we're using the
8 word "efficiency" here, which is appealing when you're
9 talking about a piece of the payment being based on paying
10 back the cost of the machine. And you're right, we have to
11 start with what is, and I'm learning more and more about
12 what that is all the time.

13 But taking a step back from that, the word
14 "efficiency" here is being used very narrowly, and I think
15 that's what Mike said. How much you use the machine
16 increases the efficiency of the use of the machine. But
17 taking Nancy's comments, I thought we were supposed to be
18 talking about efficient provision of patient care. And, you
19 know, I just wanted to sort of incorporate that comment with
20 Nancy's, that if we could think about efficiency in a
21 patient-centered way rather than a machine-centered way,
22 maybe that would help us.

1 MR. HACKBARTH: We do need to do that, and we need
2 to look at other payment methods that might accomplish that.
3 But remember what's at stake here is the relative payment
4 for different types of services. And we've often talked
5 about how primary care is underpaid and we've got problems
6 there. This kind of adjustment goes to the distribution of
7 dollars within the physician payment system and is one path
8 -- not the only path, maybe not even the most important
9 path, but it's one path to address some of those issues.

10 MS. BEHROOZI: I just feel like the word
11 "efficiency" in the first question might be driving us in
12 different directions.

13 DR. CHERNEW: I guess two things. The first thing
14 is just a quick clarification question. How much use of
15 these machines are in episodes that one would clearly think
16 might be bundled, like coming back to follow up for cancer
17 care, versus things that are harder to bundle, like acute
18 head injury type thing, which you could conceivably bundle,
19 but there's a lot of, you know, leeway around how you code
20 that? So I wasn't sure how much that would work at the
21 margin.

22 The other thing, I guess the broader thing I would

1 say is my sense of this discussion is that, given the
2 presentation we had from Larry Casalino and Lawrence Baker -
3 - and I forget the other gentleman who spoke to us -- I
4 think we have a sense that there's been historically too
5 much of a growth in imaging. So any mechanism one could --
6 in the efficiency. So any mechanism one could come out to
7 do the redistribution is really a mechanism to get to where
8 you think you want to be given what you think is going on
9 with the services as opposed to having to justify it
10 dramatically on what the cost is or should be, I think the
11 economics would suggest some sort of two-part payment to try
12 and get it right, because there is a price low enough to
13 stop use. No. Zero. So I don't know how much above zero
14 you have to go.

15 DR. KANE: Let me know when you want to set that
16 price.

17 DR. CHERNEW: I don't want to set that price.
18 There's some price above that, though, that -- I don't know
19 how high it is. So the point is I don't think we're going
20 to get there, so it strikes me that some of this discussion
21 is sort of a convenience to adjust for a flaw that we know
22 through use and other purposes exists in the system. And in

1 that sense, I think I'm supportive of the general tone of
2 where we're going, much more so than I am addressing the
3 broader philosophical issues that it raises, because I
4 wouldn't want to be put into a transitive argument that you
5 use just to justify and now you have to apply this somewhere
6 else where I might not feel quite the same way.

7 MR. EBELER: I just wanted to sort of go back to
8 something that you said, and a couple of other people. I
9 don't have any disagreement that one wants to head towards
10 more episodes in bundling. I think what is being laid out
11 here is, given a currently flawed payment system that is
12 being used today to pay for these things, is there a way to
13 adjust this particular component to change that in a better
14 way? And this strikes me as a good, short-term payment
15 adjuster while we are simultaneously working on a lot of
16 other episodes in bundled payment arrangements. It just
17 strikes me that that is a way to think about this as we
18 develop policy for this coming year.

19 MR. HACKBARTH: Well, that was thought-provoking.
20 Thank you.

21 Okay. We're finished our presentations. We'll
22 have a brief public comment period. Limit your comments,

1 please, to no more than two minutes. Begin with your name
2 and organization. When you see this red light come back on,
3 that means you're at the end of your two minutes.

4 MR. SCHUMACHER: Thank you very much. I will pay
5 very close attention. My name is Don Schumacher and I'm the
6 president and CEO of the National Hospice and Palliative
7 Care Organization.

8 This afternoon we heard a presentation from staff
9 and conversation with the Commissioners about hospice care
10 and the issues associated with models of care. As we have
11 in the past, we invite the staff and the Commissioners to
12 also avail themselves of the hospice community's
13 considerable data and information from multiple sources so
14 that you can make fully informed decisions about the future
15 of hospice care in the U.S.

16 On behalf of the 1.4 million patients and their
17 families that received care last year and the hundreds of
18 thousands of others who could have appropriately benefitted
19 from hospice care, I'd like to make a couple of brief
20 comments.

21 Recently, the leading membership organizations of
22 the hospice industry -- these are folks that have an

1 interest in hospice care -- met and reaffirmed our common
2 values about hospice provision. Included among our shared
3 principles was recognition of the resounding success of the
4 Medicare hospice benefit over the past 30 years. Millions
5 of people have received care, and the need to preserve and
6 enhance hospice care as the model of patient and family care
7 focused at the end of life.

8 As has been discussed today, over the years the
9 patient population definitely has changed. And just as our
10 patient base has evolved, the benefit itself must be
11 modernized to better meet patients needs and match payments
12 in a cost-effective manner. We would urge MedPAC to
13 consider this important dynamic to assure that your
14 recommendations make a constructive contribution to the
15 Medicare hospice benefit and to dying Americans in the
16 United States.

17 I would make one personal comment that I think,
18 looking at your recommendations, I would start with
19 recommendation number four, which is data collection,
20 because I think making wholesale rate changes without
21 appropriate data collection will do a tremendous amount of
22 damage to patients and families in this country.

1 Paramount in our beliefs is making sure that
2 future patients and families can access in all service
3 settings the high-quality care that hospice has come to
4 symbolize. Eligibility for care should be based on an
5 assessment of the patient to assure appropriate eligibility
6 and receive support by evidence-based criteria.

7 Patients and families should know what to expect
8 and receive consistent and measurable high-quality services
9 delivered by a skilled interdisciplinary team within every
10 hospice program in this country. At the same time, and
11 importantly, the hospice community is committed to program
12 integrity, transparency, accountability, and fiscal
13 responsibility, working with this group in this room and
14 others to ensure that.

15 One last comment from myself personally. You can
16 still get a hospice license in this country and not be
17 surveyed for 11 years. That's a significant problem. Just
18 resolve these issues.

19 MR. INTROCASO: My name is David Introcaso. I'm
20 from the Marwood Group. A few comments on the hospice
21 discussion.

22 First, I think the comment of "candy store," as a

1 five-year hospice volunteer, I just find that basically
2 insulting.

3 More substantively, though, relative to length of
4 stay, I would have appreciated -- or maybe that was what was
5 considered; I hope it was considered -- some discussion
6 about the unpredictable nature of diagnosing death or
7 disease etiology. I'd say also, too, that historically we
8 all know, Jim, that hospice has been underutilized.

9 More substantively to Don's point, the data issue,
10 fundamentally reforming health care reimbursement without,
11 admittedly, little or no data I find actually truly
12 remarkable.

13 Secondly, I didn't hear any discussion whatsoever,
14 particularly on the Hill where we hear constant rhetoric
15 about P4P and VBP, no discussion about quality and how
16 you're going to tie improvement and quality at the end of
17 life with reimbursement. It's just beyond my understanding.

18 Lastly, relative to the cut, the Marwood Group
19 advises large institutional investors. They're already
20 screaming about the BNAF cut. If you don't think there's
21 going to be a capital flight, I think you really ought to
22 consider what consequences that will have.

1 And, lastly, on the private sector, I've found the
2 inherent bias towards the private sector in hospice somewhat
3 also unbelievable. That there's large growth in the for-
4 profit hospice, I don't understand why that's positive or
5 negative. It's just, you know, hospitals grow, other
6 industries grow. No one seems to make a complaint about
7 that.

8 I appreciate your time. Thank you.

9 MS. MILLMAN: Hi, I'm Diane Millman with Powers
10 Pyles Sutter & Verville, and I'd like to comment on the
11 equipment utilization discussion and on imaging in general.

12 I think that there are a number of aspects of this
13 discussion that I find troublesome. I think the first is
14 that there's an awful lot of time that's been spent on this
15 issue by the Commission that I'm aware of, and I think it's
16 real important to emphasize that CT and MRI rates today and
17 for the foreseeable future are not even based on the
18 methodology that's being discussed. It's based on a DRA
19 methodology which is a cap. That cap for MRI and CT is not
20 what it used to be. If folks are thinking MRIs of \$1,000 or
21 \$2,000, what we're talking about of MRIs is about \$300 at
22 the most, CTs at about maybe \$200, something like that, and

1 going down.

2 I think it's really also very important to
3 understand that the physician fee schedule methodology is a
4 very carefully balanced system, and what is being talked
5 about is one assumption among very many. There are indirect
6 costs, for example, that are paid under the physician fee
7 schedule -- that's lights, overhead, all of the rest of it -
8 - that are allocated almost 75 percent based on physician
9 work. Physician work has nothing to do with how much you
10 pay for your lights. So, therefore, a surgeon who leaves
11 his office and spends a lot of time doing a complex surgery
12 in a hospital gets paid for the lights that are -- gets paid
13 overhead that is far in excess of what an MRI facility gets.

14 So if you're going to look at the payment system,
15 don't pick and choose your assumptions. You need to look at
16 it holistically.

17 Finally, what I would say is with respect to the
18 DRA rates for MRI, CT, PET, all those highly capital cost
19 equipment, that's what's being paid right this minute.
20 Fundamentally, the capital costs for those MRIs, for those
21 CTs in hospitals are spread across the hospital. The rates
22 that are paid, the rates that are paid today both in free-

1 standing and in hospital systems do not take into account
2 appropriately the capital that is used for those. That's
3 why they're so low.

4 So I would really caution against making
5 precipitous judgments. You're going to have a 5-percent
6 additional across-the-board cut for technical component
7 services and, in fact, for all services because of the
8 conversion factor that's just come out, which is going to
9 hit disproportionately all technical component services.
10 This is an industry that has taken a lot of cuts. It's
11 continuing to take cuts, and I would caution against picking
12 and choosing your assumptions and mucking with the
13 methodology to get at a perceived overutilization problem
14 rather than looking at a way to look at appropriate
15 utilization and how to address that.

16 Thank you.

17 MR. HACKBARTH: Okay. We are finished for today.

18 We will reconvene at 9:00 a.m.

19 [Whereupon, at 5:22 p.m., the meeting was
20 recessed, to reconvene at 9:00 a.m. on Friday, November 7,
21 2008.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, November 7, 2008
9:00 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, J.D., Chair
JACK C. EBELER, M.P.A., Vice Chair
MITRA BEHROOZI, J.D.
JOHN M. BERTKO, F.S.A., M.A.A.A.
KAREN R. BORMAN, M.D.
PETER W. BUTLER, M.H.S.A
RONALD D. CASTELLANOS, M.D.
MICHAEL CHERNEW, Ph.D.
FRANCIS J. CROSSON, M.D.
THOMAS M. DEAN, M.D.
JENNIE CHIN HANSEN, R.N., M.S.N., F.A.A.N
NANCY M. KANE, D.B.A.
GEORGE N. MILLER, JR., M.H.S.A.
ARNOLD MILSTEIN, M.D., M.P.H.
ROBERT D. REISCHAUER, Ph.D.
WILLIAM J. SCANLON, Ph.D.
BRUCE STUART, Ph.D.

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MIPPA Medicare Advantage payment report -- Scott Harrison, Dan Zabinski	3
Medicare Advantage quality update -- Carlos Zarabozo, John Richardson	60
Principles for measuring physician resource use -- Jennifer Podulka	98
Public Comment	N/A

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

2 MR. HACKBARTH: Good morning. We start today with
3 two sessions on Medicare Advantage, the first on the
4 mandated report to Congress. Dan, are you leading -- Scott?

5 DR. HARRISON: Good morning. Today, Dan and I
6 will present some preliminary analysis we have undertaken to
7 start on the Medicare Advantage payment report that was
8 mandated for us in MIPPA.

9 This is our mandate. We've been assigned three
10 specific tasks. We must evaluate CMS's measurement of the
11 fee-for-service county-level per capita spending. MIPPA
12 also directs us to study the correlation between the fee-
13 for-service spending measure and MA plan costs to deliver
14 Part A and B benefits. Based on the findings from the first
15 two tasks, we are to examine alternate approaches to MA
16 payment other than the county fee-for-service approach and
17 to make recommendations as appropriate.

18 In this session, I am first going to give some
19 background on MedPAC's past positions and recommendation on
20 Medicare Advantage payment. Then I'm going to present our
21 preliminary analysis on the first two tasks and present a
22 concept for one alternate payment approach. And then Dan

1 will finish by present analysis of an alternate approach
2 using different payment areas.

3 MedPAC has a long history of supporting private
4 plans in the Medicare program. The Commission strongly
5 believes that beneficiaries should be given the choice of
6 delivery systems that private plans can provide.

7 Private plans, through financial incentives, care
8 coordination, and other management techniques have the
9 potential to improve the efficiency and quality of health
10 care services delivered to Medicare beneficiaries, and if
11 the plans are paid appropriately, plans would also have the
12 incentive to be efficient for the Medicare program and for
13 the taxpayers that support Medicare. However, MedPAC has
14 expressed concern that excessive payments to plans have been
15 attracting inefficient plans to Medicare Advantage.

16 As a very quick reminder of how we pay, let me
17 just reintroduce some terms to help new Commissioners follow
18 the rest of the presentation. A bidding process is combined
19 with administratively-set bidding targets, which are called
20 benchmarks, to determine the capitated rates paid to plans.
21 Plans submit a bid for the basic Medicare benefit and it is
22 compared with the benchmark. If the bid is higher than the

1 benchmark, the plan is paid the benchmark and beneficiaries
2 would pay the difference with a premium. However, if the
3 bid is below the benchmark, the plan is paid its bid plus 75
4 percent of the difference between the bid and the benchmark
5 and the remaining 25 percent of the difference is retained
6 by the Medicare program. The plan must then use its share
7 of the difference to provide extra benefits. The valuation
8 of those benefits includes plan administration and profit.

9 Now let me come back to the point that we have
10 attracted inefficient plans to the MA program. This system
11 could be efficient for the Medicare program except that the
12 benchmarks are now considerably above 100 percent of
13 fee-for-service payments in many areas of the country.
14 These high benchmarks have resulted in payments to plans of
15 113 percent of fee-for-service spending, well in excess of
16 what it would cost the Medicare program to cover the same
17 beneficiaries in fee-for-service.

18 Now, this slide comes from a table in our last
19 March report. In the second column, we have the average bid
20 as a percentage of the expected Medicare fee-for-service
21 cost for the population the plan is bidding on. If a plan
22 bids 100 percent of Medicare fee-for-service, Medicare would

1 consider that the plan is providing the Medicare benefit
2 package as efficiently as the fee-for-service program.

3 We found that the average 2008 bid is 101 percent
4 of fee-for-service spending. This means that beneficiaries
5 on average are now enrolled in plans that are less efficient
6 than fee-for-service Medicare. As you can see, the bids
7 vary by plan type and not all plan types are inefficient.
8 For example, HMOs bid an average of 99 percent of fee-for-
9 service. Private fee-for-service plans, however, bid an
10 average of eight percent more than fee-for-service spending.

11 These bids, combined with high benchmarks, produce
12 payments to plans that are well above fee-for-service
13 spending for all types of plans. However, some argue that
14 the high benchmarks are okay because the beneficiaries are
15 receiving extra benefits. However, those extra benefits,
16 according to the plan bids, are worth 12 percent of fee-for-
17 service payments and Medicare is paying 13 percent to get
18 them, and the 12 percent includes plan administration and
19 profit. Even for HMOs on average, only one percentage point
20 of the extra benefits are funded by plan efficiencies and 12
21 percentage points are funded by the extra Medicare payments.
22 Looking at private fee-for-service plans, Medicare pays 17

1 percent so that members may get nine percent in benefits.

2 MedPAC has argued that the original purpose of
3 private plans in Medicare was to provide care more
4 efficiently and thus allow beneficiaries to receive extra
5 benefits funded by those efficiencies. But Medicare should
6 not pay more so that beneficiaries who choose inefficient
7 plans are able to get extra benefits. The Medicare program
8 should be financially neutral in the beneficiaries' choice.

9 The Commission last made MA payment
10 recommendations in our June 2005 report. I would like for
11 you to keep in mind one of those recommendations regarding
12 financial neutrality as we go through my part of the
13 presentation today. We recommended the Congress should set
14 the benchmarks that CMS uses to evaluate Medicare Advantage
15 plan bids at 100 percent of the fee-for-service costs. CMS
16 estimates fee-for-service costs as county-level estimates of
17 fee-for-service spending and our mandate directs us to
18 examine those estimates.

19 So now let's look at CMS's measurement of county-
20 level spending. I'm going to present it at a highly
21 simplified level, but I can give you more detail on
22 question.

1 CMS uses a multi-step process to estimate expected
2 county-level fee-for-service spending. Each year, the
3 actuaries begin by tabulating spending from the fee-for-
4 service claims files based on the county of residence of the
5 beneficiary who received the Medicare covered service. The
6 totals are then averaged and standardized for risk and a per
7 capita spending figure for each county is calculated as a
8 five-year average.

9 Generally, CMS is as accurate as one could
10 reasonably expect, but there are a few issues we want to
11 look at more closely. One issue is the timeliness and
12 completeness of the claims data that CMS uses. On this
13 issue, we need to do more investigation before we consider
14 making a judgment. We have had some concern about the
15 stability of the estimates, and Dan will address that issue
16 later in the session.

17 And now I will discuss two issues that were
18 specifically raised in the mandate, Veterans Affairs, or VA,
19 spending on Medicare beneficiaries and administrative costs
20 included in the fee-for-service estimates.

21 MIPPA specifically requires us to determine
22 whether the fee-for-service measures fully incorporate

1 Department of VA spending on Medicare beneficiaries.
2 Currently, the Medicare fee-for-service estimates do not
3 include any spending by the VA for Medicare beneficiaries
4 who are eligible to receive care under both Medicare and
5 Veterans health programs. Plans are concerned that this
6 lowers the per capita fee-for-service spending measures.

7 CMS has proposed to test the relationship of VA
8 spending for Medicare beneficiaries and the MA benchmark and
9 modify the calculations of fee-for-service spending, if
10 there is a need. Essentially, they would remove any
11 beneficiaries who are eligible for benefits from the VA when
12 they calculate the per capita fee-for-service spending and
13 see if there was a difference compared with when those
14 beneficiaries were left in the calculation. This approach
15 has promise and we encourage CMS to move ahead. CMS did not
16 have all of the data it needed to implement the strategy for
17 2009, but the actuaries told us they expect to be able to
18 implement it the next time.

19 On net, we don't know whether the proposal would
20 raise or lower benchmarks because we don't know whether
21 veterans use more Medicare services because they are sicker
22 or use fewer Medicare services because they substitute

1 services from the VA.

2 MIPPA also requires us to determine whether the
3 fee-for-service measures include all appropriate
4 administrative costs. Using the HHS budget documents, we
5 figure that the CMS administrative costs attributable to the
6 Medicare program would be under \$3 billion while total
7 benefit spending is in the \$400 billion range, meaning that
8 the total administrative cost to administer the benefits is
9 well under one percent of the benefit spending.

10 The fee-for-service spending estimates are
11 adjusted upward to account for more than half of those
12 administrative costs because those costs are for processing
13 fee-for-service claims. CMS does not have to pay to process
14 claims for MA members.

15 The rest of the costs are not included in the fee-
16 for-service estimates because those costs include CMS
17 funding to perform administrative functions for the Medicare
18 program as a whole, for example, fraud and abuse monitoring.
19 These functions are retained by CMS even for beneficiaries
20 who have enrolled in MA plans. Further, some of the funding
21 is actually used for the administration of the MA program.

22 Now, in summary here, the costs of claims

1 processing accrue solely to fee-for-service and are included
2 in the fee-for-service spending estimates while other
3 administrative costs are spread across the entire Medicare
4 program and are thus not added to the fee-for-service
5 estimates. We find this to be an appropriate allocation of
6 costs, because even if there are some costs that could be
7 attributed solely to fee-for-service, the amount of these
8 costs would be so small, any adjustment would be negligible.

9 The mandate also asks us whether the fee-for-
10 service measure is correlated with plan costs. While there
11 are many possible ways to measure costs, the mandate
12 instructs us to use the plan bids to determine costs.

13 To directly answer the mandate, we measured the
14 correlation between plan bids and expected fee-for-service
15 spending for an equivalent population. Correlation measures
16 how two variables move in relation to each other.
17 Correlation statistics range from minus 1 to plus 1. If the
18 two have no linear relationship, the correlation would be
19 zero. If one variable was always relatively high when the
20 other was, then the correlation would be positive one.
21 Correlations near one show high correlation and correlations
22 near zero show low correlation, and negative correlation

1 values just means that the two variables tend to move in
2 opposite directions.

3 We find there is a strong correlation between plan
4 bids for 2009 and expected fee-for-service spending.

5 Overall, the correlation was 0.88. This means that plans
6 serving areas with high fee-for-service spending were likely
7 to have high bids and plans serving areas with low fee-for-
8 service spending were likely to have low bids.

9 We calculated the correlations separately for four
10 plan types and found that there was high correlation within
11 each plan type. HMOs had a correlation of 0.89, while PPOs
12 and private fee-for-service had correlations of at least
13 0.93. The correlations were higher for plan types that tend
14 not to have relatively tight networks of providers. This
15 means that the bids of plans that are more likely to pay
16 providers based on Medicare rates are more closely
17 correlated to the level of fee-for-service spending in their
18 service areas.

19 Although our mandate asks us to look at
20 differences by geographic area, we are limited because CMS
21 does not gather county-level bids. We were able, however,
22 to explore differences between urban and rural plans. We

1 selected a group of 1,500 plans that drew their entire
2 enrollment from urban counties and designated them as rural
3 plans, and rural-only plans were rare, but we did find 125
4 plans who expect to get 90 percent or more of their
5 enrollment from rural counties. We designated these 125
6 plans as rural plans.

7 We found that there was a high correlation of plan
8 bids and fee-for-service spending within both urban and
9 rural areas. However, the correlation was somewhat stronger
10 in rural areas. As with the plan type differences, this
11 finding suggests that plans that are more likely to have to
12 pay providers based on fee-for-service Medicare rates,
13 namely the rural plans, are more likely to have bids that
14 are highly correlated with fee-for-service spending.

15 Incorporating the findings from the first two
16 tasks, MIPPA asks us to examine alternate approaches to MA
17 payment. Specifically, we are asked to examine approaches
18 other than the approach using payments based purely on
19 county-level fee-for-service spending. The mandate suggests
20 that the Congress is interested in exploring payment
21 approaches that would maintain broad plan availability.
22 These approaches might involve paying rates closer to plan

1 costs rather than focusing only on local fee-for-service
2 costs.

3 Today, I will discuss such an approach that uses a
4 blend. Dan will discuss an approach with larger payment
5 areas momentarily. And there are other benchmark-setting
6 approaches that I mentioned at the last meeting that we will
7 investigate more in future meetings.

8 We raised the possibility of using a blend of
9 local and national fee-for-service costs in the past. The
10 particular formulation of a blend could seek to incorporate
11 fee-for-service spending in plan costs. We have shown
12 earlier that plan costs are correlated with fee-for-service
13 spending, but we don't know how closely plan costs track
14 fee-for-service spending. We could use regression analysis
15 of fee-for-service spending and plan costs to see how
16 closely they track and to determine the blend.

17 Before we talk about using a blend to set
18 benchmarks, let's see how the benchmarks look now. Along
19 the bottom axis, we see counties arrayed from highest to
20 lowest fee-for-service spending. The axis up the side shows
21 the current benchmarks. Again, these are more theoretical
22 than real. We have greatly simplified how the current

1 benchmarks are calculated really on this slide to make two
2 points. First, benchmarks are not allowed to fall below a
3 legislatively-set floor no matter how low fee-for-service
4 spending is. We simplified the drawing to show one floor,
5 although there are actually two.

6 The second point here is that for non-floor
7 counties, benchmarks are a little over fee-for-service for
8 some technical reasons and for some policies that are due to
9 expire over the next few years. So the pink-purplish line
10 there represents the general level of benchmarks, although
11 in reality they are more scattered in relation to fee-for-
12 service spending.

13 Now let's talk about a blend in general. This is
14 an illustration of where benchmarks would be set using a
15 local/national blend. The orange line represents a
16 local/national blend where the benchmark is set
17 incorporating local fee-for-service spending and the
18 national level of fee-for-service spending. The two lines
19 meet at the national average, represented by the thin blue
20 line there. Benchmarks in areas with less than the national
21 average fee-for-service spending, say rural Nebraska, would
22 be higher than their local fee-for-service spending, and

1 areas with spending above the national average, Miami, for
2 instance, would see benchmarks lower than local fee-for-
3 service spending. The blend line would get steeper as we
4 increased the local/national blend toward 100 percent local,
5 which is the green line.

6 As I mentioned, the particular blend could be
7 informed by the regression of plan costs on fee-for-service
8 spending. We haven't finished running that yet, but as an
9 example, if we found that plan costs rose, say, 60 cents for
10 a dollar increase in fee-for-service spending, we could use
11 a 60/40 blend to keep benchmarks resembling plan costs. At
12 a future meeting, I will simulate the effects of a blend on
13 2009 plans, assuming they did not change their bidding
14 behavior.

15 And now Dan will talk about payment areas.

16 DR. ZABINSKI: Currently, the county serves as a
17 payment area for MA plans as each county has a benchmark
18 against which plans must bid in order to serve that county.
19 As a result of the process for setting county benchmarks,
20 some counties have their benchmarks set equal to its per
21 capita fee-for-service spending.

22 But using fee-for-service spending at the county

1 level does present some problems. First, some counties have
2 low populations which can make their fee-for-service
3 spending unstable over time because unusually high or low
4 health care use among a few beneficiaries can cause
5 substantial year-to-year changes in their fee-for-service
6 spending in these low-population counties. Therefore, it's
7 possible that a county can have a measure of fee-for-service
8 spending that differs from its typical level. This can be
9 carried forward into an erroneously high benchmark and can
10 remain too high indefinitely through the mechanism for
11 updating the benchmarks.

12 A second problem that is caused by using fee-for-
13 service spending at the county level is that adjacent
14 counties often have very different fee-for-service spending
15 and consequently can have very different benchmarks. If
16 adjacent counties have very different benchmarks, plans may
17 offer less comprehensive benefits in the county with the
18 lower benchmark or they may avoid that low-cost county
19 altogether, creating appearances of inequity between those
20 adjacent counties.

21 In previous work on payment areas, the Commission
22 evaluated alternatives to the county definition that address

1 the problems presented by counties. From this analysis, in
2 the June 2005 report to the Congress, the Commission made a
3 recommendation that said, among urban counties, payment
4 areas should be collections of counties that are in the same
5 metropolitan statistical area and in the same State, and
6 among rural counties, payment areas should be collections of
7 counties that are in the same State and that are reflections
8 of health care market areas, such as health service areas,
9 or HSAs. The idea of an HSA is a group of counties whose
10 Medicare beneficiaries receive most of their short-term
11 hospital care at hospitals that are in the same group of
12 counties, and we refer to this combined MSA/HSA as MSA/HSA
13 definition of payment areas.

14 One point I would like to make is that this is not
15 the HSA definition developed by researchers at Dartmouth
16 University. Instead, it was developed by researchers at the
17 National Center for Health Statistics.

18 Now, replacing the county definition of payment
19 areas with this MSA/HSA definition would address the
20 problems presented by counties that we discussed earlier.
21 First, it would increase the stability of fee-for-service
22 spending at the county level. For example, we found that

1 from 2007 to 2009, the average change in fee-for-service
2 spending would be about 2.6 percent under the county
3 definition, with changes in some counties exceeding 15
4 percent. In contrast, we found that the average change
5 would be only 2.0 percent under the MSA/HSA definition with
6 no county having a change of more than 15 percent. And this
7 greater stability under the MSA/HSA definition would reduce
8 the chance that a county would have an estimate of its fee-
9 for-service spending that exceeds its typical level,
10 reducing the chance that a county has an erroneously high
11 benchmark.

12 Secondly, the MSA/HSA definition would reduce the
13 prevalence of large differences in fee-for-service spending
14 between adjacent counties. This would result in more
15 similar benefits being offered in adjacent counties.

16 Now, the MSA/HSA definition would also have other
17 important effects, including, first, it would effectively
18 approximate market areas that plans serve. This is
19 important because if payment areas do not accurately reflect
20 plan market areas, you run the risk of having payments above
21 plan costs in some parts of a payment area and below plan
22 costs in other parts. This potential for losses in some

1 parts of a payment area could cause plans to avoid the
2 payment area altogether, even if they are profitable in
3 other parts of the payment area.

4 Also, using the MSA/HSA payment areas would have
5 some redistribution effects. In particular, MA spending
6 would be redistributed among urban counties and among rural
7 counties, but the MSA/HSA definition would not redistribute
8 spending from urban counties to rural counties or the other
9 way around. This is because this definition of payment
10 areas never combines urban counties with rural counties into
11 the same payment area. Also, spending would not be
12 redistributed from one State to another, and this is because
13 this definition of payment area never combines counties in
14 different States into the same payment area.

15 To close, our next steps for this report are
16 twofold. First, based on Commissioners' input, we will
17 develop alternative payment approaches to the MA program.
18 The one that Scott already discussed is a blend of national
19 and local fee-for-service spending. Also, we will examine a
20 national benchmark that is adjusted for geographic
21 variations in prices and other factors. We will then
22 simulate the effects of these approaches under the county

1 definition as well as the MSA/HSA definition of payment
2 areas. In particular, we will look at the frequency and
3 magnitude of payment changes that plans would face and how
4 many beneficiaries would be affected by payment changes. In
5 these simulations, we will assume static behavior so that
6 there will be no changes in plan participation, plan
7 bidding, or beneficiary enrollment.

8 That concludes, and we turn it over for your
9 discussion.

10 MR. HACKBARTH: Thank you. Good job. So let's do
11 first our round of clarifying questions.

12 MR. EBELER: Thank you very much. Scott, if you
13 could go to slide five. This is always very helpful data.
14 Just two things. One, the policy question here, of course,
15 is whether there should be extra payments at all, even if
16 they do generate extra benefits, and so let's -- but the
17 clarifying question is this extra benefits column. I'm very
18 proud to have worked in the health plan community in
19 Minnesota and nationally for a number of years. I never
20 could figure out how to explain to an employer, a budget
21 person, or my mom how my administrative costs and margin
22 counted as an extra benefit.

1 [Laughter.]

2 MR. EBELER: And so my question -- especially my
3 mom. She's not big on that.

4 So my question is, will we be able to split out of
5 that column the administrative costs and margins and the
6 extra benefits accruing to beneficiaries at some point in
7 this analysis?

8 DR. HARRISON: We would have data on the bid as a
9 whole that would show the medical portion, the
10 administrative portion, and the margin, I believe they call
11 it.

12 MR. EBELER: So that will be --

13 DR. HARRISON: We could do that, yes.

14 MR. EBELER: Thank you.

15 MR. BERTKO: Scott, just a quick clarification on
16 the VA change. DOD costs are also one of those things. Is
17 that included in the VA or is it VA alone?

18 DR. HARRISON: Let's see. CMS was going to do DOD
19 as well, yes. It's just that our mandate didn't mention it.

20 MR. BERTKO: Okay. Thank you.

21 DR. CROSSON: Scott, on slide 15, the one that
22 shows the blend, you may have said this and I may have

1 missed it. I think you said the blend you modeled here on
2 this was 60/40.

3 DR. HARRISON: It wasn't.

4 DR. CROSSON: It wasn't?

5 DR. HARRISON: Frankly, this is a randomly drawn
6 line.

7 DR. CROSSON: The question is, then, maybe you did
8 say it or didn't, the goal here in recommending a blend
9 would be what? In other words, what would be the criteria
10 you use to determine the ideal slope of that orange line?

11 DR. HARRISON: Okay. So let's say we do a
12 regression and it comes out that the plan bid is equal to
13 some constant plus -- and we've been getting numbers, and
14 we're not ready to do it yet, but we've been getting numbers
15 in the 70 to 80 percent range. So let's just say it's 75.
16 So if plan costs seem to go up by 75 cents for every dollar
17 of fee-for-service spending in an area, then I think the
18 idea would be to set the blend at 75 percent local and 25
19 percent national. This isn't necessarily our idea, but this
20 has come from outside.

21 MR. HACKBARTH: The goal, as I understand it, is
22 to lift the line at the bottom end of the distribution and

1 lower it at the top. And as for there being an analytic
2 test of how to determine the slope of the line, I don't
3 think that there is, at least in --

4 DR. HARRISON: Well, I think the idea is that if
5 you use that line, you would be getting closer to
6 approximating plan costs, and so there are some people out
7 there, I think, that want to pick plans closer to their
8 costs.

9 DR. CHERNEW: [off mic] Are you proposing
10 initially to get rid of the floor?

11 DR. HARRISON: You would get rid of the floor if
12 you were doing a blend, yes.

13 DR. CHERNEW: So this would just be the line?

14 DR. HARRISON: Right.

15 DR. MARK MILLER: And let's just be clear on the
16 language here. The mandate has asked us to look at these
17 types of ideas. I don't think there's a proposal. We're
18 just trying to work through how people think through these
19 kinds of ideas. I just want to be clear in the public about
20 the vocabulary.

21 MR. GEORGE MILLER: Good report, and just a
22 clarifying question. I think, Dan, when you were mentioning

1 about rural counties and urban counties that you would make
2 sure that you would not blend -- did you say you would make
3 sure they would not be blended together?

4 DR. ZABINSKI: Yes. I mean, well, just in that
5 particular payment area, we keep the urban counties with the
6 urban counties and the rural with the rural counties.

7 MR. GEORGE MILLER: But like in West Texas, for
8 example, there are some urban counties that are surrounded
9 by rural counties --

10 DR. ZABINSKI: Right.

11 MR. GEORGE MILLER: -- and you would make sure
12 that that urban county and the rural counties would not be
13 blended together?

14 DR. ZABINSKI: Yes. The idea is that -- defining
15 urban in this case is a county within an MSA. That's the
16 demarcation.

17 MR. GEORGE MILLER: Okay. Thank you.

18 DR. REISCHAUER: A couple of things. When you're
19 talking about the VA folks, you said it could be that they
20 are sicker and therefore use more services. But in a sense,
21 that would be picked up if you had a good risk adjustment,
22 so --

1 DR. HARRISON: Yes. The actuaries are actually
2 going to look at the risk-adjusted spending differences by
3 putting them in, yes.

4 DR. REISCHAUER: Right, so that doesn't really --
5 then when you were talking about administrative costs being
6 excluded --

7 DR. HARRISON: But Bob, right now, we don't know
8 the risk scores of some of the VA people because the
9 diagnoses related to their treatment may be held by the VA
10 and Medicare doesn't see them, some of them.

11 MR. BERTKO: I will come back later, but I have a
12 little difference of opinion with Scott on that particular
13 comment.

14 DR. REISCHAUER: With respect to the
15 administrative costs, I don't know if I got this right, but
16 I thought I heard you say that for some of the ones that are
17 appropriately focused on fee-for-service, like the payment
18 by the intermediaries and all that, that's in there, and
19 then everything else is sort of taken out and isn't
20 included, and it struck me that some of the most expensive
21 administrative things are rightly associated with Medicare
22 Advantage, I mean, risk adjustment, the whole bidding

1 process. I mean, these are very complicated things and if
2 we're going to slice and dice this in an appropriate way,
3 they should really be loaded onto Medicare Advantage.

4 DR. HARRISON: I think we decided not to slice and
5 dice because as a percentage of the estimates, they really
6 would be very small. So we --

7 DR. REISCHAUER: Okay.

8 DR. HARRISON: -- not getting deeply into the
9 budget, we decided to say that that was okay.

10 DR. MARK MILLER: I also think the general tack
11 here is what we are saying is whether a beneficiary is in
12 managed care or fee-for-service, the program, Medicare, has
13 to engage in a bunch of activities -- eligibility
14 determination, fraud and abuse, making policy. And you're
15 saying that there might be a level of effort associated to
16 MA that's higher. But even sometimes when you think about
17 fee-for-service, if you think about like competitive bidding
18 for DME, there's levels of effort that really you could
19 imagine situations where it's quite intense on the fee-for-
20 service side. And given that and the small number, we kind
21 of --

22 MR. HACKBARTH: My recollection from the paper,

1 Scott, was that we're talking about four-tenths of one
2 percent of total spending, something like that that we would
3 be divvying up.

4 DR. HARRISON: Right. You'd be divvying up,
5 right, four-tenths of a percent.

6 DR. REISCHAUER: You mean just \$3 or \$4 billion?

7 DR. HARRISON: Right.

8 [Laughter.]

9 DR. KANE: When will we know what the actual costs
10 are? Right now, all of your analysis is based on plan bids.
11 At what point are we going to know what the actual spending
12 on Part A and B benefits is, because I know there is some
13 effort to collect at least some kind of encounter data about
14 that. And will that, in fact, affect this notion of
15 creating or driving the benchmark closer to actual spending?

16 DR. HARRISON: The encounter data is still a
17 couple of years away, at least. But then you would have to
18 have some modeling of what the costs of those encounters are
19 and that would be yet another step. So it would be a while.

20 DR. KANE: So you're not collecting anything to do
21 with their actual costs on Part A and B? It's just their
22 plan bid costs?

1 DR. HARRISON: Right.

2 DR. KANE: There's never going to be a data set on
3 what it actually cost them for A and B?

4 DR. HARRISON: The plans are supposed to submit
5 with their bid -- they go back a couple of years and they
6 say what their A and B costs were. In fact, it might even
7 be at the contract level.

8 DR. KANE: So you can't get it at the county
9 level.

10 DR. HARRISON: No.

11 DR. KANE: But if you made larger service areas
12 the way we're recommending, maybe they could do that, or is
13 that out of the question, too?

14 DR. HARRISON: Hopefully, you'd approximate the
15 service areas that they're using, so it might get closer.

16 MR. HACKBARTH: We're still on round one.

17 DR. STUART: I'd like to go back to slide 11. I'm
18 trying to interpret what that top row really means, because
19 the row on HMOs is the only one in which you have estimates
20 for urban and rural areas separately. So why would the
21 urban and rural area overall be any different than the
22 subset for that particular -- for the subset of HMOs if you

1 don't have non-HMOs in rural areas?

2 DR. HARRISON: There are a few, but just not
3 enough for me to put a number up there. Yes, you see
4 they're very close to the HMO numbers.

5 DR. STUART: I guess I think it gives you the
6 impression of something that it really isn't. So it's
7 really an interpretive issue. I mean, if it's really the
8 HMOs that are driving this, then to say that it's all MA
9 plans is not particularly informative, let's put it that
10 way.

11 DR. HARRISON: Well, the mandate asked us to do it
12 like that.

13 DR. STUART: Okay. And the second issue is, and
14 it gets back to the VA spending and it's an interpretive
15 question, and that is have you looked at the distribution of
16 VA spending geographically?

17 DR. HARRISON: We don't have any such thing, no.

18 DR. STUART: I'm sure VA does.

19 DR. HARRISON: Well, CMS has been talking with
20 them for years about it and hopefully they will get it.

21 DR. DEAN: On slide five, I'm still confused about
22 the relationship between the bids and the payments. In the

1 middle column, we have the bids, but either the left or the
2 right-hand column, why are the payments higher than the bids
3 if the payments are supposed to be based on the bids?

4 DR. HARRISON: The payments are based on the
5 benchmark.

6 DR. DEAN: But isn't the benchmark set in
7 relationship to the fee-for-service spending?

8 DR. HARRISON: No.

9 DR. DEAN: Oh, okay. I guess that's what I'm
10 confused about.

11 DR. HARRISON: Right. For 2008, the benchmarks
12 actually average about 118 percent.

13 DR. DEAN: Oh really? Okay. I guess that was the
14 part I didn't understand. And that's fee-for-service
15 spending plus what?

16 DR. HARRISON: It's sort of historical artifacts
17 of how they got that way. You had the floors. You had IME
18 spending. You had this budget neutrality adjustor that went
19 in.

20 DR. DEAN: I see.

21 DR. HARRISON: And then you can have sort of
22 random mistakes or randomness on the fee-for-service numbers

1 that Dan had talked about, where one year it's high and you
2 stay on that high road.

3 DR. MARK MILLER: But I want to give just a
4 different answer, okay? All that's correct --

5 DR. DEAN: You're going to make me more confused.

6 DR. MARK MILLER: No, no, no, hopefully less
7 confused.

8 DR. DEAN: Okay.

9 DR. MARK MILLER: All of that is correct, okay,
10 but fundamentally, what's happening is that the Congress set
11 the payment rates administratively in certain areas of the
12 country above fee-for-service.

13 DR. DEAN: I see.

14 DR. MARK MILLER: And Scott?

15 DR. HARRISON: Right. The floors were set, and
16 that's where a lot of it comes from.

17 DR. CHERNEW: I think, and I'm not 100 percent
18 sure that this is important, but I actually think it is to
19 answer this question and subsequently. There is, I think
20 Dan was alluding to, this ratchet effect, which if you --
21 the floor gets updated, I believe, according to a minimum
22 update percent. So if you are high at one point in time and

1 then your next year you are low, you can't drop back down to
2 low for any statistical variance. And so over time, you see
3 this ratcheting up of the level that is going to give you
4 this gap because of the way the floor is moved, because I
5 think there's a ratchet in it.

6 MR. HACKBARTH: [off mic] It contributes to this.

7 DR. CHERNEW: Yes, that's what I mean.

8 DR. MARK MILLER: But the point is, that's all set
9 in law.

10 DR. CHERNEW: Right. There's a legal ratchet
11 about how the updates work.

12 MR. BUTLER: Slide five seems to be a favorite.
13 It's mine, too, but I have two clarifying questions. Let's
14 look at the 101 percent at the top. What that says is that
15 the Part A and Part B spending is one percent more than
16 would have been. That's the first --

17 DR. HARRISON: Yes. The plans have said that --

18 MR. BUTLER: Right, and that --

19 MR. HACKBARTH: This is the plan bid.

20 MR. BUTLER: This is their cost --

21 MR. HACKBARTH: The bid -- the bid --

22 MR. BUTLER: This is their bid, which would cost

1 them more -- I'm sorry, not the payment, the bid compared to
2 the fee-for-service --

3 DR. HARRISON: Right. Now, the bid also would
4 include administrative costs and profit for the plan. That
5 would be in their bid.

6 MR. BUTLER: No, that's on the right-hand column.

7 MR. HACKBARTH: Well, no --

8 DR. MARK MILLER: Let me just take a shot here.

9 MR. BUTLER: I thought I had it.

10 DR. MARK MILLER: The way to look at this number
11 is the plans are saying to deliver A/B benefits, it's 101
12 percent of what fee-for-service is.

13 MR. BUTLER: Okay. So the 12 percent is in the
14 101?

15 DR. HARRISON: No. The 12 percent is for benefits
16 above the A and B benefits.

17 DR. CHERNEW: [off mic] They get paid 13 percent
18 and they lower the Part D premium and other things.

19 DR. REISCHAUER: But they're able to provide A and
20 B benefits probably for 92 percent or something like that of
21 fee-for-service. And then there's profits and extra
22 administrative costs which they add on which gets up to 101.

1 Then we pay them 113 and they have to do something with the
2 extra money by law, and they provide extra benefits or
3 rebates.

4 MR. BUTLER: Okay. I think what was -- I
5 understand the payments, that it's got the 12 percent in it.
6 I mean, I can add the numbers across there. I'm still a
7 little -- because the footnote says extra benefits. That
8 footnote gets to be a little bit confusing.

9 DR. HARRISON: It's the administration and profit
10 that's allocated to the extra benefits as opposed to the
11 whole --

12 MR. BUTLER: Yes, because you said the
13 administration is in the bid itself --

14 DR. HARRISON: Right.

15 MR. BUTLER: -- and now the footnote kind of says
16 it's in the extra benefits and fee-for-service. So that's
17 what confuses me.

18 DR. HARRISON: It's in both places, yes.

19 MR. BUTLER: So is there any way we get at -- get
20 back to the 0.4 percent, the cost of running the Medicare
21 program -- if you were to put it in the fee-for-service,
22 it's 0.4 percent. What a bargain. And even then, it's

1 overstated because we said part of the cost is --

2 MR. BERTKO: The administration that's in there is
3 the claims administration for fee-for-service, which is,
4 what, about two percent or so, Scott?

5 DR. HARRISON: No, it's gotten really low.

6 MR. BERTKO: Smaller? Okay.

7 DR. HARRISON: Smaller.

8 MR. BUTLER: Let me finish. In the document
9 itself, it says that if you took the cost of running the
10 Medicare program, and it's not just the claims part, that's
11 part of the point. There are other costs in the 0.4 percent
12 besides just running claims, and it sort of why you said
13 even that is maybe a little bit overstated. But if you were
14 to take the costs, you would add 0.4 percent to the fee-for-
15 service and you're saying it's not worth it and it's a
16 little bit less than that, right?

17 So I guess my question and clarification, is there
18 anywhere in this we will understand what the cost of
19 administering this apparatus is versus the 0.4 percent? Is
20 there anything in our data that --

21 DR. HARRISON: You mean administering the MA plans
22 or --

1 MR. BUTLER: Not Medicare's cost of administering
2 the MA program, but there's a lot of costs of setting up the
3 networks and running the thing and so forth --

4 DR. HARRISON: Okay. We will come -- probably
5 next month, we will sort of do our regular MA stuff and
6 we'll try to have the medical costs, the admin, and the
7 profit separated out for you.

8 MR. BUTLER: But that's what you should be getting
9 as part of the medical loss ratio typically. It's part of
10 what you get the value out of setting the thing up for. I'm
11 just curious what that piece of the cost is. Okay. Now
12 that we're all straight on this one, I think I understand it
13 pretty well.

14 The second is that the legislative mandate here
15 really, as I read it, it looks like they're really focusing
16 mostly on the definition of the geographic -- what unit of
17 payment. Do you go from county? Do you do service? Do you
18 do a blend with -- they're asking us to advise on really the
19 geographic boundaries as much as anything. In the short
20 run, are they also looking at, you know, broader kinds of
21 recommendations beyond just that, or how should we view our
22 short-term charge with respect to modifying these payments?

1 MR. HACKBARTH: They are asking us for a couple of
2 different things. One is to look at the unit of payment,
3 county and whether some other unit ought to be substituted
4 for county, and that was the piece that Dan talked about.
5 We made recommendations on that in the past to go to larger
6 units.

7 The second piece has to do less with the unit of
8 payment than the distribution of payments across geography,
9 and that's what the blend is about. Is there an alternative
10 way to distribute the payments across geography that takes
11 into account how plan costs vary geographically, not just
12 how Medicare fee-for-service costs vary geographically? And
13 the idea there is potentially a blend, and then if you put
14 up the graph, that leads to a very different distribution of
15 payments at the low end and the high end.

16 MR. BUTLER: Right, all geography related. But
17 we're not looking in the short term at this, for example,
18 the benefit issues and how to lump that or not lump it into
19 our thinking long-term about how Medicare Advantage is paid
20 for.

21 MR. HACKBARTH: Yes. You know, there are a bunch
22 of Medicare Advantage issues that are important and

1 interesting to look at --

2 MR. BUTLER: But beyond the --

3 MR. HACKBARTH: The strategy that we're adopting
4 right now is to try to do an early report to Congress by
5 focusing very specifically on the questions that they asked,
6 the mandate --

7 MR. BUTLER: Okay. I think I understand.

8 MR. HACKBARTH: And then we can go back later on.
9 In fact, a number of Commissioners have said they would like
10 to go back and look at the broader issues in Medicare
11 Advantage. But to get an early report out, we really have
12 to zero in on the three specific questions that they asked.

13 On the table -- I wonder whether it would be good
14 whenever we have a table to always include benchmark
15 information. There's sort of an instinctive effort to add
16 and subtract these columns and figure out how you get one
17 from the other and you really need the benchmark information
18 there for people to sort of see the relationships.

19 Okay. We're on to round two now.

20 DR. CHERNEW: My question is if a plan has to give
21 back by law 75 percent to the beneficiary if they are under
22 the benchmark and 25 percent gets held by Medicare, what

1 incentive do they have to actually be more efficient?

2 DR. HARRISON: Well, they still want to attract
3 beneficiaries, so they want to bid so that they have
4 something to give back to them.

5 DR. CHERNEW: But what sort of the troubles me in
6 the blend, if you were to show the graph, the blend one --
7 under a blend like this, if a plan to the right were above
8 the blend but below the fee-for-service, in other words,
9 above the red, if that is red, and below the green, if that
10 is green, they would be potentially saving money relative to
11 all the fee-for-service program in their area, but according
12 to the blend, they wouldn't get paid for doing that, and I
13 think that's the challenge in the spin that you're doing.

14 On the other side, I think the key issue with the
15 floor, I have a real problem with the floors because I'm
16 very concerned about this legislative ratcheting effect of
17 how the floors work and so I think an advantage on the left
18 side of the graph is you get rid of a lot of -- I believe, I
19 don't know how much -- you get rid of a lot of the sort of
20 overpayment, because historically over time, through both
21 legislation and other legislative aspects of the program,
22 payments have gone up higher than you would have expected in

1 the fee-for-service system in those areas.

2 DR. REISCHAUER: It's not just the benchmarks.
3 That affects the -- I mean, the floor. It affects the
4 benchmarks everywhere.

5 DR. CHERNEW: No, I agree. So I agree. There are
6 a lot of those types of problems, but I think it's
7 particularly relevant from the left side of this.

8 DR. MARK MILLER: And Scott, if you would track
9 this, you said it would get rid of the overpayments? I
10 think that all depends on what you set the payment at before
11 you blend it. You could set the payments at 150 percent of
12 fee-for-service, then do the blend, and, of course, your --

13 DR. CHERNEW: [off mic] You could ratchet it up
14 or down but it does--it does affect the incentives of plans
15 to go in to places that are high cost versus low cost and
16 generally become more efficient. I personally think,
17 actually, the incentives -- I know they want to get more. I
18 actually think that's a relatively weak incentive compared
19 to if you were six percent cheaper at a relatively -- you
20 don't get to capture a lot of that savings the way that it
21 is legislatively set up, if you could do that.

22 MR. HACKBARTH: It also, at the high end, if you

1 have the blend line as opposed to the green line, it affects
2 the incentives of beneficiaries to move because it reduces
3 the additional benefits that are their reward for perhaps
4 opting into a more closed, confining delivery system.

5 MR. BERTKO: A number of comments. I'm actually
6 going to start with this slide and say that while I think
7 this is a perfectly good way to think about a blend, another
8 way, and I'm going back to my recollection of our report
9 probably from June 2005, another glide path to getting there
10 might be to blend using market areas and market costs that
11 is a bid-oriented one. Mike, it would have some of the same
12 effect, I think, that you're headed towards, which is the
13 highest payment areas tend to be the ones where HMOS, in
14 particular, can be most cost effective. And so the bids
15 actually -- and I think, Scott, you'd probably -- I know
16 mostly about Florida, where the bids are actually quite a
17 bit under the fee-for-service benchmarks and I believe
18 that's true in other very high payment areas across the
19 country.

20 DR. HARRISON: It might be. We're not sure.

21 MR. BERTKO: It might be. Yes. So that would
22 have the advantage, though, of not being arbitrary as this

1 one is. I think several people asked that question, and it
2 would be more oriented. And, as I'm guessing, in the low-
3 payment areas, there's a certain cost for dealing with CAH
4 hospitals and other kinds of things that would tend to bring
5 the bids up.

6 MR. HACKBARTH: Are you saying, John, calculate
7 the new system without any reference to fee-for-service
8 costs --

9 MR. BERTKO: No.

10 MR. HACKBARTH: -- just base it solely on bids in
11 an area?

12 MR. BERTKO: Well, perhaps ultimately, but in a
13 glide path towards that, it would be a blend between, say,
14 whatever the benchmarks are today or what they might become
15 and the market costs of the bids in those areas.

16 MR. HACKBARTH: Well, as I understand the orange
17 line, it is a blend of bids and fee-for-service costs,
18 right?

19 DR. HARRISON: No. The orange line is just
20 bidding local fee-for-service costs and national fee-for-
21 service costs.

22 MR. BERTKO: That's the issue, and we already

1 tried that with BBA.

2 MR. HACKBARTH: But the mandate, they said that
3 they wanted us to look at a blend that included plan costs.

4 DR. HARRISON: I didn't notice that, but I'm sure
5 they'd be interested, but I don't think it's specifically in
6 the mandate.

7 MR. BERTKO: No. And so whether you do it in the
8 short answer but at least for the longer-term answer, I
9 would suggest putting that into our thinking.

10 MR. HACKBARTH: I guess I was inferring that from
11 the fact that they wanted us to look at the relationship
12 between plan costs and fee-for-service costs as one element
13 of the mandate.

14 DR. HARRISON: Yes. I guess that I thought that's
15 what they wanted to do with the blend.

16 MR. HACKBARTH: Yes, and so I was just inferring
17 from that that one of the options that they wanted us to
18 look at is using the plan costs and -

19 MR. BERTKO: Again, as I recall, in I think that
20 2005 report, we actually had that as one of our four options
21 in there.

22 Second comment, and this goes to the VA/DOD stuff.

1 I think I'm okay with everything Scott had in the slides,
2 but partly to somebody else's question here, I don't have VA
3 experience, but we've got some DOD experience from my former
4 employer who was a big TriCare contractor and it's our
5 experience that people use both systems. We, in fact, had a
6 funny term for people who would emerge unexpectedly, calling
7 them ghosts, because they'd come out of the woodwork in
8 certain circumstances. And so I quite like the idea of
9 removing both claims and people from the denominator,
10 because right now, people are in the denominator, thus
11 lowering the fee-for-service rate book by that amount.

12 On the risk adjustment side, I agree with your
13 statement there, Scott. We can't tell whether it's up or
14 down, but there's an implied risk adjustment already in
15 there and the way that the HCC works, hierarchical condition
16 categories, if a person is served by both the VA and the
17 fee-for-service system, it's likely that their risk score is
18 already captured because it's not additive for the same
19 condition. It's, in fact, nested under it. So it's likely
20 that -- well, I'm guessing that the risk scores wouldn't
21 change all that much.

22 That is, you've captured some element of the risk

1 scores already, the net effect being that, A, I think there
2 would be, on average across the country, a modest bump up by
3 doing this, but secondly, and somebody asked about this, the
4 distribution of VA/DOD people is quite concentrated in
5 certain counties. Out of the 3,000 counties, I'm guessing
6 500 of them probably have most of the VA/DOD personnel
7 because that's where the facilities are, or that's where the
8 big facilities are.

9 So we're likely to see some bump when it's done,
10 but to someone who asked why hasn't this been done before,
11 several of us have been pounding on that door, and to the
12 credit of OACT, it's very, very difficult and they are
13 making some progress finally after a bunch of years.

14 MR. GEORGE MILLER: This may be more of a
15 clarifying question. Where would payments for DSH and sole
16 community providers be calculated, and how is that accounted
17 for?

18 DR. HARRISON: I believe that they are in the
19 fee-for-service measurement.

20 MR. GEORGE MILLER: How?

21 DR. HARRISON: They're included in the
22 fee-for-service numbers.

1 MR. GEORGE MILLER: Is that administrative costs?

2 DR. HARRISON: No, there's a DSH adjustment that's
3 paid for hospitals.

4 MR. GEORGE MILLER: Right.

5 DR. HARRISON: I believe that's captured when they
6 look at the claims.

7 MR. GEORGE MILLER: Okay. And one second
8 question. What about critical access hospitals? Is that
9 also calculated?

10 DR. HARRISON: It should be, yes. Now, one of the
11 problems is that when they measure the spending in a county,
12 they take -- they start January 1 and then they let the --
13 and they go through December and then they wait six more
14 months for all the claims to come in. Some claims aren't
15 cleared by even six months, and so we're going to look and
16 see if there's sort of a predictable distribution of late
17 claims. But we've gotten some sense that maybe some
18 hospitals tend to get tougher cases that are more likely to
19 last more than six months out, and so it might be every year
20 that they have a slightly higher payout than is captured and
21 so we'll look at that. That's one of the outstanding
22 issues.

1 DR. MARK MILLER: But Scott, I want to make sure I
2 followed all of this exchange. The fee-for-service
3 benchmarks, if services are provided in a county by a fee-
4 for-service provider, they get counted in building up the
5 fee-for-service expenditures which turn into the benchmarks.
6 On this last point about the claims delay, that's sort of a
7 current year problem and the benchmarks are based on five-
8 year averages.

9 DR. HARRISON: But they do not go back to the
10 previous years and update them --

11 DR. MARK MILLER: I see.

12 DR. HARRISON: -- and that might be something we
13 would say something about.

14 DR. MARK MILLER: And that's something that we're
15 going to look at for a future meeting. But to your direct
16 question, those providers should be represented and built up
17 in the benchmarks.

18 DR. HARRISON: I'm guessing that the CAHs, for
19 instance, are paid all year on their claims, and yes,
20 there's probably a settlement at the end of the year, but
21 hopefully that's a small settlement and it could go either
22 way.

1 DR. CHERNEW: And I think it's a lagged five-year.

2 MR. GEORGE MILLER: But it's a year behind, so how
3 do you calculate that? That settlement would be in the next
4 year.

5 DR. HARRISON: The settlement wouldn't get in. So
6 yes, if the settlements were always up, that would be a
7 problem and so that's something we're going to try to look
8 at.

9 DR. CHERNEW: I thought the benchmarks were a
10 five-year lagged, so it was in fact from year eight to --
11 fee-for-service are T-minus-eight to T-minus-three for --

12 DR. HARRISON: Right. For 2009, they're using
13 2002 to 2006.

14 DR. CHERNEW: Right.

15 DR. HARRISON: But, I mean, you've got to remember
16 that the 2009 rates are put out early in 2008, so the 2007
17 wouldn't have spun out by then.

18 DR. CHERNEW: Right, but I was just saying that
19 they have time to get -- I don't know if they do, but they
20 certainly have time to get some of that done because --

21 DR. HARRISON: Some of the back years done, yes.

22 DR. CHERNEW: Yes, because they're doing a five-

1 year average, but they're not doing a five-year average
2 right up until the day where they're doing it. They're
3 doing a five-year average. They've already lagged it so
4 they could get at least a complete financial picture.

5 DR. HARRISON: Right.

6 DR. KANE: I think it would be helpful in thinking
7 about this and in considering what we would like to
8 recommend to have an idea of what the impact on the Part B
9 premium of the non-MA enrollees is in any of these
10 benchmarks. I think part of the reason we are concerned
11 about the benchmarks is that the Part B premiums are paid by
12 everybody and this comes out of that, and so sort of what is
13 the impact on the Part B premium of paying 112 percent of
14 fee-for-service costs? So that's just something I'd like to
15 see --

16 DR. HARRISON: Right, and we've had that in our
17 past reports.

18 DR. KANE: But I think people don't always read
19 back, because some people don't even know where to look to
20 read back. So I would just like to keep that as a
21 highlight, because I think in considering the interests of
22 the beneficiaries, this is really a very important

1 consideration.

2 DR. MARK MILLER: Can I just back in behind that?
3 Scott, in December, when we go through and do the MA
4 landscape, what we call it, we usually report the premium
5 effect and then we also have at least sometimes reported the
6 HI trust fund effect.

7 DR. HARRISON: Yes, once in a while we've done
8 that, but --

9 MR. HACKBARTH: The premium effect last time we
10 looked at it, about \$2 per month?

11 DR. HARRISON: Yes, \$2 to \$3, I think.

12 DR. KANE: I just think it's something that we
13 should keep in mind and have that in front of us all the
14 time.

15 MR. BUTLER: One general comment. Whether you're
16 a big believer in Medicare Advantage or not, the more we
17 understand these kinds of data, this is at the heart of the
18 opportunity in improving the performance and expenditures
19 under Medicare. So the more we understand this and the more
20 we research it, I think the better off we're going to be.

21 Now, this may be a dumb suggestion or question,
22 but I know the floor was set at one point in time because in

1 certain markets, I believe, if I remember right, people
2 weren't participating. They said, I can't do it in
3 Minneapolis or New Mexico or whatever because the numbers
4 don't work, suggesting there must have been some flaw in the
5 data in some ways because I think people took a close look
6 at it and really believed they couldn't. So we set a floor.

7 Has anybody considered the other end of the
8 spectrum and said, why not a ceiling? If the numbers are
9 kind of flawed in some way, you could see a ceiling at the
10 top and achieving some of the same things that a floor is to
11 narrow the -- it's a very simplistic thing, but I suspect
12 there are some comparable areas where it just doesn't make
13 sense to accept the data as it comes through and I could see
14 how you could maybe do it that way, too. Simplistic, but --

15 MR. HACKBARTH: Peter, you referred to it as a
16 flaw in the data and that was the reason for the floors. I
17 don't think it was necessarily due to a flaw in the data as
18 much as a difference in market dynamics. In many but not
19 all, in many of the low-end cost areas, it's difficult for
20 private plans to compete with Medicare because the providers
21 have a lot of market power and plans find it difficult to
22 negotiate and get rates that are comparable to Medicare's,

1 whereas in many, although not all, of the high-end areas,
2 there's a lot of providers and it's a rich environment for
3 plans that can play providers against one another and
4 negotiate and get favorable rates. So it's not a flaw in
5 the data and how the calculations are done as much as
6 different market dynamics at the different ends of the
7 continuum. Some areas are better for private plans than
8 others just in terms of market structure.

9 DR. SCANLON: There was also a scale issue, which
10 is that some of the lowest APCC counties were very rural
11 counties and there were situations where you could have very
12 high penetration of a managed care plan, but you'd have very
13 few enrollees. And so the cost of setting up a network was
14 prohibitive in terms of going into that kind of a county.

15 DR. STUART: And just to clarify further, the
16 ability of plans to reduce the cost is a function of the
17 cost and that we really need to keep in mind. I mean, it's
18 not just markets. It's difference in the underlying
19 predilection to spend money. And in that light, I think it
20 might be useful if we had an empirical version of this chart
21 which showed for areas as you go up that green line what the
22 bids were in those counties so that we would see what you're

1 likely to change when you do these blends.

2 And my guess is that we're going to find that the
3 bids look somewhat like that blend line. In other words,
4 they're going to be above fee-for-service at the very low
5 spending areas, if they bid at all, but they're going to be
6 below the bid in those very high-cost areas. And John was
7 saying in some high-cost areas, I'll bet overall it's going
8 to be below that average.

9 MR. BUTLER: Then just one follow-up, Glenn. That
10 would suggest to me, though, then maybe Medicare shouldn't
11 go into those markets with a floor. If we're going to be a
12 prudent purchaser and get -- as we talked about yesterday,
13 why enter the market? You get a better deal now. Why
14 accept a higher price?

15 MR. HACKBARTH: [off mic] That's the point I've
16 been making.

17 MR. BUTLER: Suckered in.

18 [Laughter.]

19 DR. BORMAN: If we could go to page 11 for a
20 minute, and this may be an incredibly simplistic question
21 because, of course, Peter's simple question was not simple,
22 but mine will be. The correlation here is ballpark 0.8,

1 0.9, okay. Now, that means, then, that roughly 80 percent
2 of the variation -- 0.9 times 0.9, 0.81 -- is accounted for
3 by this relationship, or whatever this relationship is a
4 proxy for, right? So that says that there is somewhere
5 around 20 percent that's not accounted for here. Do we have
6 any reason to know, believe, would we speculate, is there a
7 major dominating factor in that other 20 percent or is it a
8 myriad of small factors that are not worth considering or
9 easily manipulable or worthy of our time?

10 DR. HARRISON: I think a lot of it is going to be
11 market dynamics. But the other thing is, this can only
12 measure linear relationships. Maybe linear is not exactly
13 the right model. Maybe you should be having logs or square
14 roots or all kinds of things. So there's all kinds of
15 possibilities that maybe it's not a straight line anyway.

16 DR. CHERNEW: [off mic] You can still measure
17 that.

18 DR. HARRISON: Oh, yes, we could. I think market
19 dynamics would be some of it.

20 DR. MILSTEIN: At the same time we're considering
21 this somewhat narrow question under MIPPA, the Medicare
22 Advantage plan is being obviously actively discussed as a

1 source of Federal budget relief. I think many of us kind of
2 chafe at the narrowness of this request and I wonder if we
3 might, in the process of staying within the boundaries of
4 the request, surface information that might inform a very
5 active and very important debate going on concurrently.

6 And among the pieces of information that I would
7 commend that we pursue, and this actually came up at our
8 retreat last summer, is information that the plans have on
9 what within their networks, subject to the managed care
10 incentives that these MA plans use, efficient providers are
11 actually able to deliver the benefit for, because the
12 relationship between that number and the number that we have
13 been looking at on slide five is breathtaking. There are
14 provider systems, at least in the discovery process that
15 I've been embarked on with some grant support funding, that
16 are delivering this benefit for 60 percent of the premium.

17 And even if you grant that we need to add onto
18 that the plan administrative costs, in the context of an
19 overall Congressional statement that Congress wants to begin
20 figuring out how to pay what efficient health care delivery
21 actually costs, I think mobilizing that information and
22 embedding it in our deliberations might -- in addition to

1 potentially giving us some ideas within the narrow mandate
2 that we've been asked to address -- might also serve as
3 information that might be quite useful in current
4 deliberations on Capitol Hill.

5 DR. REISCHAUER: This is just a question, Scott,
6 that was raised really by Nancy's remarks. How are Part A
7 only folks handled? We have an increasing fraction of the
8 population that's working past the age of 65. They become
9 automatically eligible for Part A. They don't sign up for
10 Part B because they're in employment situations which
11 provide them with health insurance. This probably varies
12 very significantly by geographic area, the fraction of the
13 total population, and will become increasingly more
14 important. I'm wondering, do they back all those people
15 out?

16 DR. HARRISON: They actually do Part A and Part B
17 separately.

18 DR. REISCHAUER: Separately?

19 DR. HARRISON: Right, and so you'd have only the
20 Part A eligibles in one pot that you're looking at the
21 average for and you'd only have the people buying Part B in
22 the other pot, and then they put them together.

1 DR. REISCHAUER: But even that is wrong. I mean,
2 I've been a Part A beneficiary for some time and have never
3 obviously taken advantage of it. That must skew the data.

4 DR. HARRISON: There is also working aged
5 adjustments, though, in the risk model, too. So you'd be in
6 the denominator, but you'd have a working aged designation.
7 Sorry.

8 [Laughter.]

9 DR. REISCHAUER: Hey, be careful, young guy.

10 MR. HACKBARTH: That affects the distribution of
11 the dollars as opposed to the level of the dollars, the
12 working aged adjustment.

13 DR. HARRISON: Well, it goes into the risk scores.
14 So you wouldn't show any dollars, but you'd also show a very
15 low risk.

16 MR. EBELER: Bob, I think of you as working
17 experienced, not working aged.

18 Nancy asked the question in the first round that I
19 think is an appropriate question for a very large purchaser
20 here, which was what -- and I'm sort of phrasing it more in
21 terms of moving towards a recommendation at some point in
22 this process, which is shouldn't we be getting data from

1 health plans about what they're spending on a lot more of a
2 real-time basis? It's not going to help us make the
3 judgment that we're having to make here, but folks sitting
4 here five or six years from now will really benefit from
5 that. It just struck me. I think you gave the right answer
6 under current policy. It sure is worth thinking about as a
7 large buyer how to do that.

8 The second large buyer thing that I would put on
9 the table, I don't know for this part of the report, because
10 it may be outside the boundary, but for longer term, is most
11 large purchasers don't dump off 100 percent of the risk to
12 health insurers. They engage in various types of risk
13 sharing and different types of corridors. The government is
14 doing that in Part D in different ways. It is worth
15 thinking about. I just sort of put it out there as a
16 placeholder. Again, I don't know that it fits into the
17 confines of this first request, but at some point it just
18 seems worth talking about.

19 MR. HACKBARTH: Yes, I agree, those are both
20 important issues. I think we would be hard pressed to
21 handle those, effectively address them in the short term, in
22 this cycle, but they're among the many Medicare Advantage

1 issues to come back to.

2 Okay. Thank you. Good job. We're done on this
3 for today.

4 Our next Medicare Advantage presentation is on
5 quality information. You'll recall that we have another
6 mandated report asking us to develop an approach for
7 comparing quality in Medicare Advantage to quality in the
8 fee-for-service system and this presentation is part of
9 that.

10 MR. RICHARDSON: Good morning. Today, we will be
11 giving you an update on recently released information on
12 quality of care that Medicare beneficiaries receive in
13 private health plans. The presentation includes results
14 from our analysis of publicly available data on the
15 performance of individual Medicare Advantage plans and a
16 review of a report on this topic released last month by the
17 National Committee for Quality Assurance. We also will
18 review the major sources of data on quality in Medicare
19 Advantage plans and discuss how the performance results from
20 different types of MA plans may be affected by
21 characteristics of the data sources.

22 Please note that the findings we discuss today

1 only pertain to Medicare Advantage plans and their coverage
2 of Medicare Part A and B benefits, not the quality of stand-
3 alone Part D drug plans or of the drug coverage provided by
4 Medicare Advantage plans.

5 The primary source of data on the quality of care
6 for enrollees in health plans, whether those are Medicare,
7 Medicaid, or commercial plans, is the Healthcare
8 Effectiveness Data and Information Set, or HEDIS. HEDIS was
9 developed and is maintained by the National Committee for
10 Quality Assurance, or NCQA. HEDIS measures include clinical
11 process and intermediate outcome measures and they address a
12 broad range of clinical activity, such as diabetes care,
13 treatments for cardiovascular disease, medication
14 management, and screening for certain types of cancers.

15 Most types of managed care organizations have been
16 required to report HEDIS measures as a condition of
17 contracting with Medicare since 1997. Currently, some
18 special HEDIS reporting rules apply to PPOs, which we will
19 discuss in more detail later. Private fee-for-service plans
20 are not required to report HEDIS results now, although some
21 private fee-for-service plans are reporting some HEDIS
22 measures on a voluntary basis, and we'll talk about that in

1 a moment. For all MA plan types, mandatory HEDIS reporting
2 will begin for services provided on or after January 1,
3 2010, under a provision of the recently enacted Medicare
4 Improvements for Patients and Providers Act, or MIPPA.

5 The second source of health plan quality we
6 examine is the Health Outcomes Survey, or HOS. The HOS is a
7 longitudinal survey of a continuously enrolled cohort of
8 Medicare plan enrollees that provides information about the
9 two-year changes in their physical and mental health status.
10 Not all MA plans currently participate in the HOS survey,
11 but as with HEDIS, MIPPA requires that all of the plans will
12 participate in the HOS starting in 2010.

13 For the HEDIS analysis, we used two sources of
14 data, the Annual State of Health Care Quality Report from
15 NCQA, which NCQA released on September 4 of this year, and
16 the Medicare public use files with HEDIS scores for MA
17 plans, which are reported to CMS. Our reporting on HOS
18 survey is based on information posted on the HOS website and
19 some discussions with CMS staff who are responsible for
20 administering the survey.

21 In brief, our analysis of the 2008 HEDIS data show
22 that MA plans overall made marginal improvements on their

1 average scores compared to the previous year's report. This
2 year, the average scores across all plans improved over the
3 prior year's averages for about half of the HEDIS measures,
4 while in last year's report we found that only about one-
5 third of the scores showed any improvement from the
6 preceding year.

7 As in our 2007 report, we found again this year
8 that there would have been more year-over-year improvement
9 but for the generally lower scores of newer MA plans, which
10 brought down the overall average scores on a number of
11 measures. Carlos will explain this finding and our other
12 key HEDIS results in more detail in a moment.

13 Looking at HEDIS performance across the different
14 types of MA plans, our analysis indicates that Medicare PPO
15 plans performed relatively well in comparison to HMO plans.
16 And in a new development this year, we also had HEDIS data
17 for the first time from a set of private fee-for-service
18 plans that comprise a significant portion of total private
19 fee-for-service enrollment. HEDIS scores for these plans
20 were generally the lowest among all MA plan types.

21 In the case of the Health Outcomes Survey, the
22 most recent results are better than those reported in the

1 private period, but there continue to be a number of plans
2 whose enrollees report worse than expected physical and
3 mental health outcomes. I will provide more detail about
4 the HOS results at the end of the presentation. First,
5 though, we want to drill down into the HEDIS results.

6 This slide summarizes the findings of the NCQA's
7 2008 State of Health Care Quality Report, which published
8 HEDIS scores for services provided in 2007 by Medicare,
9 commercial, and Medicaid plans. In releasing this year's
10 report, the NCQA stated that in comparison to commercial HMO
11 plans, this year's data marks the second year in a row of
12 relatively flat performance by Medicare health plans.

13 Specifically, commercial HMO plans improved on 44
14 out of 54, or 81 percent, of the HEDIS measures that were
15 applicable to a commercial health plan population. Sixteen
16 of these measures showed statistically significant increases
17 over the previous year's scores. Medicare HMO plans, on the
18 other hand, improved on just over half of the 45 measures
19 applicable to that population, with statistically
20 significant increases on only six measures. NCQA also noted
21 what they called unsettling declines in the rates of
22 screening for breast and colon cancer reported by Medicare

1 HMO plans.

2 For PPO plans, the 2008 report indicated that
3 Medicare PPOs posted HEDIS rates that were higher on most
4 measures than commercial HMOs. In fact, they were about the
5 same as those for Medicare HMOs, while commercial PPOs
6 generally had lower scores than the HMO plans in that
7 sector.

8 Carlos will now go over the findings from our
9 analysis of the latest HEDIS data reported by plans to CMS.

10 MR. ZARABOZO: Based on our analysis of CMS public
11 use files with HEDIS data, we found a situation that was
12 similar to what we reported last year. We compared newer
13 plans with older plans, that is, plans that had been in the
14 Medicare program since 2003 or earlier are compared to plans
15 that started their Medicare contracts in 2004 or later. We
16 found that older plans tended to have better HEDIS scores
17 than newer plans. Consequently, the overall averages are
18 lower because of the number of new plans that have entered
19 the Medicare program over the past few years.

20 Because much of what we'll talk about concerns the
21 differences between older plans and newer plans, here we
22 show you the distribution of older and newer plans. This

1 table shows that in terms of number of plans, older plans
2 are in the minority in the count of plans that are reporting
3 HEDIS data. That is, the majority of plans that are in the
4 HEDIS data, 56 percent, are plans that started contracting
5 with Medicare in 2004 or later, after the Medicare
6 Modernization Act of 2003 made a number of significant
7 changes in the program.

8 However, among plans reporting HEDIS data, the
9 large majority of enrollees are in the older plans, not the
10 newer plans. Seventy percent of the enrollees in the data
11 set are in older plans.

12 Here we show the make-up of the newer plans.
13 Again, we are defining newer plans as plans that began their
14 Medicare contracts in 2004 or later. The newer plans are
15 mostly HMOs, 52 percent. However, a large number of the
16 newer plans are PPOs, 40 percent.

17 Looking at the enrollment distribution, almost
18 half of the enrollees of what we are calling the newer plans
19 are in private fee-for-service plans. The remaining
20 enrollment is divided almost equally between PPOs and HMOs.
21 PPOs and HMOs each have about 28 percent of the enrollment
22 among newer plans.

1 As was mentioned, older plans generally have
2 better HEDIS scores than newer plans. If we confined our
3 analysis to only those plans that have been operating in
4 Medicare since 2003 or earlier, that is the older plans, we
5 would find that these kinds of plans showed improvement in
6 three-quarters of the HEDIS measures between last year and
7 this year. However, for some measures, newer plans
8 outperformed older plans, as in the case of monitoring of
9 participant use of certain medications, and older plans
10 showed declining performance in the measures tracking the
11 avoidance of harmful drug disease interactions.

12 The next slide shows that there can be striking
13 differences between newer plans and older plans in HEDIS
14 scores. Some of the HEDIS measures track intermediate
15 outcomes. Here, we show one of those measures for
16 comprehensive diabetes care. This graph shows that there is
17 a 13 percentage point difference between older HMOs and
18 newer HMOs in the percent of patients with diabetes who have
19 low cholesterol levels. And I want to point out about this
20 measure, this is a so-called hybrid measure which I'll talk
21 a little bit more about in a minute.

22 To return to a point that NCQA made, Medicare PPOs

1 perform relatively well. Here, we show that average HEDIS
2 scores for PPOs are about equal to or better than average
3 HMO scores in more than half the cases. For this table, we
4 are only looking at measures reported on by at least half of
5 the PPOs in the data set.

6 Private fee-for-service plans will not be required
7 to participate in HEDIS until 2010 under recent changes in
8 the law. However, CMS encouraged plans to voluntarily
9 participate in HEDIS. This year, we have data from 14 plans
10 representing about half of the current private fee-for-
11 service enrollment. Sixty-three private fee-for-service
12 plans have yet to report HEDIS data. As we previously
13 mentioned, in general, private fee-for-service plan scores
14 are lower than the scores of other plan types.

15 Using two of the measures for screening in HEDIS,
16 this graph illustrates the points in the preceding two
17 slides. One point is the private fee-for-service plans have
18 scores that are lower than HMOs and PPOs. Looking at the
19 second set of bars, as shown by the red bars, rather -- the
20 red bars are the private fee-for-service scores -- this
21 graph also shows one of the cases in which average PPO
22 scores are higher than average HMO scores. Looking at the

1 second set of bars for the measure of glaucoma screening in
2 older adults, the PPO score shown in the middle cross-
3 hatched bar is better than the average HMO score, shown in
4 the light blue bar.

5 Continuing with the example of glaucoma screening
6 in older adults, this graph again shows that PPOs perform
7 well and it also illustrates the better performance of older
8 HMOs compared to newer HMOs. In this graph, we are
9 comparing new plans and old plans but making
10 differentiations based on the structure of the plan. Here,
11 you see that if you separate newer HMOs and older HMOs, the
12 older HMOs have much higher average scores on the glaucoma
13 screening measure. The columns are shown in descending
14 score order. The older HMOs in the first column have the
15 highest average scores. You also see that PPO average
16 scores, the second column, are much higher than scores for
17 newer HMOs on this measure and that private fee-for-service
18 plans have the lowest score in this grouping.

19 In an earlier slide, we looked at one of the HEDIS
20 measures for comprehensive diabetes care, showing the
21 striking difference in the percentage of patients with
22 diabetes who had controlled their cholesterol. We compared

1 older HMOs with newer HMOs. We limited our comparison to
2 HMOs and did not include the other plan types, PPOs and
3 private fee-for-service.

4 By contrast, in looking at the glaucoma screening
5 scores, we examined all plan types, not just HMOs. The
6 reason for making a distinction when we compare certain
7 scores across plans is for some measures, differences in
8 scores between plans reflect different rules regarding how
9 to measure and report for HEDIS. For most measures, all
10 plans are on an equal footing in reporting their HEDIS
11 scores. For most measures, all plans base their scores on
12 administrative data, such as claims.

13 However, for 13 measures, including the
14 comprehensive diabetes care measures, HMOs can use a scoring
15 method that allows them to increase the score. HMOs can
16 bring medical records to supplement the data collected
17 through administrative records. This method of potentially
18 increasing a HEDIS score is not available to PPOs or private
19 fee-for-service plans for these 13 measures. The method is
20 also optional for HMOs. That is, an HMO can choose to
21 report solely on the basis of administrative data. So it
22 may affect the finding regarding the cholesterol management

1 among HMOs.

2 In its HEDIS guidelines, NCQA has noted that this
3 issue will be resolved by reporting year 2011, when all
4 plans will have a uniform reporting structure when reporting
5 on the care provided in 2010, and PPOs will be able to
6 report on the so-called hybrid measures.

7 Another factor that could explain the variation in
8 HEDIS scores we have seen between older plans and newer
9 plans is that newer plans may have lower scores precisely
10 because they are new to the HEDIS measurement and reporting
11 process. The argument would be that as the newer plans gain
12 expertise in using HEDIS, their scores should improve over
13 time. One test of the validity of this argument is to look
14 at newer plan scores to see if the newest plans have lower
15 scores than plans that have some experience in reporting
16 HEDIS scores.

17 Here, we show the results for six intermediate
18 outcome measures comparing brand-new HMOs, so to speak,
19 against plans that are also newer plans but which reported
20 HEDIS data both this year and last year. That is, we are
21 comparing the newest HMOs against relatively more
22 experienced HMOs. For these six measures, the newest plans

1 are better than the more experienced plans on four out of
2 the six measures.

3 Another point to mention on the subject is that
4 what we are defining as new plans, those that started their
5 Medicare contracts in 2004 or later, may not be new to
6 HEDIS. Many newer plans are sponsored by organizations such
7 as national chains that are not new to HEDIS reporting and
8 the Medicare or Medicaid or commercial sector. For example,
9 12 out of the 14 private fee-for-service plans that are
10 reporting HEDIS data this year are parts of larger
11 organizations that have longstanding Medicare HMO contracts.

12 We would also note that among the newer plans, we
13 have the 76 PPOs reporting HEDIS results that we classify as
14 newer plans because of the start date of their Medicare
15 contract. These newer plans often have average HEDIS scores
16 that are above the averages of older HMOs.

17 As a final note on this issue, in your mailing
18 material, we discuss the issue of plans reporting HEDIS
19 scores of zero on some measures or very low scores. We
20 found that in many cases, the low scores were reported by
21 older plans that had been Medicare contractors for many
22 years. So being new to the Medicare Advantage program does

1 not always explain a particular plan's low HEDIS scores.

2 We plan to continue looking at this question to
3 examine other plan characteristics or other factors that
4 contribute to the wide variation in HEDIS scores, such as
5 plan size, plan experience in the commercial sector, or
6 perhaps regional variation in plan scores.

7 We will now turn to the final section of our
8 presentation with John giving you an update of the recent
9 results from the Health Outcomes Survey.

10 MR. RICHARDSON: Just to briefly remind everyone
11 what the HOS is, the HOS assesses a plan's ability over time
12 to maintain or improve the physical and mental health of its
13 Medicare members. The survey is administered to a random
14 sample of members from each MA plan at the beginning and end
15 of a two-year period. For each member who participates at
16 both ends of the survey, a two-year change score is
17 calculated, taking risk adjustment factors into account, and
18 the member's physical and health status is categorized as
19 better, worse, or the same as expected. Plan level results
20 are calculated based on aggregated individual outcomes.

21 The most recent HOS results were released in
22 August of this year and report on the physical and mental

1 health status changes for a sample of MA enrollees who were
2 enrolled in the same plan in 2005 and 2007. The latest
3 results are similar to those covering the preceding two-year
4 period of 2004 to 2006. About 90 percent of the plans
5 showed health outcomes within the expected range, and about
6 ten percent had outcomes that were either better than
7 expected or worse than expected. We refer to these plans as
8 outliers. What is different in the most recent time period
9 is that although a number of plans still show worse than
10 expected outcomes, a higher number than last year show
11 better than expected outcomes. I'll explain that in a
12 minute.

13 Looking specifically at the separate physical and
14 mental health outcomes captured by the HOS, we see that for
15 physical health, there were more plans whose enrollees
16 reported better than expected physical health changes in the
17 most recent time period compared to the previous cohort.
18 But looking across the most recent group, there were still
19 more plans whose enrollees reported worse than expected
20 outcomes compared to those with better.

21 For mental health outcomes, the results were
22 uniformly positive in the latest results in that there were

1 more plans with better than expected mental health outcomes
2 compared to the previous cohort, and within the current
3 group, the majority of outlier plans are outliers because
4 their enrollees' mental health outcomes were better than
5 expected.

6 These points are shown quantitatively on this
7 slide, where you can see on the physical health measure,
8 which is the first two lines, there was an increase from two
9 to seven in the number of plans with better than expected
10 outcomes and a slight decrease in the worse than expected
11 physical health category. On the other hand, looking just
12 at the 2005 to 2007 cohort, there are still more plans with
13 worse than expected physical health outcomes rather than
14 better than expected, by eleven to seven.

15 In the case of mental health HOS measure, there
16 were more cases of better than expected results and fewer
17 worse than expected compared to the preceding time period.
18 And just looking at 2005 to 2007, there were more plans that
19 had better than expected outcomes rather than worse.

20 That concludes our presentation. We look forward
21 to your questions and discussion. Thank you.

22 MR. HACKBARTH: Okay, let me see the hands of

1 people who have clarifying questions.

2 DR. DEAN: A couple of things. First of all, as I
3 understand it, none of these changes were really tested for
4 statistical significance, is that true?

5 MR. ZARABOZO: That's right, except our -

6 DR. DEAN: A lot of them are really fairly small
7 changes. I think it may be a stretch to say that it is
8 better or worse.

9 And secondly, especially the last data that just
10 presented, or in general, do we have any indication about
11 how these performances relate to the fee-for-service
12 population? I mean, I'm sure you don't on any HEDIS data
13 because I don't think any of that gets reported. Does the
14 Health Outcomes Survey follow fee-for-service people?

15 MR. ZARABOZO: We are looking at attempting to get
16 a comparison based on the questions in the Health Outcomes
17 Survey that have been posed to fee-for-service beneficiaries
18 to do the comparison between Medicare Advantage and the fee-
19 for-service program, and Arnie is well aware of this issue.
20 CMS has the ability to do that comparison, so we're trying
21 to work on getting that comparison.

22 DR. DEAN: And finally, you talked about some

1 HEDIS data that -- all of that for like the private fee-for-
2 service plans would have to come from claims data, right? I
3 mean, there is no --

4 MR. ZARABOZO: Correct.

5 DR. DEAN: And yet, some of that data, like
6 cholesterol control and so forth, that can only come from
7 chart review.

8 MR. ZARABOZO: Well, the so-called hybrid measures
9 are both administrative claims data -- they specify, for
10 example, CPT codes that would indicate meeting certain
11 things. But this is why the PPOs are not expected to report
12 the hybrid measures. They are not -- in the CMS data, you
13 see a lot of reporting of the hybrid measures by the PPOs.
14 These are the measures that can include the medical chart
15 review, and as I mentioned, can improve the score for an HMO
16 that chooses to look at medical records.

17 DR. DEAN: I didn't understand that. PPOs, why
18 are they not -- it said they are not allowed to use that.
19 Why are they not allowed to use that?

20 MR. ZARABOZO: I think it's because it's assumed
21 they don't have full access to the medical records to give
22 them the contracting structures. In other words -- and

1 therefore, it would not make it a comparable comparison
2 between PPOs and HMOs and across PPOs.

3 MR. HACKBARTH: Anybody else on this? Ron?

4 DR. CASTELLANOS: Just a clarifying question. Do
5 you know if any of the MA plans get bonuses based on their
6 HEDIS score?

7 MR. RICHARDSON: Not under Medicare.

8 MR. ZARABOZO: Within the plan, you mean, that
9 they are --

10 DR. CASTELLANOS: Within the plan, yes.

11 MR. ZARABOZO: Potentially. I don't know if HEDIS
12 is the basis of scores, but, I mean, there is the practice
13 of better quality. For example, in California, HealthNet
14 has a list of better performing medical groups and so on. I
15 assume that HEDIS may be a factor there.

16 DR. CASTELLANOS: I think it does happen in the
17 real world.

18 MR. RICHARDSON: Yes.

19 MR. HACKBARTH: So your question, Ron, is whether
20 plans within their internal payments --

21 DR. CASTELLANOS: Within the internal plan use
22 bonuses to increase --

1 MR. HACKBARTH: Yes, they do

2 DR. CASTELLANOS: It's a reverse on pay-for-
3 performance --

4 MR. HACKBARTH: Yes, they do.

5 DR. CASTELLANOS: -- but it does happen. That's
6 what I'm trying to say.

7 MR. HACKBARTH: Yes.

8 DR. KANE: Just linking back to our discussion
9 yesterday about medication therapy management programs, is
10 there a collection of questions around that? They seem to
11 be disease-specific rather than if you have more chronic
12 conditions and you're managing ten medications. Is there a
13 question in HEDIS that addresses that issue and would help
14 us understand better whether there's medication therapy
15 management?

16 MR. ZARABOZO: It is only the specific measures
17 for specific drugs.

18 DR. KANE: Okay.

19 DR. CHERNEW: So you reported the sample size,
20 which is good, but some of them seem small, so I was
21 wondering how many of the differences were statistically
22 significant and how comfortable are you with any risk

1 adjustments that are done or benefit design effects. A lot
2 of these things have to do with use of medications and other
3 things and many of these things have to do with the
4 enrollees doing something, like getting screened. So
5 benefit design could be important. And, of course, there's
6 obviously selection effects as the people who join the
7 different plans. So I'm just curious as to how you feel
8 about the statistical significance and the general
9 adjustments to these things.

10 MR. ZARABOZO: We have not done analysis based on
11 statistical significance. Also, on the risk adjustment, the
12 measures are supposed to be not needed -- you don't need
13 risk adjustment. But as you point out, a lot of these are
14 adherence issues and so you have an issue of what kind of --
15 you need to recognize there are differences in the
16 populations and how do you recognize those differences is an
17 issue.

18 MR. BERTKO: Two questions. Carlos, I think I
19 heard you say some of the HEDIS measures came from
20 administrative data, and so you nodded then, and the
21 question is can you then go to fee-for-service and get the
22 comparable measure calculated from fee-for-service?

1 MR. ZARABOZO: Yes, you could do that. As Nancy
2 mentioned I think last session, the Dartmouth, those people
3 have done this. Now, the measures that they used are
4 actually -- several, I think, are hybrid measures, so
5 they're not directly comparable. But if you look at the
6 averages in fee-for-service across, for example, the
7 hospital referral regions, what you see is that at the very
8 high end, you have HMO scores, but also at the very low end,
9 below the fee-for-service averages are plan scores. So this
10 sort of is related to the question of we have plans
11 reporting zero, we have plans reporting low scores. So on
12 that comparison, you have both extremes coming from the
13 health plans as opposed to coming from fee-for-service.

14 MR. BERTKO: Okay. Good. I know I've worked with
15 Beth McGlynn on the RAND administrative measures of quality,
16 also, whether that would go in.

17 The second question was whether, and this is an
18 Arnie kind of question, do you have the ability to display
19 the best of the plans in either HMO or PPO mode to see what
20 we might be striving for?

21 MR. ZARABOZO: In terms of just their scores?
22 Well, yes, in terms of like a composite? Yes, which is what

1 NCQA does when they do their U.S. News kind of thing.

2 MR. BERTKO: I would be interested in seeing that.

3 DR. MILSTEIN: This question pertains to slide 21.

4 I'm not sure whether I tracked the prior question and answer
5 a few minutes ago, but I'll reframe it and give you a chance
6 to potentially re-answer the same question. The outcomes
7 better or worse than expected, isn't that based on a
8 statistical definition of expected?

9 MR. ZARABOZO: It's case-mix adjusted expected,
10 yes.

11 DR. MILSTEIN: So that would be -- these
12 differences are -- and I also, just to make sure I --

13 MR. ZARABOZO: Yes, but in terms of the HEDIS
14 scores, yes.

15 DR. MILSTEIN: Thank you. And the second question
16 is, am I right that the norms here, where we see better or
17 worse than expected, it's normed to just like an average
18 population. It's not subject to any special management.

19 MR. ZARABOZO: It's the average within the MA
20 sector.

21 DR. MILSTEIN: Within the MA sector?

22 MR. ZARABOZO: Right.

1 DR. MILSTEIN: Okay. Thank you.

2 DR. CHERNEW: I'm confused. You said on 21 these
3 are statistically significant, better or worse than
4 expected, but there are these multiple comparisons, so I am
5 not sure I can explain the asymmetry. But if you have 100
6 plans and you have a statistical threshold for what is
7 better or worse than expected, you are going to have a
8 certain number that are better than expected or worse than
9 expected in the outlier tails just by pure chance. It's
10 constructed so that would have to be the case, I think.

11 MR. ZARABOZO: I don't think so because you have
12 years in which there is zero, zero worse and zero better
13 than expected.

14 DR. CHERNEW: So then would the better than
15 expected bars have to be constructed in a way that's
16 different than the statistical -- there has to be some other
17 measure of expectation there --

18 MR. ZARABOZO: Right, and I'm not sure --

19 MR. RICHARDSON: We could follow up on that
20 specific question.

21 MR. HACKBARTH: Any other clarifying questions?
22 Hearing none, let's go to round two.

1 MR. EBELER: Thank you very much. This is very
2 interesting. Two sort of requests for whether there's
3 additional data that would be helpful. One relates to our
4 push on the fee-for-service side for delivery reform and
5 whether it's possible to look at -- both HMOs and PPOs have
6 different degrees of relationship with the delivery system
7 and whether it's possible to make some distinctions about
8 that. I actually think John's question will implicitly get
9 to some of this answer, but an HMO isn't an HMO and a PPO
10 isn't a PPO. So if it's possible to produce those data.

11 The second is related to what you flagged about
12 the definition of new plans and the fact that a lot of new
13 plans are, in fact, presumably part of Humana or United or
14 Wellpoint. Would it be possible to aggregate these data in
15 effect at the corporate level? I mean, Rachel's data
16 yesterday showed that we can put a half-dozen plans in the
17 room and have 50 percent of the MA beneficiaries covered.
18 There's advantages and disadvantages to that type of scale.
19 The advantage would be for CMS to be able to sit down with
20 those folks, look at their quality data, look at the
21 variation among their various sectors, and challenge these
22 major players to do the improvements. So could we aggregate

1 the data at the corporate level would be the second
2 question.

3 MR. ZARABOZO: Yes, we can do the aggregation at
4 the corporate level, and yes, as you say, an HMO and a PPO,
5 sometimes the distinction is not clear. As I mentioned, in
6 some cases, we have plans that are new PPOs that are
7 operated by an HMO in a particular service area that have an
8 exactly matching service area. Presumably, the network is
9 very similar. So we are looking at a comparison of those
10 kinds of plans.

11 MR. EBELER: Again, the one break point, if we're
12 right on what we're talking about in the fee-for-service
13 Medicare is the degree to which they're connected to
14 delivery and whether that distinction is possible.

15 MR. ZARABOZO: For example, you could find out the
16 -- well, if we could, I don't know that we can -- the degree
17 to which out-of-plan utilization occurs, that is non-network
18 providers are used within a PPO, but I'm not sure that we
19 could find that out when we have encounter data. Everything
20 is going to rely on encounter data.

21 MR. HACKBARTH: This point about the variation
22 within these categories, statutory categories, HMO, PPO, et

1 cetera, I think is critically important, and I vaguely
2 recall that Harvard Pilgrim Health Care now participates in
3 Medicare as a private fee-for-service plan.

4 MR. ZARABOZO: Yes.

5 MR. HACKBARTH: Just as an illustration of these
6 legal categories are not really representative of what
7 happens on the ground in the real world.

8 MR. ZARABOZO: As a matter of fact, because
9 Harvard Pilgrim dropped off of the HEDIS scoring between the
10 previous period, their absence affected the averages such
11 that there was one measure that would have improved had
12 Harvard Pilgrim been in the measure in the sets, but they
13 were not.

14 DR. CROSSON: Could I just respond to the first
15 part of Jack's question, because that was going to be my
16 question, also, and it has to do with the question of what
17 are some of the factors influencing the difference between
18 newer and older plans. It is, I believe, the nature of the
19 delivery system, because I suspect that there are many more
20 older plans that have organized delivery systems with whom
21 they've worked for a long time than in the newer plans.
22 That would be something to show, but I believe that's the

1 case.

2 There actually has been work done by Steve
3 Shortell's group to break down -- with NCQA to break down
4 the NCQA HEDIS data by delivery system type. It was
5 published about a year and a half ago or so. So I thought
6 it might be useful to actually take a look at that, if we
7 could do that.

8 MS. HANSEN: Mine is probably more of almost going
9 back to the practice level, delivery system. On page nine,
10 the slide nine, the whole point of medications comes up with
11 some of the performance of newer plans vis-a-vis older
12 plans. The theme that's highlighted here, the example is
13 the medication aspect.

14 I wonder -- there are two questions. One is
15 related to yesterday's MTM component of it, whether or not
16 there is any way to also get some information as to the
17 utilization of any MTM practices in any of these plans. So
18 I don't know whether it's something that can be overlaid as
19 looking at this, because medications does seem to be a theme
20 on this and there is a monitoring aspect of the newer plans
21 that's noted and the older plans also are watching some
22 harmful drug disease interactions. So I just want to

1 sometimes tie whether or not these practices are making use
2 of this particular tool that's there.

3 The other one is more something that I would ask
4 some help on, whether or not the HOS that have better
5 performance over time also is reflected somehow in the HEDIS
6 measures so that there's an overlay, so that they're not
7 looked at in discrete bodies but we can begin to do kind of
8 an overlay matrix of some of these factors. So that would
9 be just of interest, to see basically what does the plan do
10 on an actual delivery side.

11 MR. ZARABOZO: We can talk to Joan about the MTM
12 relationship. The HOS data, we can get the information. We
13 have the last version. We have to do a data use agreement
14 with CMS to get the HOS information, but we can do a
15 comparison.

16 MS. BEHROOZI: Thanks. Can you go back to slide
17 five? We were talking about old and new plans, new plans
18 often being subsidiaries or whatever, related to existing MA
19 plans, but they're also related to existing commercial
20 plans, so it's not just about being experienced at reporting
21 HEDIS data or collecting it or whatever but they actually
22 know how to do it better. So why is it that Medicare is not

1 getting what commercial purchasers of HMO and -- well, HMO
2 plans, at least, are getting? Do we know anything about
3 what's behind that? Is there not adequate risk adjustment
4 or something?

5 MR. ZARABOZO: Well, I think it might reflect
6 stability in the market. That is, the commercial market is
7 more -- I mean, if it is the new issue, the set of
8 commercial plans has probably not changed very much in the
9 last couple of years.

10 MS. BEHROOZI: But aren't they run by the same, I
11 mean, you have the corporate-level data looking across
12 commercial --

13 MR. ZARABOZO: Yes. That's why looking in more
14 detail about are these chain organizations, are these not
15 chain organizations, do they have a commercial presence or
16 not in an area, I mean, the area might be the issue, for
17 example, if they're -- it could be a large national chain
18 newly enters a market solely for Medicare, so that may not
19 be quite the same situation as a large chain in a current
20 market is adding Medicare. So that may be a difference,
21 also.

22 MS. BEHROOZI: I just wonder if there's data that

1 we could dig into to see whether, side by side, we're just
2 getting a worse product from the same producers of the HMO
3 products. Are the expectations not as high or what's the
4 problem?

5 MR. ZARABOZO: We could do some types of
6 comparisons of commercial to Medicare. For example, the
7 U.S. News, the NCQA U.S. News rankings, they have the
8 commercial rankings and they have the Medicare best plan
9 rankings and sometimes there's overlap, not necessarily
10 always. Minnesota, for example, posts all of the HEDIS
11 reports from all of its health plans on the web and there
12 you can do the comparison of commercial to Medicare within
13 the same plan, actually. I mean, we also would like to look
14 at that to see how they're doing.

15 MR. HACKBARTH: Could one explanation be that it's
16 the same company, but you're talking about different patient
17 populations with different distributions of illness and they
18 may be strong in an area where you have a smaller number of
19 Medicare beneficiaries and weak in an area where you have
20 more Medicare beneficiaries?

21 MR. ZARABOZO: Yes. I think looking at the
22 Minnesota numbers might show that, that it's the same plan

1 but a different population, really.

2 MR. RICHARDSON: An example of that would be the
3 commercial plans rely a lot on pediatric measures and those
4 obviously are not applied in the Medicare measure set. So
5 when you're looking just at these numbers of measures and
6 how many improved or not, you need to --

7 DR. CHERNEW: A plan would share some amount of
8 its processes across -- if you were one plan that had both
9 commercial and not, you wouldn't do things necessarily
10 differently. You might have certain different initiatives
11 in one population, but you'd do much the same thing. The
12 differences are likely to be because of the network where
13 the patients are actually going to or the nature of the
14 patients, they're different patients --

15 MR. ZARABOZO: Yes.

16 DR. CHERNEW: -- as opposed to the plan deciding,
17 we're not going to focus our diabetes management in the
18 over-65, because most of the time, they'll try and do the
19 same things within those --

20 MR. ZARABOZO: Yes, and sometimes the Medicare
21 networks are different from the commercial networks for a
22 given plan in a given geographic area.

1 DR. CHERNEW: People may just live differently,
2 because the commercial plans are going to have employers.

3 MR. ZARABOZO: Yes.

4 DR. CHERNEW: They're going to live in a certain
5 place --

6 MR. ZARABOZO: Many differences.

7 MR. BUTLER: A comment and a question. The
8 comment is when I read through this, it's just a reminder
9 again of how fundamentally different the health plan agenda
10 is on these things versus the provider community that's not
11 involved in risk. It's just shocking. And Ron mentioned
12 incentive compensation. All the way up our silos, we're
13 working on totally different things that don't come
14 together, and neither one is a bad agenda, but they're not
15 connected in a partnership in a way that's going to improve
16 things. Somehow, we have to bridge those gaps wherever we
17 can to make a difference, because believe me, there's a lot
18 of intellectual energy going into quality improvement and
19 the more it could be sync-ed up, the better. So that's just
20 a comment.

21 The question is, some of the HEDIS measures, my
22 experience with them and so forth, in the employer-insured

1 market, one of the issues was constant turnover, high
2 turnover enrollees. You know, you never had longitudinally
3 a way to look at whether you're making a difference. I
4 don't know, but my question would be if you turn 65 today,
5 you're likely to live to 85. I'm not sure what the number
6 is, but you're going to live a while. As the baby boomers
7 emerge, are we going to be able to have a much better
8 opportunity to look longitudinally in how we are doing
9 across the years and really make a difference in this
10 population that might be a little different from the under-
11 65 population? Another very specific question, how long are
12 people staying in the same plan would be a more direct way
13 of answering.

14 MR. ZARABOZO: Medicare beneficiaries generally
15 stay in the same plan and there is very little turnover,
16 really, as a percent of the enrollment.

17 In terms of longitudinal results, the Health
18 Outcomes Survey is what we currently have for longitudinal
19 results.

20 MR. BUTLER: Does it leave you with some optimism
21 we'll get better and better data then to see how we're
22 really doing?

1 MR. ZARABOZO: I'm trying to think whether at the
2 plan level we could -- one issue currently is maybe the
3 growth in enrollment explains some of these changes, just
4 that large enrollment growth, you have to handle it. You
5 have to manage it. So it's not quite stable at the moment.
6 But over time, I think we could do a comparison of how is a
7 specific plan doing with a relatively stable population over
8 time. So yes, potentially, you can compare based on HEDIS
9 data.

10 DR. CHERNEW: I was just going to pick up on the
11 point earlier about the heterogeneity in quality within plan
12 types and add that I think it's important that we don't in
13 interpretation condemn the program or malign it for those
14 plans that do poorly or view it as simply the average, but
15 instead -- this is probably an Arnie comment -- strive to
16 figure out how to make those that might not be performing as
17 well perform better, because I do think that it's possible
18 that the MA program can, in the best cases, show us how well
19 we could do and I think that's important to recognize
20 instead of just looking at the averages.

21 MR. HACKBARTH: Arnie, you're having a real
22 impact.

1 DR. MILSTEIN: I realize this has not come up
2 before and the feasibility of doing this within the time
3 that we need to deliver the report, I'll leave it to you to
4 judge. But one of the things that is emerging in a number
5 of efforts to measure and improve performance is the danger
6 of an overly narrow dashboard of measures. I'll just give
7 you a frame of reference. I think in HEDIS there are, what,
8 40 or 50 quality measures, and if you were to ask about how
9 many things would you want to track if you wanted to
10 optimize care for seniors, one window on that is the so-
11 called ACO measure set that RAND developed, which I think
12 has 450, so it's --

13 And the reason I think this might be important to
14 at least footnote in our report is that there is emerging
15 evidence that one of the unintended consequences of focusing
16 on that which is easier to measure, or easier for all
17 parties to agree on, let's call it, the HEDIS measure set,
18 there's actually emerging evidence that one of the
19 consequences of focusing on a narrow set of measures is that
20 the aspects of performance that are not being measured are
21 often declining due to lack of attention. At least in our
22 report, we could pull some of those published results in.

1 I guess my only comment is that it would be, I
2 think, useful given these emerging findings if we could
3 address in our report the feasibility of a bigger measure
4 set. I mean, the beauty of a bigger measure set is it
5 really then makes so-called teaching to the test infeasible.
6 In other words, if you're being tracked on 150 things, it's
7 very tough to not begin to think about systematic quality
8 improvement across the board, whereas if you're being
9 tracked on a narrower set, it enables saying, well, let's
10 just hire a bunch of QA nurses and just focus on this
11 narrow, on tracking and dogging these narrow measures rather
12 than focusing on what I think we would all like to see,
13 which is kind of a step back and sort of asking, what is a
14 systems approach to optimizing quality across all 450 things
15 we'd like to see done perfectly for seniors.

16 DR. REISCHAUER: This is interesting, but I sort
17 of have the feeling it's not getting at the real questions
18 that we should be asking, and others, I think, have brought
19 this up. The fundamental question is how does Medicare
20 Advantage compare to fee-for-service, and once we have the
21 answer to that question, then we have to ask ourselves,
22 should there be a minimal threshold above which after, say,

1 three years of participation a Medicare Advantage plan has
2 to meet because we're, in a sense, stimulating an
3 alternative delivery system that might make people worse off
4 in some cases.

5 I think, like Mike, believe the potential is
6 actually in the other direction, but one never knows with
7 all of the alphabet soup of types of organizations we have
8 and we should therefore be maybe looking at the top ten
9 percent in each of these categories of types and saying,
10 well, what is the pay-for-performance system or the other
11 set of incentives that we need to develop to get everybody
12 up there who is in this game?

13 While we're looking at sort of one aspect of the
14 variation here, which seems to be the characteristics of
15 plans -- are they new, are they old -- what we need to also
16 look at if we're trying to explain how this changes over
17 time is the characteristics of beneficiaries, you know,
18 education, income, age, length in plan, et cetera, and the
19 characteristics of the market areas they're in. Does
20 geography matter? Is it hugely difficult in rural areas to
21 get these kinds of measures up to levels that would exceed
22 fee-for-service? And so we should really try and

1 restructure what it is we're after in the long run when we
2 go through these analyses each year.

3 MR. HACKBARTH: Okay. Thank you very much.

4 We are on to our final session, which is
5 principles for measuring physician resource use.

6 Whenever you're ready, Jennifer.

7 MS. PODULKA: Thanks, Glenn.

8 Good morning. Today I want to sort of switch
9 tracks. We are continuing to conduct our data analysis of
10 physician resources use measurement, and I promise I'm going
11 to come back to you at future Commission meetings with more
12 than enough results to make everyone's palms sweat. But
13 today I want to take a qualitative, more broad perspective
14 and get your input on some issues related to that.

15 First, I need to remind everyone that in the March
16 2005 report to the Congress, the Commission recommended that
17 Medicare measure physician resource use and share the
18 analysis results with physicians in a confidential manner.
19 In its most recent March report, the Commission recommended
20 that Congress require the Secretary, following two years of
21 this confidential feedback, to make data on physician
22 resource use public and be prepared to use those data

1 analysis results to adjust physician payments.

2 At the time we noted that this recommendation was
3 motivated by a sense of urgency over how the distribution of
4 Medicare physician payments is distorted by incentives that
5 encourage the overuse of some services and the underuse of
6 others. Secondly, we were concerned that Medicare's
7 physician fee-for-service payment system does not
8 systematically reward physicians who provide higher-quality
9 care or care coordination; and, third, that it offers higher
10 revenues to physicians who furnish the most services,
11 regardless of the value of those services.

12 This summer the Congress enacted our first
13 recommendation on confidential feedback in the Medicare
14 Improvements for Patients and Providers Act of 2008, or
15 MIPPA. And as we discussed at the September Commission
16 meeting, CMS has already begun work that they refer to as
17 the Resource Use Report pilot that will implement physician
18 confidential feedback, and note that MIPPA granted the
19 Secretary a great deal of flexibility in how to design that
20 program.

21 So today this is an opportune time for the
22 Commission to discuss how they envision that Medicare's

1 physician resource use measurement program should work, and
2 I want to note that CMS is explicitly seeking our input and
3 that of others on this program.

4 We have already addressed some fundamental
5 questions, but others remain. For what we've addressed,
6 fundamentally we would like Medicare's program to measure
7 physician resource use and provide feedback to encourage
8 efficiency, which is defined both by resource use and
9 quality, and discourage inefficiency. Payment adjustments
10 could directly reward efficiency and penalize inefficiency
11 and, thus, may help to abate Medicare's growing spending for
12 physician services. Also, the program should encourage
13 thoughtful reflection and discussion among physicians about
14 how their practice patterns drive resource use.

15 So that's understood, but that brings us to
16 several open questions, the first of which is: Should the
17 program measure physician resource use in multiple ways?
18 Most of our analysis has focused on using episode groupers
19 as one way to measure resource use. Episodes are important,
20 but they probably should not be the sole measure of
21 physician resource use. Additional measures such as per
22 capita utilization, quality, rate of generic drug

1 prescribing, and others could be included to produce a more
2 complete picture. Also, we've already discussed how the
3 program should provide physicians with both summarized data
4 and more detailed information, such as breakouts by type of
5 service.

6 A second question here is: Should the program
7 provide feedback to most physicians or focus only on outlier
8 physicians? Focusing only on outliers would be more
9 administratively feasible for CMS and less costly, while it
10 would still offer the opportunity for some positive impact
11 by altering the practice patterns of the most inefficient
12 physicians.

13 Alternatively, there would be advantages to
14 providing feedback to most Medicare physicians. Note that
15 it would be unrealistic to expect the program to provide
16 feedback to all Medicare physicians. Physicians' resource
17 use should only be measured and compared to their peers if
18 they provide enough of a beneficiary's care to be considered
19 responsible for that individual or the episode and if they
20 treat enough beneficiaries and episodes to warrant
21 comparison. Giving detailed feedback to physicians across
22 the entire efficiency distribution would allow even non-

1 outliers to recognize any efficiencies they may have, such
2 as overuse of advanced imaging, and work towards improving
3 them.

4 A third question here is: Should the program
5 measure and provide feedback to individual physicians,
6 groups, or both? Some argue that when physicians are
7 organized into group practices, they should be measured and
8 receive confidential feedback or public reporting as an
9 average for the group practice. However, about 40 percent
10 of U.S. physicians practice solo, and comparing group
11 practices can be problematic in communities where these
12 groups are so large and command so much market share that
13 there are too few peers for comparison. So if you think of
14 it in this way, when one measures physician resource use,
15 you need to balance the need for sufficient experience for
16 each physician versus a sufficient number of peers for
17 comparison.

18 And, finally, MIPPA requires that Medicare conduct
19 education and outreach activities as part of the physician
20 feedback program; but given CMS's limited resources and
21 numerous responsibilities, these new efforts will be
22 challenging. CMS could partner with other entities, such as

1 physician organizations and specialty societies, to support
2 physicians in interpreting feedback reports and using them
3 to improve practice patterns. Another possible approach
4 would be to work through the quality improvement
5 organizations, or QIOs, or redirect their current efforts.

6 Next, the Commission may want to discuss and
7 embrace a set of principles to guide Medicare's physician
8 resource use measurement and feedback program. Numerous
9 other groups, such as the Consumer-Purchaser Disclosure
10 Project, National Quality Forum, and many others, have begun
11 to outline their own principles. Furthermore, we may want
12 to know which principles should be adhered to from day one
13 of the program versus those that should be considered future
14 goals. Some possible principles are listed here. I'm going
15 to discuss these now using statements rather than questions,
16 but I want to note that these are straw proposals, and all
17 are on the table for discussion.

18 First, for transparency, Medicare's measurement
19 methodology and a description of the data used should be
20 made publicly available. Currently, CMS's RUR pilot relies
21 upon commercially available episode grouper software
22 packages. This allows Medicare to evaluate features in

1 these software packages that could be included in a
2 Medicare-specific software package. I want to stress, we
3 have never expected Medicare to purchase off-the-shelf
4 software. In its history, the program regularly contracts
5 with vendors to develop tailored programs, such as
6 diagnostic related groups, or DRGs. The final program used
7 for physician resource use should also use a Medicare-
8 specific transparent method.

9 Second, the principle -- sorry these aren't quite
10 parallel, but actionable. Feedback should include detailed
11 breakout, such as by type of service, provider, and
12 condition, in addition to overall scores.

13 Third, on risk adjustment, MIPPA gives the
14 Secretary discretion to choose to adjust data for
15 beneficiaries' health status and other characteristics. We
16 feel that the program must do so to measure resource use as
17 appropriately as possible. The good news is that existing
18 episode grouper software packages do include different forms
19 of risk adjustment, and other measures of resource use if
20 they were used, such as per capita utilization, should also
21 be risk-adjusted.

22 Next, multiple measures. The program should

1 analyze physicians' resource use using multiple measures,
2 such as per episode, per capita, quality, and rate of
3 generic drug prescribing. However, the program should not
4 be delayed until all of these measures are ready. Instead,
5 the program should begin with as many measures as are
6 appropriate and transition to full implementation over time.
7 Even once it's fully implemented, the program should be
8 flexible enough to weight or even exclude any of these
9 measures where appropriate, such as excluding rate of
10 generic drug prescribing for physician specialties that do
11 not regularly prescribe drugs.

12 Next, opportunity for physician input. The
13 program will need to balance Medicare's need to make
14 methodology decisions necessary to begin implementation and
15 a physician's right to be fairly measured. There are at
16 least three mechanisms that currently exist to ensure that
17 physicians' collective and individual concerns are
18 addressed:

19 First, CMS's RUR pilot is specifically designed to
20 garner physician input.

21 Second, the resource use measurement and feedback
22 program should be included as part of the physician proposed

1 rule published each year. It's included this year, and this
2 gives physicians and others an opportunity to comment.

3 And, third, physicians' individual payment
4 concerns can already be appealed through an established
5 system that includes carriers, administrative appeals
6 boards, and administrative law judges.

7 And, finally, the principle that measurement will
8 improve over time. Ideally, changes in physicians' year-to-
9 year resource use measurement results should be due to
10 changes in their practice patterns alone rather than changes
11 in our measurement methods. However, this program will be
12 an entirely new endeavor for Medicare. It is unrealistic to
13 expect that the measurement methodology that they use in the
14 first year will remain unchanged in the future.

15 One way to help deal with this would be to pilot
16 test any future refinement to measures by including them,
17 highlighted as such, in the detailed feedback for a year or
18 two before including them into overall scores.

19 Now I'm going to move away from discussing
20 Medicare's physician resource use feedback program and
21 address a separate issue that the Commission may wish to
22 address. There is interest in releasing Medicare claims

1 data so that entities such as private plans can aggregate
2 Medicare data with their own to measure physician resource
3 use. Data aggregation could address the small "n" problem
4 where private plans, because of their low market share, have
5 too few physicians or too few claims from physicians to
6 appropriately measure their resource use. This would work,
7 first, by adding Medicare data to the private plan's data to
8 increase the number of claims and patients so that the
9 plan's contracted physicians would each have more experience
10 to measure. It would also add more measurable physicians
11 for peer comparison.

12 For example, if a private plan contracts with only
13 two pediatric cardiac surgeons, it would have an
14 insufficient peer group for comparison. Aggregated data for
15 Medicare would allow the plan to compare its two pediatric
16 cardiac surgeons to many others of the same specialty.

17 One should understand that releasing Medicare
18 claims data could assist private plans in their measurement
19 of their physicians, but without reciprocal data sharing
20 from these plans, Medicare would not benefit from the data
21 aggregation. And data aggregation may not be as necessary
22 for Medicare, which, as the largest U.S. health care payer,

1 has many physicians with sufficient n's for analysis.

2 Data aggregation is also suggested as a way to
3 address the problem of physicians receiving contradictory
4 efficiency scores from different entities. However,
5 releasing Medicare claims data for aggregation would not
6 result in consistent physician scores without some mechanism
7 for standardizing the measurement methodology. Remember
8 that there are at least three major episode grouper software
9 packages that entities can choose from, and that measurement
10 using episode groupers requires numerous methodology
11 decisions which we've discussed here, such as grouping
12 claims into episodes, attributing to physicians, selecting
13 comparison peer groups, selecting minimum number of
14 episodes, and many others. Entities can make perfectly
15 legitimate but different methodology decisions on each of
16 these that will lead to different results using the same
17 claims data.

18 The issue becomes even more complex once other
19 measures besides episodes, such as per capita utilization,
20 are added. There is no standardized method for aggregating
21 these with episodes into a single overall score for
22 physicians. The question then is: Could or should

1 measurement methodology be standardized? If the answer is
2 yes, Medicare or another entity could develop and
3 disseminated detailed specifications for physician resource
4 use measurement methodology, including which episode grouper
5 software package to use, which methodology decisions to
6 make, and how to aggregate measurement results into single
7 physician scores. However, to cover all methodology
8 decisions, I want to note these specifications would need to
9 be fairly detailed.

10 In addition, it is unclear if there could ever be
11 a mechanism to enforce compliance with these standards.
12 Alternatively, claims data from Medicare and other payers
13 could be pooled within a single entity, such as CMS, AHRQ,
14 or an as-yet-to-be-formed public-private partnership. That
15 entity could use these aggregated claims to measure
16 physician resource use and release the results. If the
17 output provided detailed results by type of service,
18 provider, condition, and so forth, along with overall
19 scores, private plans and other entities could merge these
20 results with their own and apply the results in unique ways
21 to suit their needs.

22 So before I finish, I want to leave you with two

1 broad questions to help shape the discussion.

2 First, would the Commission like to discuss, and
3 possibly embrace, a statement of principles for Medicare's
4 physician resource use measurement and feedback program?

5 Secondly, would the Commission like to discuss the
6 question of whether Medicare should release claims data in
7 addition to the analysis results that will be released
8 separately from the resource use program for data
9 aggregation?

10 That concludes my presentation. I look forward to
11 your discussion.

12 MR. HACKBARTH: Thank you, Jennifer.

13 Clarifying questions for Jennifer?

14 MR. EBELER: One on this data aggregation issue.
15 The way it's phrased is Medicare releasing it so that a
16 private entity can combine Medicare and the entity and look
17 at it. Can it also work the other way where both Medicare
18 and the private entity get to look at the aggregated data?

19 MS. PODULKA: You hit on something. I addressed
20 this in a somewhat purposely vague way because there's
21 competing and numerous recommendations. In general, we've
22 heard that there are several entities that would be eager to

1 see Medicare claims data to be able to aggregate it. And so
2 in that sense, it would be releasing Medicare claims data,
3 presumably through a public use file or something else.

4 There are also numerous competing and not always
5 detailed proposals for aggregating other data from other
6 entities, and so what I'm saying is if we go the first step
7 and release Medicare claims without the mechanism for the
8 second step of releasing other claims and pooling them,
9 Medicare wouldn't be the one to benefit.

10 MR. BUTLER: Just a quick -- so I can focus my
11 comments in round two. These are two specific questions.
12 They're not all the questions that you asked. On page 5,
13 you had the principles. Is that what you mean in -- because
14 that's a much narrower question than some of the other
15 things like episode versus per capita and so forth?

16 MS. PODULKA: Absolutely. I think of this as two
17 stages. First is do you want to talk about principles, and
18 a valid answer is, no, we'd like to wait and see what
19 happens, or no for some reason. If the answer is yes, then
20 absolutely, we could go back to the slide with the five
21 detailed principles and discuss those individually or
22 however you guys choose.

1 MR. BUTLER: I'd put it this way: Most of my
2 comments were on should you focus on episode or per capita
3 or some of the other questions in there, I assume you want
4 feedback on that. It didn't look like that included that.
5 If it does, that's fine.

6 MR. GEORGE MILLER: Mine is a process question,
7 also. I don't know if I should wait until round two,
8 because it has to do with the opportunity for physician
9 input and the appeal process as being one of those
10 opportunities. I'm not sure that -- I'm not a physician,
11 nor do I play one on TV, but I'm not sure a physician would
12 think that that's an appropriate input to say at the end of
13 the process they get to appeal. But I'll until round two.

14 MR. HACKBARTH: [off mic] Why don't we come back
15 to that.

16 DR. CHERNEW: I was confused, in part, by Jack's
17 question about the release of the data, and I've lost track
18 now of what's meant by releasing the data, because I guess I
19 was -- surely you don't mean just releasing Medicare claims
20 data broadly so people could just get the claims data,
21 because there'd be all the HIPAA and other -- but in order
22 for this to work, you would need to have the provider ID

1 numbers and a whole series of other things.

2 So I'm just confused now about what's meant by
3 releasing claims data, what that actually means.

4 MS. PODULKA: There actually is a specific court
5 case going on right now where an organization did seek to
6 gain access to Medicare claims with provider identifiers and
7 use these for analysis. Again, there are competing
8 proposals and multiple parties are interested, and some of
9 those proposals include Medicare should make claims
10 available.

11 MR. HACKBARTH: With encrypted information on
12 beneficiaries, but provider IDs, presumably subject to data
13 use agreements of the sort that we discussed. That's a
14 question. Feel free to --

15 MS. PODULKA: Yes. I don't want to get bogged
16 down in details because I'm not a lawyer, nor do I play one
17 on TV. But the current court case actually is a dispute
18 between -- beneficiary privacy aside -- provider privacy.
19 And right now there are district courts that interpret it
20 that way.

21 MR. HACKBARTH: Just to be clear, what I was
22 referring to is the policy issue. Congress can write a

1 statute that renders the court case moot. And so what I
2 think we ought to be talking about is not the litigation,
3 but what are the policy principles that should guide this if
4 we think it's a good idea.

5 DR. MILSTEIN: On this point, because there have
6 been a number of congressional legislative proposals
7 directly on this over the years, and nobody is
8 conceptualizing releasing information that would remotely
9 allow identification of individual beneficiaries. Every
10 proposal that's put out there would, for example, using
11 intermediary organizations, kind of the brothers or sisters
12 of QIOs. But the idea is always to do it in a way that
13 would never jeopardize beneficiary identifiability.

14 DR. CHERNEW: But for research purposes, they
15 assume things are identifiable. If you knew the person's
16 doctor and a date of service, it would be considered
17 identifiable. And so you couldn't do what we're talking
18 about here.

19 The only thing I'm saying, this is -- I'll save it
20 for round two.

21 DR. MARK MILLER: I just want to make sure that
22 the question that drove Michael's first question is clear to

1 everybody at the table -- and not at the table. There's two
2 questions on the table. The first one refers to Medicare's
3 release of analyzed data on the performance of the
4 physician. The second question is should raw claims level
5 data be released to other actors to use in their process of
6 measuring physicians. And I know you get it. I just wanted
7 to make sure everybody does, in case that was unclear.

8 MR. HACKBARTH: Let me see hands for round two.

9 DR. CROSSON: In answer to the general question
10 about principles, I guess my answer would be yes. I think
11 we stimulated this direction, and, therefore, we have
12 presumably some long-term responsibility for it and I think
13 also some interest in seeing how it plays out.

14 I had a different thought about, you know, what
15 some of the principles might be. It seemed to me that
16 there's a question of focus, first of all, and a lot of
17 these have to do with, you know, how this is going to be
18 received by the physician community and whether it's going
19 to turn out to be, in the end anyway, appreciated and
20 valuable or it's going to be rejected.

21 So it seems to me that one principle ought to have
22 something to do with the relative importance of what's being

1 measured and reported on. And the more important that is --
2 and there are a number of ways of describing that, but
3 certainly the total cost to the Medicare program and the
4 health impact of the particular issue on beneficiaries, are
5 at least two ways of thinking about that. The more
6 obviously important the issue is that's being measured and
7 reported on, I think the greater respect the physician
8 community and others are going to have for that.

9 In terms of the question of whether it should be
10 directed at just physician outliers or more broadly report
11 to physicians, my bias would be that it should be
12 information received by the majority of physician, because
13 the thought that we had when we started talking about this
14 was that this sort of feedback -- that is, where I as a
15 physician stand in the spectrum of performance relative to
16 other physicians -- would have potentially a broad, salutary
17 effect as opposed to trying to simply identify bad actors.
18 So I would have that bias as a principle.

19 And then the third one has to do with, again, I
20 think the relative resistance that this type of thing may
21 create, and that we ought to try to pick things that at
22 least initially are the most bulletproof, you know, where

1 the information is as solid as it can possibly be, where
2 there is a minimum number of vulnerabilities so that people
3 can look at it because of some issue around risk adjustment
4 or some issue around the accuracy of data, point out
5 something that's wrong with it, and then dismiss the entire
6 effort. And I know that some of those things may have some
7 inherent conflicts within them, but I do think that each one
8 of those things has a certain importance.

9 MR. GEORGE MILLER: Thank you. In a follow-up to
10 my question, I would say, first, yes, I think we should move
11 forward with this. But my question primarily is on the
12 content of the opportunity for physician input and the best
13 way to design that input. Again, I would submit that saying
14 the appeal process as a part of that I don't think is
15 appropriate, although that mechanism still could be in
16 there, but I don't think that is physician input. That
17 happens at the wrong side of the table from my standpoint.
18 And I would agree that physician outliers, looking at a
19 small subset -- and I would favor input from physicians to
20 help design this in a broad base, and using some form of
21 evidence-based measurement program to get the broader input
22 would be appropriate from my point of view.

1 DR. MILSTEIN: I would suggest that the best
2 answer would be yes to both questions. I'd say that being
3 involved in a number of these programs in the private
4 sector, it's fair to say that most physicians who are not
5 part of managed care medical groups really don't know, you
6 know, how they compare to their peers on total resource use.
7 Many are very interested to know and want to know and would
8 be interested -- especially if the target is total resource
9 use, not just focusing on their services alone -- in playing
10 a proactive role in helping solve the affordability crisis
11 of health insurance in the U.S., including the Medicare
12 program.

13 I agree with Jay that, you know, the risks of
14 doing this wrong are high, but the benefits of doing it
15 right are very high. There is really a very -- you know,
16 there's often a focus in these programs on the risks, but
17 there's also some fantastic benefits. I think it's very
18 well illustrated. Tom Lee, a physician in Boston, you can
19 still click on a New England Journal of Medicine website and
20 get his sort of personal account of how useful he found it
21 for the first time get resource use measures from plans.

22 Last, but not least, I think the second question

1 is very important because part of doing this right and
2 making it be maximally useful to physicians is to minimize
3 the amount of statistical noise in the reports they get.
4 You know, what you don't want is for a doctor to be told
5 you're terrible or you're terrific or you're mediocre when,
6 in effect, that determination was due as much to the small
7 sample size on which they were judged by a particular
8 insurer. And so I think there's tremendous benefit in us
9 engaging on this second question and, per Mike's comment,
10 making sure that it's done in a way that is absolutely
11 bulletproof with respect to beneficiary confidentiality,
12 because if you don't nail that, then all is lost. And,
13 fortunately, if you look at some of the more enlightened
14 congressional proposals on this issue, for example, the
15 bipartisan legislative proposal that Hillary Clinton and
16 Judd Gregg put forward last year, they've done a very nice
17 job of thinking through how you could blend Medicare data or
18 make Medicare data blendable with commercial data so you
19 address the problem of adequate cell size and giving the
20 doctors an accurate score, but in a way that is absolutely
21 bulletproof with respect to protecting beneficiary
22 confidentiality.

1 MR. BERTKO: I'll start by saying I've got to
2 agree with Arnie and Jay strongly and then add a couple
3 things to that.

4 The first is having MedPAC say something about the
5 principles I think is a Good Housekeeping Seal. This will
6 be controversial no matter what, and if we can get to those
7 bulletproof measures that we can reach consensus on, I think
8 that's extremely valuable.

9 The second is to kind of address this second
10 question. I think there is a strong reason to have
11 reciprocal data exchanges for a couple of reasons. The
12 first one is Medicare has got the gold standard data set.
13 It's extremely useful. But even in my experience in a
14 couple of states, that wasn't big enough. And so getting
15 the back and forth would be somewhat useful to Medicare and
16 extremely useful to the private sector on this.

17 The second part of this data exchange that is
18 useful is that there could be a spillover effect. If you
19 can clean up the private insurance sector, it's likely --
20 and I think proven by Lawrence Baker, and, Mike, I think you
21 even did some work on this -- that if it works in the
22 private sector, it's likely to have a positive, beneficial

1 effect on the other side.

2 The last part is just to, again, say what Arnie
3 said in different words. There's a lot of inappropriate
4 care, as shown by the Fisher-Wennberg analysis. And to the
5 extent that this can be used to explain some of that
6 inappropriate care, I think there is tremendous room for
7 savings. Report cards could be issued. I've had some
8 experience with that. I think the effort is on the big side
9 because it's probably best done on the county medical
10 society level or MSA level. We have in my past life had the
11 experience of going out there and explaining it. I won't
12 say it's well received, but it's appropriately received by
13 the physicians in the area, and it needs a fair amount of
14 explanation. This is new and different, so getting it out
15 there, perhaps having a joint Medicare-private sector
16 presentation type of thing, could be extremely useful. So
17 let's go for it.

18 DR. MARK MILLER: Can I get you to say something
19 else, John? Because your very last point about the unit of
20 analysis was a little bit -- I hadn't quite heard you say
21 that before. Do you think that if information is conveyed
22 at that level, the individual physician feels like they have

1 enough information to do something about their practice? Or
2 maybe I misunderstood the last --

3 MR. BERTKO: No, no, you said that -- my
4 experience limited to a couple of markets is that you can
5 show these things. In one particular market, in fact, at
6 the medical group level, small practices of between five and
7 ten physicians in a particular specialty, when compared to
8 specialty performance in that market, would show there are
9 one or two outliers, and they can help fix themselves.

10 DR. MARK MILLER: I see. So you would show the
11 individual physician, but just relative to their market?
12 That's what you --

13 MR. BERTKO: I would start with that, but I'm not
14 going to end with it because I think as -- I think Arnie
15 would agree with me on this. Our overall would be to say
16 fix it in this market and then fix it -- move on to try to
17 have more uniform results across the country.

18 DR. CHERNEW: I'll make two comments. The first
19 one is I can think of a lot of reasons why we would want
20 more access to Medicare claims data. Physician profiling I
21 think is but one, and so anything we could do to open up the
22 floodgates of allowing access to Medicare claims data I

1 think is incredibly important. And I think the privacy
2 issues are also very important, and I think historically
3 they have been interpreted too stringently. Under the
4 current privacy -- I think it could change the current views
5 of privacy in order to get this done, because right now the
6 stuff you would need to do this would require a violation of
7 the current, very stringent views of privacy. You would be
8 able to -- you know. So that's one.

9 But I think we should strongly encourage more
10 access to claims data, including Part D. Strongly I think
11 that. It's important.

12 I'm thinking of not even saying anything else and
13 just singing. Thank you.

14 The second point, though, that I'd like to make is
15 I think there's an underappreciation of the statistical
16 issues that arise when trying to release aggregate data even
17 if you had large sample sizes. And there's a great paper I
18 would encourage you to look at by Tim Hofer and Rod Hayward
19 looking at this. It was hospitals, not physicians. But the
20 problem is largely that even if you perfectly risk-adjust
21 and have reasonably large sample sizes -- and I'm not sure I
22 know what "reasonably large" is. Because you have these

1 incredible multiple comparisons, you don't appreciate that
2 there's a thousand physicians and they're all the same.
3 You're going to find some subset of physicians just by
4 chance -- even if your statistics are working great for
5 statistical significance and all other kinds of things, you
6 will find some by chance that are outliers, by definition,
7 almost always. There are ways of getting around that, but I
8 think those statistical issues aren't appreciated, and I
9 think until we think through what is essentially a multiple-
10 comparison/heteroskedasticity problem --

11 MR. HACKBARTH: Maybe you should have stopped.

12 [Laughter.]

13 DR. CHERNEW: -- we should be really careful in
14 advocating release of the information broadly.

15 MR. HACKBARTH: Will you make a presentation on
16 that next time?

17 MS. PODULKA: I plan to work "heteroskedasticity"
18 into my next presentation.

19 Can I ask one clarifying thing? Release of
20 information, are you referring to raw or analysis results?

21 DR. CHERNEW: I was using Mark's dichotomy, so the
22 first thing, I think, it's very important on raw data that

1 we release more of it and worry about privacy in a more
2 rational way. But what I was referring to when I was
3 talking gibberish was the release of aggregate data, these
4 sort of report card things. I think the individual
5 physician level report card, even if you had all the
6 physicians' claims data, you might do a good job if your
7 hypothesis was Tom is average or better than average or
8 whatever it is. But if you had a thousand Toms or a hundred
9 thousand Toms, there's always going to be someone who per
10 chance is in that outlier group. And the work that Tim and
11 Rod suggested was, in fact, under reasonable assumptions
12 most of the people you identify as bad would not be. They
13 would just be randomly identified. And then --

14 DR. MARK MILLER: But, Mike, if you're making the
15 dichotomy, does the release of the raw data out into an
16 environment that is not going to necessarily be sensitive to
17 those issues going to -- so you're going to see that problem
18 multiply throughout.

19 DR. CHERNEW: I agree with that, but I think
20 there's other real advantages to having the raw data
21 available. This is what I asked in my first clarifying
22 question. We haven't had the DUA-HIPAA discussion to allow

1 researchers to try and use the raw -- you can't even get the
2 raw data now to do things that are so much more basic than
3 this that I think that anything we could do to allow access
4 to the raw data would be useful, but we have to deal with
5 all the --

6 DR. MARK MILLER: Let me take you to what I'm
7 starting to hear, and I'm really sorry to interrupt because
8 I know I'm not supposed to take so much time. But I just
9 want people to think about this because -- do I hear you
10 saying to release the data out into the wild and let people
11 begin to analyze it, and Medicare should not be doing this
12 until it gets all of its statistical ducks in a row? And
13 then you would have this occurring throughout, you know --

14 DR. CHERNEW: What I was saying was we should
15 encourage Medicare to move forward to a more sensible
16 release of data. I'm not sure how to do that in this
17 privacy useful way. So I think that's a useful discussion
18 as to how to improve access to Medicare claims data, and I
19 think that transcends the issue of physician profiling
20 stuff. I would probably be hesitant to just have Medicare
21 claims data up on a website somewhere. I wouldn't want to
22 do that. That I don't think would be a particularly good

1 idea. But I do think more use of Medicare data in a bunch
2 of -- I think we could do a much better job than that.
3 That's the first issue.

4 The second issue is I would not release out into
5 the world aggregated data on physician performance until I
6 was comfortable with the statistical issues that those
7 physicians that get the two lower bars or, you know, the big
8 black -- the circle with the black all filled in, the
9 Consumer Report one, that I was convinced that those were
10 not statistical artifacts. So I think doing the
11 aggregation, giving it back to the physicians, beginning to
12 move in this way is good. But my understanding of the
13 program in general is the cost of having some really
14 erroneous people identified is really big.

15 MR. HACKBARTH: Are you saying, Mike, that you
16 would advocate confidential feedback to physicians?

17 DR. CHERNEW: Yes.

18 DR. STUART: I don't agree with that. I think we
19 could learn a lot from what happened when CMS started
20 publishing the mortality rates from hospitals, because
21 essentially it's really the same issue, a statistical issue
22 here.

1 Mike is right that, you know, if you use 95-
2 percent confidence intervals, that means that 5 percent is
3 going to be outside those confidence intervals. That's just
4 the way it's described.

5 However, this is not going to be a static program.
6 This is going to be a dynamic program. And here the
7 statistics work for you rather than against you, because the
8 odds of somebody by chance being in the tail two or three
9 times in a row is really, really tiny. And so if you're
10 thinking about it dynamically, then I think you come up with
11 a different set of triggers in terms of whether you'd like
12 to have this private or public.

13 MR. HACKBARTH: Bruce, the statistics are way
14 beyond me. To me that sort of sounds like, well, maybe what
15 you want to do is do confidential feedback for a period of
16 time until you can get to the point where you can so, oh,
17 this person has been out there, you know, three times in a
18 row or -- that's a risk adjustment question.

19 DR. STUART: I think that we all agree that we
20 want to go through this process and learn about it
21 confidentially before, you know, you hit the big times.

22 DR. KANE: I guess I'll start with trying to

1 follow on that conversation. I'm also hoping it's not just
2 statistics that determines outliers, but some sort of
3 normative -- whenever possible to have normative standards
4 of here's what we're looking for, and here's the people who
5 get to that. You know, there are some positives that can
6 come out of this, not just focusing on negatives, but that
7 there be a normative standard for some types of episodes.
8 That's what we're looking for, not the average, the 50th
9 percentile, the 95th percentile, or the outlier -- I mean,
10 outlier isn't really what you're looking for, often. You're
11 just trying to push people towards a normative standard.

12 I'd also hope that there would be both quality and
13 cost considerations, and that relates again back to this
14 idea that it should be a normative standard, not just some
15 statistical creation that creates outliers.

16 I guess my frivolous concern was that this
17 physician resource use measurement program not be -- the
18 acronym not be RUMP, because I don't want to read that over
19 and over again for the next ten years.

20 The other piece, I think, is that there should be
21 -- as a principle, I think we should try to put at least as
22 much resource effort into the educational purpose as to the

1 payment and punitive purpose or cost efficient -- whatever.
2 I mean, I think people don't think hard about how adults
3 learn enough in these things, and coming out with something
4 that gives you a report that kind of insinuates that you're
5 not doing it right automatically keeps people from wanting
6 to learn to adapt.

7 So I think we really need to get some people in
8 here who help us understand how, when you give people this
9 kind of information, how they can turn it into an
10 educational event and not into something that they have to
11 defend and protect the reputation and worry about, you know,
12 this is an attack on their clinical autonomy, for instance.
13 There's a lot of reasons why physicians would resist this
14 information that I think if we think hard about how it's
15 communicated and how it's used -- and, again, if it it's
16 more normative than statistical, for instance, and has
17 quality as well as cost, for instance -- these are the kinds
18 of things that physicians will be motivated to improve. And
19 I know the VA has had a very successful experience in
20 learning how to communicate these kind of clinical standards
21 to physicians who dramatically change their performance
22 because of it.

1 So I would just like us to educate ourselves, at
2 least, on how do you do this in a way that encourages, you
3 know, active embracing of this rather than a resistant,
4 defense response.

5 And then my final concern about a principle is
6 that not only do we protect beneficiary confidentiality but
7 that there be some concern about beneficiary access in this.
8 I know when the surgical program, the cardiac surgery
9 results in New York were released, I think there was a lot
10 of concern that physicians would just start avoiding high-
11 risk people who might have a bad outcome that would be hard
12 to explain. So we do need, I think, to also consider what
13 might happen to beneficiaries who are likely to make
14 somebody look bad and think about how do we try to deal with
15 that. It's really not just statistics. It's how do we
16 define good performance, how do we communicate it, and how
17 do we protect the beneficiaries in the process. So I think
18 we do need to discuss these principles, but mine would be a
19 slightly different list than the ones here.

20 Then, finally, yes, I think we should discuss --
21 we already are -- whether we should release claims data.
22 But, I don't know, my sense again, along the same idea that

1 how you do it is so important, I am fearful that 50
2 different or 100 different players all releasing data in
3 their own unique way could be detrimental to the goal of the
4 program, of Medicare, of saying let's try to do this in a
5 constructive way. I wish there was some big black box that
6 everybody could put their data into and the reports all come
7 out -- everybody can use them their own way, but they all
8 come out kind of consistently formatted and that there's
9 this process that's attached to that before anybody uses
10 them for profiling or tiering or telling beneficiaries who
11 they should and shouldn't -- so that's just my bias, but
12 that's something I know we'll talk more about in the future.

13 MR. HACKBARTH: I just want to agree with what you
14 said about how important it is to think through what this
15 looks like from the physician perspective. I think both
16 Karen and Ron have made this point in previous discussions.
17 this is about how to get physicians to embrace the
18 information to improve their practice.

19 Tom Lee has thought a lot about this and worked to
20 use these data within the Partners Network to try to get
21 physicians to improve. So I think that there are people out
22 there who are very smart, agree with the objective, who may

1 be able to teach us some things about how to get it done.

2 DR. CASTELLANOS: Being a practicing physician,
3 I'm going to have a lot to say on this issue. To answer
4 this question, I don't think there's any question we need to
5 make a statement of principle. There is a big disconnect
6 between what we think is happening here in the medical
7 community and the information the medical community has.
8 Now, some of the specialty organizations and some of the
9 organizations in medicine have this information, but it has
10 not filtered down to where the tire hits the road. And we
11 need to let the practicing physician who's out there every
12 day understand what we're trying to accomplish. There's a
13 big disconnect there. There really, really is.

14 We need to talk about the pathway of what we're
15 trying to do, and I think we've outlined that so many, many
16 times from private getting out the information to public
17 disclosure, to perhaps impacting on reimbursement. But how
18 we present this is really going to be extremely delicate
19 because this could blow up in everybody's face. It really
20 could.

21 There are a couple of questions that I have, and
22 one is: Who do you present it to? Just what Arnie said.

1 Every physician wants to know how he or she is doing. You
2 know, we're all competitive. We talked about this last year
3 and the year before. We're all competitive. We wouldn't
4 get where we were, we wouldn't have gotten into medical
5 school, we wouldn't have done that. And I want to see how I
6 do, and, gosh darn, if I'm not doing a good job, I want to
7 make some corrections. So that's extremely important that
8 we do that. Extremely.

9 Now, obviously, most of the money is going to be
10 in the outliers, and that's where you're going to really
11 perhaps focus. One of the very big concerns I have is this
12 education and outreach, and there's been virtually no
13 discussion on that. One of the questions I have is: Who is
14 going to do that? Well, there's only one or two groups that
15 can do it. My specialty of urology, there's nobody in CMS
16 that knows much about that unless he's a urologist. So
17 you're going to have to go to my specialty society. For
18 Karen, you're going to have to go to her specialty society.
19 And you have to embrace those specialty societies or medical
20 organizations like the AMA, et cetera. And you're going to
21 have to ask them to develop -- and most of them are
22 developing clinical pathways. Most of them are developing

1 evidence-based medicine. We need outcome data. We need
2 outcome data because we don't have clinical effectiveness.
3 I can't tell you what's best because we don't have that
4 data. We need to collect that data, and the only person
5 that can collect that data is the specialty organization.
6 It can be done, and I think most physicians want to do this.
7 And I sincerely believe that this can happen.

8 One of the questions I have and it's drilling down
9 probably more than anything else about one of the resource
10 measurements of generic prescriptions, you may not know, but
11 in Florida the pharmacy has to fill that prescription by
12 generic. So you're going to have a disproportionate
13 collection of data. And I'm not sure if that's one of the
14 most appropriate measures to do with generic prescriptions.

15 You know, I could talk about a lot of other
16 things, but I'd really like to hear what Tom and Karen and
17 the rest of you have to say also.

18 MS. BEHROOZI: There's been a lot of discussion
19 about how to invent the best wheel, but I really feel like
20 the thing that we can do that would be most helpful to
21 physicians -- having this be acceptable and embraceable by
22 physicians and useful to physicians -- and to consumers is

1 to work on having there be one wheel and having it be the
2 best wheel, rather than having us develop a wheel and having
3 Blue Cross develop a wheel and having the State of New York
4 develop a wheel. Because as Joan said yesterday about the
5 pharmacists who have to be trained to comply with all these
6 different MTM programs, doctors are going to have to hire,
7 you know, at least one person, if not a whole staff, to
8 figure out how to appeal the aggregation of data, the
9 attribution of data, the correctness of the data that's used
10 to judge them by, the judgments that are made based on those
11 data. So I think aggregation of data and standardization of
12 methodology is really important, you know, a black box with
13 -- the appropriate black box, a really smart black box that
14 can invent the right wheel. And obviously Michael, who
15 speaks in a language I don't understand, has to be part of
16 that, and people like him.

17 But I think that's so important. I'm thinking of
18 my credit scores. I applied for an online bank account. We
19 won't go into why. It has something to do with what's gone
20 on the past couple of months and what the smartest
21 investment would be, right? I get a notice back that I'm
22 not eligible to open this account. You know, I'm doing

1 okay. I'm not wealthy, but I'm doing okay. I got to check
2 -- there are three different credit reports. One has me
3 with an alias that is my husband's last name, which I never
4 use. One has me with one of my home addresses being my work
5 address. There's all these other things. And then there's
6 various bill payments that some say I've been late on and
7 others say I'm on time on. I don't have time to go back and
8 fix all of that.

9 So I'm like the physician who doesn't have time to
10 fix all of that and challenge all of that. Meanwhile, a
11 decision is being made about me that impacts my life. And
12 the bank isn't getting accurate information about me. Maybe
13 I'm a perfectly good depositor and they should be happy to
14 have my money.

15 So it's really, really, really important, and I'm
16 not going to sing, but I think that's the point I want to
17 end with.

18 DR. DEAN: Probably most of what I have to say has
19 already been said. Certainly what both Ron and Mitra just
20 said is so important. This is a terribly important
21 undertaking. I think it's potentially an extremely valuable
22 undertaking, and it could certainly blow up in our face if

1 it's not done right. And it could set us back a long ways
2 if it's not done carefully and properly. And it's very
3 tricky for all the reasons Mitra just outlined so
4 graphically. I mean, for a whole lot of reasons, this is
5 technically difficult.

6 So I guess I would say, first of all, a strong yes
7 to the first question, and that we really need to be
8 proactive in terms of involving physician organizations and
9 let them know what is in store and trying to educate the
10 whole community that this is not just a cost-cutting thing;
11 this is really intended to increase the value that the whole
12 society gains from health care, because certainly especially
13 the outliers are going to say, well, I'm doing the best I
14 can and now they tell me I can't do all these things that I
15 have to do to save my patients. Well, we know that's mostly
16 overstated and mostly not true. But we've got to be up
17 front and realize that those arguments are going to come.

18 The transparency is important. I think proactive
19 involvement with the stakeholders is important, and the
20 emphasis on education that Nancy and Glenn have both
21 commented on, to try and emphasize, you know, why this is
22 being done -- I mean, clearly cost saving is a big issue,

1 but presumably, if we can get the value proposition right,
2 the cost saving will follow automatically.

3 So I would certainly say a strong yes to the first
4 question. The second question I guess I would leave to
5 people that know more about data than I do. But I would say
6 that the list of principles that you've outlined are very
7 well done and I think a great starting point. They
8 obviously will have to be refined, but I think it's
9 important that we be up front about stating what we're
10 trying to do, how we're going to do it, and why it's
11 important.

12 MR. BUTLER: So I think you're getting yes and yes
13 on the questions. In terms of the focus on the principles,
14 one side of me says we're headed towards more highly
15 organized systems of care between particularly hospitals and
16 doctors that need to be re-engaged in managing risk, and
17 probably at a higher than an episode of care level, if we're
18 going to make an impact. So I like per capita, but I don't
19 think that's where we should start.

20 If we're serious about per episode, if that's
21 where we're headed as getting the next level of risk on the
22 table, from a very practical standpoint I think that ought

1 to be the focus of the release of the data. I think we
2 learned from DRGs being introduced, when Thompson and Fetter
3 were saying it's just for utilization management, and we
4 were kind of getting used to seeing data, and so when it
5 ultimately came about, people kind of already had an idea of
6 what it was and where it was headed. I think episode of
7 care is the same kind of concept, so that the more we can
8 kind of get that data on the table, it will force some very
9 interesting questions. You'll find it's not the individual
10 doctor versus the group. You're going to find that the
11 audience may be a PHO. You won't even know who to
12 necessarily send it to in an episode. Who's the -- you've
13 got multiple physicians in the same episode. It will force
14 those issues on the table in a way that will really advance,
15 I think, our own understanding of whether it can be
16 successfully applied for payment purposes.

17 So that would be my focus and my suggestion of
18 where we ought to focus our own efforts.

19 DR. BORMAN: Certainly the consensus of yes and
20 yes with caveats to each has clearly emerged. I'd like to
21 step back and say first I think when we discuss this issue,
22 it's important to be very up front about context and support

1 it in the context and capturing on the -- you know,
2 specifically acknowledging there's the background of
3 sustainability, there's the focal point of the physician as
4 the director of resource consumption or an agent for
5 resource consumption. But I think there also has to be a
6 clear acknowledgment of the vast majority of people behave
7 very professionally and want the best outcomes, both on an
8 individual patient and aggregate population level. And I
9 think, as has been said very eloquently, this is the
10 opportunity for engagement. It is also an opportunity for
11 enormous disruption, but it certainly is an opportunity for
12 engagement. And I think that whatever we put out about
13 this, the opening piece has to be a very positive context,
14 just as a general thing.

15 I think that the excitement here about this is
16 palpable, and that's wonderful. And we have this enormous
17 vision of what it can be, where it should go, and that will
18 be great for formulating the principles. We have to
19 remember, as I think Bruce said, it's going to be dynamic
20 and that the principles we articulate we will have to keep
21 revisiting, and that they will be -- some of them will shift
22 in priority. The operationalization of them may change over

1 time. And I think we should, frankly, acknowledge that in
2 whatever we write so that we're just very clear about that,
3 that these are principles subject to re-examination, and
4 that it is a dynamic process.

5 In addition, I think while we very much are
6 excited about the long-term vision, that in order to be
7 credible, as several other people have said, the initial
8 steps have to be very focused and very thoughtful and have
9 achievable targets. I think it was Jay who first
10 articulated that in this current discussion. If we don't
11 pick some things that are almost unassailable -- I'm not
12 sure there's anything that's unassailable to a group,
13 certainly, of physicians because we're trained to take
14 things apart and to put them back together, and surgeons
15 even more so about the "take it apart." And so you
16 absolutely don't want this to get hung up in, I think Arnie
17 called it, the statistical noise. And absolutely Mike
18 raises things way over my head that are clearly valid issue,
19 and this deal of multiple comparisons about multiple things
20 generating, of course, some positive results, physicians are
21 going to be all over that in a very quick manner, because we
22 all understand that from studies in the medical literature.

1 So, again, a point of picking a set to start with,
2 we are not going to achieve the entire visionary program in
3 the first swing. So in order to allow the program to go
4 forward, let's pick some things. It may not cover 90
5 percent of physicians; it may not cover all specialties. It
6 will be an iterative process. Pick some things that can
7 work, make those work, learn along the way, and expand it
8 over time. I think those are pretty clean lessons about
9 this.

10 In terms of some of the specifics that were
11 raised, I'd just like to talk a little bit about the
12 education and research piece. I think Nancy is absolutely
13 correct that that effort is as important as the generation
14 of the information, because if you generate it and do
15 nothing with it, it has no impact. I think as has been
16 mentioned, specialty societies are some obvious partners
17 here. I would like to suggest that also probably the
18 various boards, at least for allopathic physicians, the
19 American Board of Medical Specialties and its 24 member
20 boards because they're all in various stages down the road
21 of a maintenance of certification process. And I know at
22 our own American Board of Surgery, we're struggling with the

1 notion of how surgeons can provide us enough data about
2 themselves for assessment of performance in practice. So
3 there is enormous opportunity here for this to have a
4 mechanism for outreach and, again, to be a two-fer for the
5 practicing physician who's going to worry about what Mitra
6 brought up, of what army of people do I have to bring into
7 my office, at what expense, to make this work, when
8 presumably most of the benefit or much of the benefit, at
9 least monetarily, will accrue to the system, and it will be
10 paid for, it seems like, from me as the individual.

11 So I think that, you know, we need to think about
12 those partnerships and probably bring those people in early
13 on in the discussion so that it goes forward in a way that's
14 productive for both entities. And relative to the
15 individual versus group data, I would say that if it's not
16 usable by an individual, in the end it defeats the purpose
17 to some degree. But it should be structured in a way that
18 it is aggregable in a group so that if you report it to me
19 and to each of my partners, it doesn't take -- I don't have
20 to go hire Mike to put it together in a valid way to share
21 with my group and also have a group actionable item come out
22 of it, because some of the things will be actionable by the

1 individual physician, some will have to be actionable by
2 either their partnership group, their medical staff group,
3 whatever it may be. But we have to do it in a building
4 block kind of way. It seems to me that should be the
5 criterion by which we figure out how to do the data.

6 And just one comment about outliers and then I'm
7 going to quit because I've been pretty vocal about outliers
8 a couple of times at this Commission. Recognizing the
9 statistical issue of you will identify outliers by
10 definition, you know, even if you set the bar at P.01
11 instead of P.05, there's still going to be that, and with a
12 large "n" it's going to be a significant number of people.
13 I still think that the biggest impact and part of proving
14 value to the program and value to the physician will be to
15 make sure that we at least can confidently -- that we have a
16 transparent rationale for identifying the outliers and
17 providing that information.

18 Concomitant with that has to be what George
19 brought up. There then has to be a mechanism, once you're
20 labeled an outlier, for some sort of meaningful peer review
21 that allows an analysis of whether your patient population,
22 locale, support system, whatever it may be, is just so

1 unique that indeed you are the best of the best given the
2 circumstances.

3 So I think that that process will need to happen,
4 and in order to get physicians to do that, they're going to
5 have to be offered some protection in that peer review
6 process as well.

7 I'm going to stop.

8 MS. HANSEN: The last word is really putting it
9 back in context in the lens that I oftentimes take. I'd
10 like to underscore the point that Nancy made relative to the
11 impact of beneficiaries, that as we look at this, I think we
12 do know sometimes there will be the tendency not to want to
13 take high-risk patients so that one doesn't look bad in
14 these kinds of measures. So I would like to have that
15 somewhere in the text that we have to think of the ecology
16 of this. You know, we have approximately 750,000
17 physicians, but we've got 43-plus million beneficiaries.
18 And I want to make sure that as we look at the performance
19 and improving the normative practice, of course, but just
20 thinking about the unintended consequences that could be
21 mitigated relative to, you know, tough cases and complex
22 cases, when you have a lot of multiple illnesses since

1 that's the growing population.

2 So I just want to put all of this in the context
3 of the quality of care that we want at the end of the day
4 for the beneficiaries for the value of the Medicare program.

5 Then the only other final comment I have is the
6 impact of learning I think is really there. I've been
7 reading this colloquial book, many of you know, and I don't
8 know what you think of him, but Dr. Jerome Groopman, that
9 speaks about what the impact of selection of how doctors
10 change. And I was kind of impressed by just some of the
11 work that many of you probably already know, but perhaps
12 some way of understanding the educational side of it and the
13 impact of that coming from the work of behavioral economists
14 to be able to understand, you know, what are the levers that
15 make it possible for people to do this in a way that is
16 respectful but, frankly, where the outcomes should be going.
17 So if we could, you know, take a look at that dimension
18 because it's not just the information, it's really using it
19 to make the difference.

20 Thank you.

21 MR. HACKBARTH: Thank you, Jennifer.

22 We'll now have our public comment period.

1 [No response.]

2 MR. HACKBARTH: Hearing none, we are adjourned.

3 [Whereupon, at 12:04 p.m., the meeting was
4 adjourned.]

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