

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
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Wednesday, November 8, 2006
10:10 a.m.

COMMISSIONERS PRESENT:

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WILLIAM J. SCANLON, Ph.D.
NICHOLAS J. WOLTER, M.D.

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P R O C E E D I N G S

1
2 MR. HACKBARTH: This morning we begin with two
3 sessions on the SGR mandated report, which incidentally will
4 be followed by two more SGR-related sessions tomorrow
5 morning.

6 The first SGR item is on multi-specialty group
7 practice in the U.S. Cristina, are you going to lead the
8 way?

9 MS. BOCCUTI: Yes, thank you.

10 Good morning. As Glenn just mentioned, the
11 Congress asked MedPAC to analyze alternatives to the SGR,
12 including policies that might adjust payments based on
13 physicians participation in group practices. So this we're
14 going to present some information and data analyses on the
15 topic.

16 I'm going to go through the background information
17 pretty quickly because our panelists last month reviewed
18 this material. On this slide here you can see that for the
19 most part physicians tend to work in small practices. Half
20 of all office-based physicians worked in practices with only
21 one or two physicians. And single-specialty group practices
22 are more common than multi-specialty ones.

1 In the last decade single-specialty groups have
2 grown in number, while we see little to no growth in multi-
3 specialty group practices. Researchers have attributed this
4 growth in single-specialty practices to several factors such
5 as the continued financial profitability of solo and single-
6 specialty practice styles, particularly under fee-for-
7 service revenue models which reward procedure volume growth.

8 Also, negotiating leverage can be gained at
9 relatively small sizes compared to multi-specialty groups.
10 And third, health plans retreat from tightly managed care
11 have led to growth in single-specialty practices.

12 So we attained some insight on the perceived
13 benefits and barriers to forming large group practices
14 through the site visit portion of the Community Tracking
15 Survey, which is conducted by the Center for Studying Health
16 Systems Change. This survey interviews physicians and
17 executives from health plans and hospitals. Interviewees
18 most frequently cited gaining leverage with health plans as
19 the most frequent benefit, and second gaining economies of
20 scale as a benefit for forming group practice.

21 Other benefits are listed on the slide but I'm not
22 going to go through them.

1 Interviewees also cited several barriers to group
2 practice formation with the desire for autonomy and
3 difficulty cooperating with other physicians as the most
4 frequently cited barriers.

5 Other research lends some further insight into the
6 lack of growth in large multi-specialty group practices.
7 For instance, several studies have indicated that patients
8 show some preference for solo and small group practices, and
9 consequently physicians may be responding to consumer
10 demand.

11 Some observers note that physicians' desire for
12 autonomy and independence from medical groups stems, to some
13 degree, from medical school education which seeks to train
14 all physicians to make independent decisions. Physicians'
15 preference for autonomy often makes them uneasy assuming the
16 role of followers who bestow leadership positions onto
17 others in their practice.

18 Although in the past decade we see little to no
19 growth in multi-specialty group practice, there are some
20 opportunities for growth in the future. Younger physicians
21 are more likely than older physicians to practice in medium
22 and large groups due, in part, to lifestyle practices such

1 as less on-call hours.

2 Additionally, some large groups report many more
3 physician applications than they can accept from certain
4 specialties. So another opportunity may lie in medical
5 school training. Fostering teamwork and quality measurement
6 through medical school training may increase physicians'
7 preferences for group practice.

8 Reliable and valid analyses comparing group
9 practice to solo or very small group practice is relatively
10 scarce but I'm going to review what's been published on
11 three topics, namely quality and patient satisfaction, use
12 of IT, and cost and efficiency.

13 A meta-analysis of published research did not find
14 conclusive systematic differences in quality and outcomes of
15 care between multi-specialty medical groups and solo,
16 smaller single-specialty physician practices. However, some
17 recent studies suggest that group practices outperform on
18 selected measures. Some studies have found that large
19 multi-specialty group practices and groups affiliated with
20 or owned by HMOs or hospitals were significantly more likely
21 to use recommended care management processes, or CMPs, such
22 as disease registries, reminder systems, clinical

1 guidelines. And this is in comparison with groups that were
2 more loosely organized.

3 Nonetheless, even in large groups the use of CMPs
4 was not widespread.

5 A very recent analysis found that health plans
6 with a greater reliance on physicians in group practices
7 scored higher on several HEDIS measures than plans relying
8 on more fragmented physician care systems. Despite these
9 quality differences, research has generally found that solo
10 practices and practices based on fee-for-service revenue
11 have higher patient satisfaction rates than prepaid group
12 practices or group model HMOs.

13 Greater use of electronic medical records has the
14 potential to improve the quality of the medical care.
15 According to the National Ambulatory Medical Care Survey, or
16 NAMCS, 24 percent of physicians reported use of EMRs in
17 2005, and this is up from 18 percent in 2001. This study
18 found that as medical groups increase in size their use of
19 EMR also increases. Also, multi-specialty practices were
20 more likely to use EMR.

21 While physicians in larger practices are more
22 likely to have IT, many large groups still lack clinical IT.

1 They don't use it for key clinical activities such as
2 ordering prescriptions or public health reporting.

3 So there really is no comprehensive research
4 comparing resource use between multi-specialty group
5 practice and solo smaller single-specialty practices.
6 Several studies have found that the pre-paid groups are
7 associated with lower resource use and patient costs. Note,
8 however, that we can't determine whether differences in
9 patient costs can be attributed to group practice treatment
10 patterns or to revenue incentives inherent in capitated
11 group practice. In fact, some studies have shown that fee-
12 for-service practices are more likely to compensate
13 physician employees based on volume production.

14 Studies have also shown that delivery systems that
15 include hospitals and physicians have been found to have
16 lower overall costs than more decentralized and independent
17 systems and networks.

18 Using clinical vignettes from the CTS physician
19 survey one study found that for ambulatory symptoms or
20 conditions that do not have a clear consensus on the best
21 clinical response, solo practice physicians were more likely
22 to treat or refer rather than recommend no immediate action.

1 So considering the dearth of information directly
2 comparing resource use by practice type, we embarked on a
3 claims analysis in geographic areas for which we have 100
4 percent of beneficiary claims, namely Boston, Minneapolis,
5 Greenville, South Carolina and Orange County. Our analysis
6 compares spending and utilization of beneficiaries whose
7 main physicians are in multi-specialty or hospital-
8 affiliated groups with those who are not.

9 In addition to the claims files we also used CMS
10 files that link physicians to medical groups by group name
11 and tax number. We identified beneficiaries' main
12 physicians as the physician who accounted for the highest
13 share of the beneficiary spending on evaluation and
14 management services between 2001 and 2003 and had at least
15 25 percent of the beneficiary's total E&M spending during
16 that time.

17 We identified physicians who were part of a multi-
18 specialty group or a hospital-affiliated group, such as a
19 faculty practice group, through these files and through an
20 examination of the physicians in the group.

21 And finally, we standardized payments across all
22 areas to control for input price differences and payment

1 policies as we've done with spending comparisons in our
2 episode grouper work.

3 So before I go through these results I want to
4 note that this analysis is a first step and should be
5 interpreted with caution as there are many limitations,
6 which I'll described in the next slide. So on to the
7 findings.

8 Similar to well-documented previous research
9 examining geographic differences in spending and
10 utilization, we too saw variation in spending and in the
11 number of physicians in practices among the four areas that
12 beneficiaries saw. The share of beneficiaries whose main
13 physicians were part of a multi-specialty or hospital group
14 varied from 17 percent in Greenville to 42 percent in
15 Minneapolis.

16 Despite this variation, this slide shows that for
17 all areas average total payments -- that's the third column
18 -- is lower for beneficiaries whose main physician was in a
19 multi-specialty group. Also, the last two columns show that
20 the number of physicians and the number of practices seen by
21 these beneficiaries is also lower.

22 You see draft written on this slide because

1 further analysis to address the data limitations, which I'm
2 going to go through in the next slide, may change the
3 results. So we'll keep working on it.

4 The first of these limitations is that spending
5 and utilization comparisons are not adjusted for health
6 risk. However, we did examine the average age of
7 beneficiaries in the cohorts and found that beneficiaries
8 whose main physician was in a multi-specialty group practice
9 were slightly older in three out of the four MSAs,
10 indicating that health status, to the extent that it
11 correlates with age, was not a factor.

12 A second limitation is that although we show
13 spending differences by geographic area and practice type,
14 there are many other factors that may contribute to these
15 differences. For example, area market characteristics such
16 as managed care penetration may influence practice patterns
17 and spending.

18 A third limitation concerns physician services
19 provided in teaching hospitals. Residents who see patients
20 in teaching hostels do not always bill Medicare for the
21 services they provide, so consequently payments for patients
22 in faculty practices may be lower because resident surfaces

1 were not billed. However, attending physicians may bill
2 Medicare for services provided by a resident when the
3 attending physician is directly supervising the service.

4 Another limitation we must attach to our
5 preliminary analysis stems from the challenge of classifying
6 physicians as part of a multi-specialty group. Physicians
7 may be affiliated with multiple practices and therefore bill
8 multiple tax numbers. For physicians like this we
9 attributed them to the practice where they saw the most
10 beneficiaries.

11 Also, a single practice may have multiple tax
12 numbers for business purposes, masking the true size and
13 specialty mix of the entire practice.

14 In future analyses with private data we may be
15 able to refine this practice classification. We may also
16 begin to examine patterns of care through the Commission's
17 ongoing work with episode groupers.

18 Another source of data on medical group practice
19 will come from CMS's current demonstration project. I'm
20 going to turn it over to Jennifer to discuss some of the
21 details for this.

22 MS. PODULKA: Before we concluded, we wanted to

1 briefly describe CMS's payment model that offers an
2 opportunity to capitalize on any potential differences
3 between multi-disciplinary groups and other delivery
4 systems.

5 As data from CMS's Physician Group Practice
6 demonstration become available, they will inform our
7 understanding of how these kind of organizations compare to
8 others in terms of quality and efficiency. The demo is
9 designed to study the effects of providing financial
10 incentives for Parts A and B coordination, infrastructure
11 investment, and quality improvements.

12 The 10 participating groups include various multi-
13 disciplinary group models that range in size from about 200
14 to 500 physicians. In total, the groups comprise 5,000
15 physicians and more than 20,000 Medicare beneficiaries. The
16 demo will use a total 32 quality measures that focus on
17 diabetes, CHF, CAD and general preventive care.

18 Participating physician groups can earn bonuses
19 through a shared savings model that incorporates these
20 quality measures if Medicare spends less for the group's
21 beneficiaries than for comparison beneficiaries living in
22 the same service area. Participating groups must achieve

1 cost savings that exceed 2 percent of their expenditure
2 target to be eligible for bonus payments. If a group does
3 this, 80 percent of their cost savings goes into an
4 individual group's bonus pool, as shown on the second line
5 of the slide. Medicare retains the remaining 20 percent of
6 savings.

7 On the third line you see that of the group's
8 bonus pool, a portion is paid based solely on the cost
9 savings. And on the fourth line you see that the remaining
10 portion of the bonus pool, 30 percent in the first year and
11 rising to 50 percent by the third year, is tied to the
12 physician group's performance on the quality targets that I
13 mentioned earlier. So that the group that meets all quality
14 targets will receive their maximum quality bonus and match
15 Medicare also retains any bonus set aside for quality
16 performance that is not earned by the participating groups.

17 MS. BOCCUTI: So now, on this final slide, I'm
18 going to bring us really to the task at hand, namely the SGR
19 report. So considering the large share of physicians in
20 multi-specialty groups and that some multi-specialty groups
21 do not engage in activities that improve quality and manage
22 costs, payment policies that focus simply on group status

1 per se may not effectively elicit desired practice
2 activities.

3 Rather, it might be more fruitful to focus on
4 rewarding the activities that are desirable. In doing so it
5 might provide physicians with incentives to organize into
6 the types of groups that best perform them. I've listed
7 some of these activities on the slide and you may want to
8 add or delete some.

9 This focus on rewarding activities or criteria
10 rather than simply group status is akin to the Commission's
11 previous recommendation to develop policies to encourage the
12 use of IT functions rather than simply the ownership of it.

13 Medicare could require such activities among a set
14 of criteria for favorable payment under or outside of the
15 SGR. If physicians organize into the types of practices
16 that can best perform these activities or criteria, we may
17 see a growth in multi-specialty group practices as care
18 coordination and team-based care may indeed be the key to
19 efficient health care delivery.

20 Thank you. We'll be happy to take your questions.

21 MS. BURKE: A terrific job. I had really just a
22 couple of questions.

1 One, is there any opportunity to get any
2 preliminary information on the demonstrations? I notice
3 that the report indicates 2008. Is there any midpoint or
4 information that we might have access to in the interim that
5 would give us any directional guidance?

6 MS. PODULKA: We're exploring right now the
7 possibility of including some very preliminary data,
8 especially in the SGR report. So we can certainly get back
9 to you about that.

10 MS. BURKE: My second question is on the data that
11 indicates preferences for physicians in terms of their
12 choice of going into practices. I notice the data was from
13 a survey done between 1996 and 2001. I'm not assuming that
14 there's been a radical change, but do we feel fairly
15 comfortable that that's still largely representative of
16 people's views? That's 10 years difference.

17 MS. BOCCUTI: When I look at the recent
18 publications they're always citing those studies. I'll look
19 into seeing and talk with other experts and see if they can
20 uncover anything that's more recent. It's not really a
21 challenge so much.

22 I think Larry Casalino, when he was here last

1 time, did mention that the satisfaction rates for very large
2 and well-established groups were higher than all of the
3 groups at large. So I think I might have mentioned that in
4 the mailing materials, but I'll make sure that comes
5 through.

6 MS. BURKE: And then the last question was just
7 simply there's a reference to antitrust in the course of the
8 paper, sort of around page eight or nine. And I wondered if
9 we had a better information about where specifically that is
10 encumbering the sort of grouping together of physicians?
11 How big a challenge is that in reality?

12 MS. BOCCUTI: Lawton Burns has been an FTC. He
13 was here last time. And he has actually consulted for the
14 FTC on that kind of question, and I have some FTC reports.
15 So perhaps I'll get that a little clearer and give some
16 indication of what's happened in the past.

17 MS. BURKE: Thank you.

18 MR. HACKBARTH: The antitrust issue would be more
19 a single-specialty group issue than a multi-specialty?

20 MS. BOCCUTI: I'll speak from what I vaguely know.
21 The law has to do with the number of doctors in the area.
22 So single-specialty is able to skirt -- the denominator

1 being all docs in the area.

2 But the single-specialty can kind of do well when
3 they're just all the specialists in the area. So when
4 they're the numerator -- they should be part of the
5 denominator, too.

6 MR. HACKBARTH: So you're saying they don't
7 segment the market, look at market for cardiology services?
8 They just look at all physician services?

9 MS. BOCCUTI: I risk going a little too far on my
10 knowledge base in addressing this.

11 MR. HACKBARTH: That doesn't quite ring true for
12 me.

13 DR. REISCHAUER: I have, first of all, a
14 clarifying question and then a comment on the group practice
15 demo. The clarifying question is are these Part B or Part A
16 and B expenditures?

17 MS. BOCCUTI: For the data analysis that we did?

18 DR. REISCHAUER: Yes.

19 MS. BOCCUTI: It's all spending, A and B.

20 DR. REISCHAUER: It seems so low, even at
21 standardized U.S. rates, to be \$2,000. Really?

22 MS. BOCCUTI: I was thinking about that, too, when

1 I was comparing it to Dartmouth Atlas.

2 DR. REISCHAUER: I thought we were talking about a
3 number like \$7,000.

4 MS. BOCCUTI: One thing that's different is this:
5 the numbers get a little bit higher when we include the
6 beneficiaries that were not attributed to a physician.
7 These beneficiaries had higher spending. They saw more
8 doctors, which interfered with our ability to assign them to
9 a physician because they saw so many you couldn't get the 25
10 percent threshold. So the numbers on mean spending do
11 increase a bit if we included them.

12 And perhaps it might be helpful to include those
13 means. I think there may have been some of it, but your
14 point is well taken.

15 DR. REISCHAUER: My comment about the group
16 practice demo is a question of its relevance. Just looking
17 at the information here, we see multi-specialty group
18 practice seems to be at a significantly lower level. So the
19 problem is really everybody else. And so what we're testing
20 in the group practice demo is how much better than being
21 already better can they get?

22 Which is an important question. There's no

1 question that that's true, but it doesn't strike me as going
2 to the real challenge here which is how do you either get
3 the small practices to operate more efficiently or how do
4 you get them to transform themselves into multi-specialty
5 practices?

6 MR. HACKBARTH: Although the group practice demo,
7 as I understand it, encompasses more than just multi-
8 specialty groups. We heard from the CEO of Middlesex.

9 DR. REISCHAUER: But that was a virtual --

10 MR. HACKBARTH: Yes, but the idea would be that
11 perhaps, if you can develop a payment mechanism that rewards
12 integration and coordination through shared savings that
13 physicians in a variety of individual practice settings
14 might align themselves together to take advantage of that.
15 So it's not just a payment system potentially for large
16 multi-specialty groups which are inherently limited in
17 number.

18 DR. REISCHAUER: But of course there's an inherent
19 problem with the group practice demo, which is it's
20 performance is compared to what's left or a panel. And if
21 everybody's in the game there's nobody to compare it to.
22 Wish that we had that problem.

1 DR. CROSSON: Thanks very much. I'd like to
2 compliment Cristina and Jennifer on their report. I've
3 always found it gratifying when facts support one's
4 prejudice.

5 But this is a point of that, of course, I have a
6 lot of interest in. I've spent my entire professional
7 career essentially in a prepaid group practice and believe
8 in it.

9 But it's really only more recently, as I reached
10 out a little bit beyond my own organization, that I came to
11 understand that actually some of the qualities that I had
12 attributed to prepaid group practice existed in group
13 practices which were predominately fee-for-service. So when
14 Jack Wennberg and Elliott Fisher, a year or so ago, look at
15 the resource utilization, for example, for Medicare
16 beneficiaries in the last six months of life in dollars and
17 in numbers of physicians seen, similar to this -- and among
18 the name institutions in the United States in fee-for-
19 service Medicare -- they found somewhat surprisingly that
20 one of the most efficient was the Mayo Clinic.

21 You might think and intuit that the Mayo Clinic
22 could essentially charge anything they wanted to anybody

1 because of their well-deserved reputation. But in fact,
2 they didn't. And that's predominately fee-for-service
3 practice.

4 So what is going on there? I think that's a key
5 issue for us. And this report begins to get at it. I'm not
6 sure I fully know.

7 I think one observation that I've had is that it's
8 a simple one. And even before clinical information
9 technology, physicians in multi-specialty group practices
10 share a common medical record, for the most part. In other
11 words, all of the specialists, primary care doctors, are
12 recording the information and their decision-making and
13 their justifications in one record, which is then reviewed
14 over the course of time in the course of care for the
15 patient by everyone else.

16 That does a couple of things. Number one, it
17 tends to help reduce duplication because subsequent
18 physicians know, in fact, what was done and what the
19 rationale for decision-making was. That's sort of obvious.
20 But there's also human phenomenon, which I think everyone
21 shares, physician or not. And that is that we tend to think
22 differently when we know our peers are looking at the

1 decisions that we make.

2 And I believe that, whether you want to call that
3 culture or professionalism or whatever, has always been
4 present in group practice and is going to be and is being
5 augmented by the use of clinical information technology
6 where the information is even more accessible.

7 When you add to that what I would call organizing
8 the science, which is really providing for independent-
9 minded physicians, nevertheless providing an organization to
10 the science, the standards that exist in terms of care, and
11 providing that to physicians in an easily acceptable way,
12 even for independent-minded individuals it tends to propel
13 practice in a better direction.

14 So I think that exists irrespective of payment
15 mechanism and is a function of multi-specialty group
16 practice, and we saw that little bit of that in the analysis
17 that was done here today.

18 I tend to view this as potential because I think
19 actually, when you then take the payment system and organize
20 that in a way that augments that potential and those
21 capabilities, then I think you have something that should
22 form the basis for a long-term improvement in the health

1 care system.

2 So I do think that the issue, as Bob outlined it,
3 is really what are the implications of this? And for me
4 there are both ways we can go. We can say what can we do to
5 improve the current system for practices that cannot
6 organize in this way? And I think that is useful.

7 I also think that over a long term, a Medicare
8 policy that is directed towards, in the way that was
9 designed here, facilitating and incenting these kinds of
10 activities will then lead some, not all, physicians and some
11 hospitals, I believe, to rethink the idea about the
12 organization of care into integrated systems. And I think
13 in the long term that's a good thing.

14 DR. WOLTER: I think the issue that really
15 underlies the potential for group practices to be units of
16 accountability around quality and efficiency has to do with
17 system approaches to value. And that's really the driver.

18 In addition to IT, I think group practices are
19 more likely to invest in mid-level providers and create
20 connections into the community for care in between
21 individual patient visits and to work more closely with
22 their hospital if there's not a hospital in the

1 organization.

2 I do like the comment, though, that we should
3 create incentives around behavior and results, not just
4 being a group, that makes a lot of sense to me. And the
5 Middlesex presentation last month is a very, very good
6 example of that and it would then create incentives for
7 other physicians and hospitals to create some approach to
8 coordinating how they tackle care.

9 I would put a pitch in that in these incentives
10 that we might put in place we put some focus around high-
11 volume, high-cost disease, because I think there's so much
12 potential there to both improve quality and take some cost
13 out of the system. That would be a very logical place to
14 try to get doctors and hospitals working together. And I
15 think that's also a key. It's about more organized
16 approaches to care, but it's also about how the physician
17 group, whatever that is, connects to the hospital care for
18 these high-cost, high-quality patients.

19 And so that's really back to the theme of where do
20 we find ways to put Part A and Part B together, particularly
21 in fee-for-service environments because it's obviously done
22 in the prepaid setting.

1 In that regard, in my view, the alternatives to
2 the SGR are not just about physicians in Part B but there
3 about tactics across the entire Medicare program that can
4 help us create more value. And I'm kind of hoping we can
5 position our conversation about alternatives to the SGR as
6 something about appropriate resource utilization across the
7 entire program because many of the things we're now starting
8 to put on our list really to go beyond the physician
9 community.

10 And in fact, if you look at volume drivers there
11 are many things hospitals do to drive volume in terms of how
12 they recruit, how they invest, where they're really trying
13 to create their market growth. In fact I'd say there are
14 huge forces in that area in terms of driving volume. And
15 yet all of the focus right now is on the physician side,
16 which is maybe not serving us well, although we have a
17 mandate to do this report.

18 I mentioned the role of mid-levels. I think
19 that's really critical in all of this in terms of how we
20 tackle these issues.

21 There are some underlying incentives in the
22 current reimbursement system that are counter, I think, to

1 things that create incentives to create more coordination of
2 care, more organization of care. There's so much disparity
3 between what some specialists can make versus what some
4 primary care physicians can make. And there's even
5 disparities between what one specialist makes versus another
6 that sometimes I have a hard time understanding.

7 And a lot of these things are drivers for people
8 to want to stay in a smaller practice or a single-specialty
9 practice. Certainly, the ability to own certain facility
10 aspects, and that's much more likely in certain specialties
11 than others. All of these things create incentives that
12 want to keep people in their own atomized units. And I
13 don't think that the cottage industry is going to serve us
14 as well in the next decades as it maybe has in recent ones.

15 So I think some of those existing incentives also
16 need attention.

17 And then on the PGP demo, if I could just mention,
18 I think I've mentioned this in the past, I think there's a
19 flaw in the financial design in that the first 2 percent of
20 savings can't be shared. It may be fine to have that as a
21 cliff before any sharing occurs. I meant to check our
22 projections in our group as to what we think might happen.

1 But I think there's no way we will do as well in the demo as
2 we would have under just plain old fee-for-service,
3 primarily because the first 2 percent is carved out.

4 So that could be a value of the demo, Bob. We
5 might learn some of the things that would tweak how we apply
6 this in the future.

7 Also, on the data, we didn't get our baseline
8 data, which is the data about our patients for the year,
9 before the demo started until three-quarters of the way into
10 the first year of the actual demo. I'm sorry Sheila's not
11 here. And I don't think we've seen any feedback yet, in
12 terms of our performance, and we're about a year-and-a-half
13 into the demo.

14 So that's another issue because I think most
15 excellent performance improvement does better when there's
16 much more timely feedback so you can kind of adjust course
17 and make changes to what you're doing.

18 MR. HACKBARTH: Nick could I just go back to the
19 first part of your comment and playback what I heard? I
20 just want to make sure that I got it right.

21 What I hear you saying is that within an SGR
22 option you may wish to have an opportunity for organizations

1 to get and receive payment in a method somewhat like the
2 prepaid group practice or the group practice demo. You can
3 share savings on parts A and B. There's a structural
4 incentive for physicians and hospitals and other providers
5 to collaborate. So that's one policy line.

6 The other line that I heard you mention was that
7 even if you do that within the traditional Medicare program,
8 independent of the SGR mechanism, you think it's very
9 important to identify other opportunities to begin pulling
10 providers together to bridge the A/B gap and other payment
11 silos that exist, things like bundling, DRGs, gainsharing.
12 There are a number of different ideas that we've discussed.

13 so it's important to think of it on two separate
14 tracks, an SGR track perhaps but also a traditional Medicare
15 payment policy track, as well. Did I get the question?

16 DR. WOLTER: I guess my mental PowerPoint on
17 alternatives to the SGR still more or less starts with our
18 previous recommendation that it should be eliminated and
19 that we should move away from something that hasn't worked
20 very well, but that we need to outline aggressive tactics
21 for appropriate resource utilization that would come in
22 instead of it. And I think that's still an option we should

1 consider.

2 I'm not opposed to the mini-SGR conversation and
3 all that stuff, but I'm really thinking about what's on that
4 vision list that you presented us last time and staff
5 presented us. There are many things in part A, in Part D
6 that we could really look at in terms of volume and
7 appropriate resource utilization. And then there's how the
8 dots connect because physicians, in their interactions with
9 these other parts of the program, can be real drivers of
10 improvement if we can create the right incentives.

11 DR. HOLTZ-EAKIN: I liked everything I heard until
12 the last part, which is I think it's sensible to think about
13 the SGR from a broader perspective, just having it on Part
14 B. We all know the problems with that. I think it makes
15 perfect sense to try to have the system reward payments
16 around high-quality outcomes with the efficient
17 organizations providing them.

18 I just don't want to see us throw all our hopes on
19 the second part without any evidence that it will work
20 before we give up the first. And so I want to make sure
21 that we keep track of the total dollars that are actually
22 going to go into this system before we say that we've got

1 the rest figured out.

2 MR. BERTKO: Just a couple of comments. Again, a
3 nice report as far as it went. I wanted to suggest,
4 following up with Bob's statement here, we want to think
5 about where we want to get to.

6 Number one, I think we might want to characterize
7 the Physician Practice Group experiments differently,
8 Middlesex being one that came into being -- if I recall
9 right, Geisinger and a couple of others are well
10 established. And while they might tell us about
11 effectiveness, they don't give us much about how to get from
12 single-specialty to that.

13 So along those lines, I'd encourage you to then
14 look beyond those 10 groups. I'm thinking here there are
15 IPAs in Northern California and the West Coast that you
16 might look at and probably elsewhere where if you reached
17 out to them, collect tax ID numbers or something, and run
18 parallel types of things on those to see how they worked and
19 maybe learn a little bit more about those, as well.

20 The last comment is I'm recalling from maybe
21 either the original Medicare Risk or Medicare+Choice there
22 was a PHO organization in there which, to my recollection,

1 was pretty much a failure. Some showed up and then they
2 fell apart.

3 We might be able to learn from failures in the
4 past on what happened here. I think I did some consulting
5 for them about 15 years ago, but I'm losing my memory. I
6 would ask you to maybe just check with some folks about
7 that.

8 MR. DURENBERGER: On that point, would it not also
9 behoove us to look at successful experiments which include
10 the TEFRA risk contracting process we went through starting
11 at '85, '86, '97, '99. It was a success in some parts of
12 the country, including ours, and it was not a success in
13 others because there wasn't the presence of the kind of
14 groups that we're looking at here.

15 I don't know how well that's been researched. I
16 don't know a place to go. The only person I know is a
17 health service researcher at Marshfield by the name of Greg
18 Nycz who has this thing locked. And he can just show you
19 how, in the communities in our part of the countries and
20 Hawaii and other places, they brought costs from above the
21 national average to substantially below the national average
22 in two or three years.

1 I don't know what -- we have peer-reviewed
2 organizations in place to guard against quality problems. I
3 don't know it will give you everything. But it is a success
4 story that has been watered down by the fact that we failed
5 to leave some of the savings in those communities.

6 DR. KANE: Just on examples that you might like to
7 look into, Long Island Health Network, I think there was a
8 fellow here from the last meeting who gave a comment at the
9 end. But I've been working on a case study of them and they
10 look like they've done some interesting things, mostly
11 around inpatient care. But the physicians are totally
12 community solo, there's no particular group except that the
13 hospitals have gotten together and formed a quality program
14 that affects all 11 hospitals participating. And they look
15 like they've done some interesting things around improving
16 cost and quality on the inpatient side. So it might be
17 worth looking at that model.

18 What I wanted to talk about in terms of the policy
19 discussion on SGR is, I will disclose right away that I have
20 a conflict of interest because I teach physicians management
21 skills. And I'm relating back to the comment that they
22 don't particularly learn management skills in medical school

1 or in their residency. In fact, they learn anti- management
2 skills, in my experience.

3 And they're smart people, so I'm not denigrating
4 the intelligence of physicians. But the training is very
5 negative towards leadership and being part of a team.

6 And in a program that I run for physicians to
7 teach them management skills, the very first summer we teach
8 them self-assessment, team behavior, how to lead a team, how
9 to be on a team. They come away, just after two months,
10 saying it's transformational. I know we're just scratching
11 the surface.

12 But I'm wondering if we shouldn't try to start
13 linking that up, some of the educational ways to reward
14 physicians either by saying you're going to have a better
15 payment either through less exposure to the SGR, exemption
16 from SGR, or rewarding even the hospitals that include in
17 their training and residency a required certification.
18 Again, I know I've got a conflict here. But it's pretty
19 clear to me physicians desperately need to be taught some
20 basic management skills and some awareness of organizational
21 behavior and there should be some way we can reward that.

22 I think that will get at the psychology that we

1 see of physicians refusing to accept any kind of control and
2 defending their autonomy at all costs. So I just want to
3 encourage that, that that be a part of the list of things
4 that we find a way to reward in the payment system.

5 DR. MILSTEIN: Maybe we can also revive our memory
6 of Nancy's comment when we discuss the IME topic.

7 Understanding where convergence may lie, I defer
8 to Glenn, but a few comments. First of all, I think my sense
9 is that there is a lot of support -- for whatever might be
10 created either as a supplement or as a replacement for SGR,
11 that it ought to be the sum total of resources expended
12 rather than Part B only. You mentioned let's throw in A. I
13 think we should throw in D, as well, clearly.

14 A second comment is that as I reflected on the
15 testimony we heard from our selected group of experts on
16 what is the evidence that physicians in groups perform a lot
17 better than physicians who are not in groups, I was actually
18 sobered up by their comments, saying that there are some
19 standout anecdotes that writ large the evidence is not for
20 this being a robust basis of a big bet on what we want to
21 reinforce through an SGR escape route.

22 And certainly, per Bob's comment, the evidence is

1 even more challenged with respect to IPAs and sort of ad hoc
2 -- wonderful anecdotes aside, Marshfield Clinic I agree
3 with. But if you talk to anybody who is, for example, in
4 California managing mixed groups of IPAs and multi-specialty
5 medical groups, they'll tell you that they've been at it for
6 15 years and converting type two into a type one enterprise
7 is very challenging, is almost impossible actually. They
8 can close the gap somewhat, but are they never able to close
9 the gap fully.

10 So given the fact that the evidence in favor of
11 physician groups, especially more informally adhered formed
12 groups, that being a tremendous basis of value advantage,
13 that that hypothesis is really not supported. I then
14 fallback and start to say what is it that beneficiaries need
15 physicians to lead? My view is that they need physicians to
16 lead in not small incremental change, in controlling health
17 spending trend and quality. But they need very
18 substantially motivated American physicians to get on a
19 whole different plane with respect to their level of
20 ambition and improving affordability and quality of care.

21 And so my conclusion from these observations is
22 that I hope that our solution will be biased in favor of

1 letting the numbers do the talking. That is that the escape
2 route from SGR, if we create one, should be focused on to
3 the degree to which a physician who elects to opt out -- if
4 that's the process we lay out -- is creating a substantial
5 gradient in terms of quality, patient
6 experience/satisfaction and affordability or total resource
7 use.

8 And though I certainly would bet that Permanente
9 Medical Group and other similar groups will be distinguished
10 in a performance-focused SGR escape, I would like to hold
11 open the possibility of what Larry Casalino and Lawton Burns
12 referred to as small -- I know this is a pejorative term --
13 groups of maverick physicians who under the motivation of
14 escaping from SGR begin to -- partly through the agility of
15 their smaller size -- come up with innovations analogous to
16 Southwest Airlines.

17 MR. HACKBARTH: Can I ask you about that, Arnie?
18 Your basic point makes great sense to me, that in devising
19 an escape, as you put it, you wouldn't want to be
20 prescriptive and say that only these models -- especially
21 models that have had at best a mixed history like IPA, can
22 get through. So I understand fully where you're coming from

1 on that.

2 Where I have difficulty, where it's less clear to
3 me, is how well we can assess the performance of these
4 leading edge solo practices, or two or three physician
5 practice models, in managing total costs -- which was one of
6 your earlier points -- given issues of small numbers,
7 instability, and the calculations and the like.

8 What are your thoughts on that?

9 DR. MILSTEIN: I think that is a good point but
10 not an absolute barrier. If you think about currently
11 available quality measures that would be attributable to a
12 physician or patient experience measures or total resource
13 use measures, as you begin to diminish the size of the
14 physician denominator some measures drop off.

15 But that said, we're at a point in --

16 MR. HACKBARTH: But I would think that the cost
17 measures, the ones I'm focused on in particular, the total
18 cost measures.

19 DR. MILSTEIN: Let me comment on that. That said,
20 if you look at what's evolved over the last five years in
21 America's commercial insurance sector with respect to
22 physician performance evaluation on resource use, the

1 conclusion of virtually all, if not the majority, of our
2 national commercial insurers and is that measuring resource
3 use at what I'll call the small physician group level,
4 meaning the two to five physicians that are the bulk of the
5 contracts that John and other national carriers manage --
6 that viable resource use measures are calculable and usable
7 and translatable into meaningful reductions in spending and
8 quality improvements on the quality measurement side.

9 So I think you are correct that it is more
10 challenged but I do believe that I think the convergence of
11 the thinking about the national insurers -- and many
12 regional insurers that have gone down this road -- is that
13 it is indeed feasible.

14 MR. HACKBARTH: It remains an area of interest and
15 a question for me. We've been looking at the episode
16 grouper tools as an example of how you can assess total
17 costs for particular types of cases. And that's been very
18 interesting to me. But I must say that based on what I've
19 seen to this point I still have some reservations about
20 those methods and the attribution and how well they would
21 fly in the Medicare public policy context as a tool for
22 measuring total resource use by individual physicians.

1 That's not an answer. I'm not quite there yet
2 that I have oh, we know how to do this.

3 MS. BEHROOZI: I also appreciate the conclusion
4 that you drew, Cristina and Jennifer, that it's not the size
5 or the structure of the entity. And having spent quite a
6 lot of time reading Dr. Casalino's paper last time, I can
7 understand why you would come to that conclusion but what
8 they do, the behavior.

9 I have a question about a comment that you made in
10 the paper. Maybe it has some relationship actually to what
11 Glenn and Arnie were just discussing. I'm not sure. You
12 note that there's a study that shows that patients managed
13 by family practice physicians have also been found to use
14 fewer resources. I don't know if there's more information
15 that you can give us from that study. Maybe it goes to the
16 issue of how to measure in a smaller context. I don't
17 really know what that means in terms of size and structure
18 of the practice, whether you're talking about individual
19 family practitioners or what that might show us?

20 MS. BOCCUTI: I think, connecting the dots a
21 little bit -- and maybe I should do this more in the paper -
22 - is that multi-specialty practices are more likely to have

1 primary care providers. So when they are part of the
2 practice, is it that they're multi-specialty? Or is it that
3 they have family practice involvement? Or what it is? But
4 that's a connection that was not studied directly by the
5 report.

6 But when you think about okay, this study showed
7 that family practice, when they are involved, they have a
8 better resource use or at least a more efficient one. And
9 then you think, connecting the dots, that multi-specialty
10 practices have these where single-specialty often do not.
11 You sort of make this connection.

12 But that would be us making the connection, not so
13 much the literature. But I'll see what I can do.

14 Does that help?

15 MS. BEHROOZI: I think it's just your question
16 about what are the desired activities. If it is in the
17 context of multi-specialty group practice, then maybe it's
18 worth making that an express criterion.

19 MS. BOCCUTI: It could just be having a main
20 physician. Like that's part of what the -- if we would
21 classify that as an activity. That kind of gets into the
22 pseudo-medical home, whether there would be an agreement

1 between the beneficiary and the practice, and if they had a
2 specific doctor and how that would work.

3 We could discuss that being an activity, this kind
4 of verbal soft kind of contract.

5 MS. HANSEN: This relates to the connecting of the
6 dots further. I really appreciate this and especially the
7 policy implications on this last page.

8 I wonder if there's been any research done on say
9 a well-managed, the outcome aspect, the well-managed
10 comorbidity patient who is 85 years old, somebody who has
11 congestive heart failure, diabetes and some of these other
12 multiples, and the people who don't go to the hospital.

13 Is there a way -- and I don't know if the data is
14 available to track backward on the other side, rather than
15 coming from the physician side, when you have people who
16 don't use resources very much but do have these diagnoses?
17 And coming back at it from just another way to look at what
18 were -- what these pieces of care management and quality
19 improvement activities are processes, but going back to the
20 outcome of when somebody's well-managed what does their
21 medical utilization profile look like?

22 And so it's just coming from a different end of it

1 rather than looking at it from the billing side of the
2 physicians that way.

3 So I don't know whether that's available but it
4 just fills out the side of looking at people who are well-
5 managed and may actually use very few resources, what their
6 physician profile ends up looking like. So it's a backwards
7 look. And it relates, Glenn, to the whole aspect of episode
8 groupers, which is another way to try to get at it. And I
9 know this is kind of a softer area right now, but it just
10 does fill out a picture coming from a patient side.

11 DR. BORMAN: Just a quick comment and question.
12 I'm struck here that we have a fair amount of inferences
13 about the sociology of the providers involved, predominantly
14 physicians. I think an important piece that maybe we're not
15 considering is the sociology of the patients. I recognize
16 that the data about those are probably even softer, but
17 there is a reason why certain kinds of patients pick certain
18 physician structures to interact with. A small physician
19 office is a lot less intimidating to some patients than is
20 walking into a very large clinic building with multiple
21 floors and multiple doctors.

22 And so I think that anything that we could sort of

1 -- I think some statement that there may be sociology on the
2 patient side may have some merit in the discussion a little
3 bit. I don't know that there are the data to answer but I
4 think it is an important factor that we shouldn't leave out
5 of the equation.

6 MR. HACKBARTH: Thank you. Well done.

7 Next up is physician outliers and episode
8 groupers.

9 MR. BRENNAN: Good morning.

10 As you all know, the Deficit Reduction Act
11 mandated MedPAC to produce a report on alternatives to the
12 SGR physician payment system. One of the five mandated
13 areas of analysis was a payment system that would key off
14 the identification of physician outliers.

15 Today, we'll be presenting some findings related
16 to our work examining the physician outlier issue.

17 First, Cristina has some slides that attempt to
18 give you an idea of the overall magnitude of physician
19 outliers in Medicare. Following that, I'll present some of
20 the technical issues involved in identifying physician
21 outliers as part of our ongoing work using episode groupers
22 and Medicare claims.

1 With that, I'll turn it over to Cristina.

2 MS. BOCCUTI: By definition, outliers are
3 considered extremely unusual observations that fall well
4 beyond the general pattern of a distribution. So
5 considering that, we have to ask ourselves two initial
6 questions regarding the SGR alternative: how much spending
7 and how many physicians would be affected by outlier payment
8 policies? And would such policies capture enough dollars to
9 warrant the effort needed to implement them?

10 So to explore these questions we examined Part B
11 payments to individual providers in 2005 to identify
12 outliers within specialties based on per beneficiary
13 spending. This exercise is conducted simply to get an
14 overall sense of total spending on outliers. It's not a
15 mechanism for adjusting payments.

16 On this slide, it shows how the outliers were
17 determined. So on the X axis we have spending per
18 beneficiary and on the Y axis we have percent of physicians.
19 So for each specialty we calculated mean per beneficiary
20 spending, which is shown there with the green line.

21 Doing so controls for the size of physicians'
22 Medicare caseload and spending differences among different

1 specialties. We also adjusted payments to control for
2 payment differences due to input prices, which is a
3 geographic adjustment to those input prices. If we define
4 outlier physicians as having per beneficiary spending that
5 is at least two standard deviations above the mean for their
6 respective specialities, then outliers make up all the
7 physicians to the right of that yellow line.

8 So how many physicians fit this definition? And
9 how much money did Medicare pay them in 2005? For this
10 slide we've put all physicians on the chart so the X axis is
11 payment relative to their specialty mean and the Y axis is
12 still percent of physicians. So for the outliers, we
13 totaled Part B payments, which came to 4.6 billion, which is
14 about 7.5 percent of Medicare's total physician payments in
15 2005.

16 And on the bottom right you can see that 1.9
17 percent of all physicians billing Medicare had per
18 beneficiary spending greater than two standard deviations
19 above the need for their specialty. So obviously, if you
20 lowered the threshold for defining an outlier, the totals
21 would increase.

22 This slide is an exercise that examines very

1 general scenarios which lower outlier payments. If payments
2 for outliers were more reduced to the specialty mean, then
3 the maximum savings would be \$3.6 billion, which is shown in
4 the green lines.

5 Savings would be about \$1 billion less if spending
6 for outliers were reduced to one standard deviation above
7 the mean, as shown in the orange.

8 If Medicare were to implement an outlier payment
9 policy, the methodology for identifying outliers would have
10 to be accurate enough to account for physicians who
11 regularly see particularly high acuity patients and patients
12 with extremely rare diseases. This exercise, of course,
13 does not account, for example, for subspecialists.

14 One method for identifying outliers could be to
15 examine resource use within care episodes. So Niall's
16 discussion explores the use of episode grouper programs to
17 identify outlier physicians.

18 MR. BRENNAN: As you all know, we've been engaged
19 in an evaluation of two commercially available episode
20 groupers over the past year or so. Because these groupers
21 can be used on large amounts of claims and can group claims
22 into clinically distinct episodes of care, which can then be

1 compared across physicians, they seem like they could be an
2 important part of a physician payment policy that keys off
3 the identification of outlier providers.

4 Indeed, these tools are used by many health plans
5 in the private sector to identify high and low performing
6 physicians, mainly for the purpose of tiering. For example,
7 patients who see physicians who have been identified as high
8 resource use have to pay higher co-pays.

9 In the remaining part of the presentation, we'll
10 focus on some of the technical issues that have to be faced
11 in calculating individual level physician scores before
12 concluding with some distribution of scores for several
13 specialties in each of the six MSAs where we have been
14 processing 100 percent of Medicare claims through the
15 groupers.

16 Once an episode has been created, in order to
17 foster system of accountability that episode has to be
18 assigned to a responsible physician. Ultimately, physicians
19 will be assigned multiple different types of episodes and
20 their overall score will reflect their individual scores of
21 these episodes.

22 For this analysis, we used a threshold of a

1 minimum of 35 percent of E&M dollars, evaluation and
2 management dollars, in order for an episode to be assigned
3 to a physician. That is, a physician needed to provide at
4 least 35 percent of the E&M-related dollars in that episode
5 in order to be assigned that episode.

6 However, I want to stress that this particular
7 official was chosen for illustrative purposes only. Some of
8 you might remember from our June report or from
9 presentations earlier this year that there may be other
10 approaches to attribution ranging from thresholds different
11 to the 35 percent chosen in this analysis to permitting
12 attribution of a single episode to multiple providers.
13 Indeed, Glenn has already raised the attribution issue
14 already this morning.

15 In general, we were pleased with the number of
16 episodes that could be attributed to a physician. Across
17 all episodes, 80 percent could be attributed to a physician.
18 For certain conditions, such as sinusitis, attribution rates
19 are much higher, in the mid-90s. We were also encouraged
20 that the attribution rates from the 100 percent analysis
21 we're talking about today using the ETG grouper were similar
22 to those from the 5 percent analysis using the MEG grouper

1 that we presented to you back in March or April and included
2 in the June report chapters, I guess an internal/external
3 foundation type thing.

4 Once individual episodes are attributed to
5 providers, we then aggregate all episodes provided by a
6 unique provider in order to construct a caseload of all the
7 care provided with by that physician. It is from this
8 sample of physician level episode totals that the final pool
9 of physicians to be measured will be defined, and against
10 whom overall scores will be calculated.

11 There is general agreement among researchers that
12 if you calculate resource use scores for a physician
13 provider below some minimum threshold level of episodes,
14 then there is a greater potential for error in the overall
15 score that you calculate. Generally speaking, this minimum
16 threshold seems to range between 20 and 50 episodes,
17 depending on who is choosing to apply the threshold.

18 Of course, the higher you set the minimum
19 threshold, the fewer physicians you will be able to measure
20 in a given area. We found that with a minimum threshold of
21 20 episodes, we were able to capture 60 percent to 70
22 percent of most specialties in most markets, most physicians

1 in those markets.

2 Of course, this does raise the question of what
3 should be done with physicians who do not meet whatever the
4 minimum threshold chosen is. While it is true that they
5 account for a small share of overall spending, because they
6 do not meet the minimum threshold, they very well may be
7 high resource use in the care that they provide. So one
8 thing commissioners may want to consider is the
9 ramifications of not measuring all of the providers in a
10 given area.

11 Another issue involved in calculating an overall
12 score for physicians is whether that score should be based
13 on all the episodes that a physician provides or just the
14 episodes that account for a clear majority of their
15 practice. This is sometimes referred to as the market
16 basket approach.

17 One can evaluate specialties and what they do most
18 frequently and eliminate any potential confounding results
19 that might be brought about by incorporating scores from low
20 volume episodes. For example, a cardiologist might be low
21 resource use in treating coronary artery disease because
22 it's a condition that reflects his chosen area of specialty,

1 but he might be high resource use on a low back pain episode
2 because he's unfamiliar with the most efficient treatment
3 protocols for that particular condition, yet a patient has
4 presented themselves with this to him.

5 In order to assess how much dispersion there is in
6 practice patterns by specialty, we analyzed the most
7 frequently occurring episodes for a range of specialties.
8 Not surprisingly, the type of episodes seen by specialties
9 such as general practice and internal medicine are quite
10 diffuse, whereas other specialties are significantly more
11 concentrated. Only three types of episodes account for more
12 than 80 percent of all episodes seen by dermatologists,
13 whereas the corresponding number of episodes that account
14 for 80 percent of all episodes for internal medicine
15 physicians is more than 70. Urology and cardiology are
16 other examples of specialties that have the majority of
17 their total episodes and dollars concentrated among a small
18 number of discrete types of episodes.

19 Once we have attributed episodes to providers we
20 can then calculate expected values and compare each
21 physician's costs for a given episode to the expected value.
22 For example, a physician with an episode of type 1 diabetes

1 has the costs for that episode compared to the average for
2 all type 1 diabetes episodes in that MSA. If a physician's
3 costs for a given episode were \$120 and the expected value
4 for that episode was \$100, the physician's ratio or score,
5 if you will, for that episode will be 1.2 and there will be
6 multiple scores for multiple episodes.

7 However, this raises the question of what the
8 comparison group should be. Should physicians be compared
9 to national, regional or even subregional expected values?
10 Further, should expected values be calculated within or
11 across specialties for each episode type? Specialty-
12 specific expected values could be thought of as a proxy for
13 risk adjustment, the idea that some specialties might see
14 more severe manifestations of certain diseases than others.
15 While the ultimate goal should be for all physicians to
16 treat patients efficiently, in the short-term holding
17 physicians accountable to a national expected value might be
18 unrealistic and might hinder physicians' acceptance of
19 episode grouping approaches. In using some form of
20 subnational expected value, physicians could be introduced
21 to the concept of being measured against the performance of
22 their peers without being compared to set of peers who may

1 practice medicine in a significantly different way.

2 Another issue that needs to be thought of is
3 whether or not observed-to-expected ratios should be
4 weighted in any way. This is something that has cropped up
5 in previous presentations where we've attempted to present
6 composite scores. For example, should ratios for episodes
7 that a physician performs most frequently receive a heavier
8 weight than episodes that are performed infrequently, in
9 light of the findings in the previous slide? While
10 weighting ratios does have a certain intuitive appeal, the
11 process of assigning weights is inherently subjective and
12 would, in all likelihood, lead to disputes as to whether or
13 not the weights were being applied appropriately.

14 I have a couple of tables to walk you through now
15 and these tables reflect the distribution of overall
16 cardiologist and urologist scores by MSA. Just to walk you
17 through the table, obviously the MSAs are going down on the
18 left, and then across on the right are percentile cut points
19 representing overall physician ratios. So if a physician
20 had 20 episodes and an observed-to expected ratio of 1.0 on
21 all of those 20 episodes, their overall score would be 1.0.

22 Again, some of the other things I've talked about

1 might lead to weighting and the different things like that,
2 could result in a slightly different score. But for right
3 now, we're taking a fairly basic approach.

4 For this analysis we calculated a within-MSA
5 episode-specific expected value. Each physician's score on
6 each episode was aggregated into an overall unweighted score
7 for that physician. We then examined overall average scores
8 by specialty in each MSA.

9 If you look at the table, you can see that 25
10 percent of cardiologists that could be measured in the
11 Boston MSA have an overall efficiency score of 0.75 or
12 better, meaning that across all of their episodes they are
13 25 percent more efficient than the average physician in
14 Boston. At the other end of the spectrum, 10 percent of the
15 cardiologists that could be measured in the Boston MSA had
16 an overall efficiency score of 1.44 or worse, meaning that
17 across all of their episodes they were 44 percent less
18 efficient than average in Boston.

19 These patterns are relatively consistent across
20 MSAs, although the average physician score at each
21 percentile does differ somewhat, most notably at the 90th
22 percentile in Phoenix, where doctors above this threshold

1 are at least 62 percent less efficient than average.

2 This table presents a similar set of scores for
3 urologists, and we can see some slightly different patterns
4 across MSAs here. Urologists in Miami and Orange County, in
5 particular, are having a wider distribution of resource use
6 scores than cardiologists in the same area from the previous
7 slide.

8 In conclusion, we continue to move ahead in
9 refining our analysis. We feel that episode groupers are a
10 useful tool that we're going to continue to explore both in
11 relation to the physician outlier component of the SGR
12 report and physician performance measurement generally.

13 We'll be back in December with more detailed
14 physician level analyses that will incorporate risk
15 adjustment and a closer look at how an individual
16 physician's overall scores might be calculated, complete
17 with information on the physician's scores on their
18 individual episodes and the ability to drill down or target
19 high resource use episodes to try and identify the practice
20 patterns that are leading to high resource use.

21 In addition to some of the technical issues that
22 we've presented here today, we'd also appreciate your

1 feedback on how a physician outlier policy might be
2 incorporated into a physician payment system. These policy
3 directions range from confidential physician feedback to
4 educating physicians or establishing corrective plans of
5 action in order to change their practice styles. More
6 interventionist approaches might include public reporting of
7 physician scores, differential payment rates, or payment
8 updates and recouping any excess profits that might have
9 occurred as a result of an excessive practice style.

10 Tomorrow Kevin will also be presenting some ideas
11 on how you might combine an outlier approach with other
12 approaches.

13 We'd be happy to answer any questions.

14 MR. MULLER: Niall and Cristina, I don't think
15 anybody of us is surprised specified that there's variation
16 in physician practice in America. We've heard a lot about
17 that. I don't quite understand where this takes us without
18 any measures of outcome, because we've also discussed that
19 in previous years, as well, in terms of the difficulty of
20 getting those measures of outcome, especially physician-by-
21 physician.

22 But could you help me understand how far we can go

1 on this without those kind of measures of outcome?

2 MR. BRENNAN: I guess we're pursuing two different
3 tracks, in terms of outcomes. You might remember in the 5
4 percent analysis we did apply some algorithms that we've
5 developed of claims-based quality indicators. So that's one
6 area that we're looking at. We know that they're not
7 perfect, but they're certainly a place to start.

8 We also are going to work with the folks who
9 produce the ETG grouper. They have produced a quality
10 component add-on to their software called EBM, I believe
11 that's Evidenced-Based Medicine, that also checks for --
12 it's not outcomes, per se, but it will look at that the rate
13 at which physicians are adhering to evidence-based practice
14 guidelines.

15 But you're right, and I think we've always said
16 that any evaluation of efficiency has to include both
17 resource use and quality.

18 MR. MULLER: I think Nick, among others, has been
19 very forceful in pointing out that effective physician
20 practice can avoid costs elsewhere in the system. So you
21 might be able to pay out a couple of standard deviations up
22 -- and I think Arnie's made the point as well -- you might

1 be able to pay a couple of standard deviations up for people
2 who avoid costs of institutionalization or readmissions or
3 can manage chronic care in a more cost beneficial way.

4 MR. BRENNAN: One of the things about the episodes
5 is that strictly speaking you should be able to identify
6 physicians who practice in a style that results in fewer
7 hospitalizations than other physicians because we're not
8 just looking -- we're looking at the full continuum of care,
9 Part A, hospital inpatient, post-acute care, and Part B
10 physician services.

11 DR. MILLER: Just so everybody follows that, so
12 that if the physician did, in fact, avoid a hospitalization,
13 they'd be more likely to be in the middle of the
14 distribution instead of at the tail because both sets of
15 data are captured, or both sides of it.

16 DR. REISCHAUER: But we get into the
17 Miami/Minneapolis problem from last time, which is if 23
18 percent of the population has chronic heart disease in Miami
19 and only 11 in Minneapolis, is that the underlying
20 distribution or not?

21 DR. MILLER: But I think what Niall was driving at
22 in some of his closing comments was that perhaps a starting

1 place for this is to go inside the market area. inside the
2 condition, and inside the specialty so that you sort of say
3 okay -- and then also, he's also got other work in progress
4 on sort of looking at how you can do overlays of risk
5 adjustment here. So we haven't ruled that out but we're not
6 able to speak to it yet.

7 But if somebody said tomorrow you have to do this,
8 one place to start might be inside the area, inside the
9 condition, inside the specialty with the notion that that at
10 least captures some of what might be related to risk. And I
11 think Niall was driving it that at the end of his talk
12 there.

13 MR. HACKBARTH: John, I think, has said that, in
14 fact, that's how at least Humana applies it.

15 MS. BURKE: I want to ask a question following up
16 on Mark's point, and I apologize if this came up while I was
17 out of the room.

18 Help me understand, and I don't know how
19 frequently this occurs, but depending on the specialty, help
20 me understand the attribution issues as they relate to
21 hospitalists, the extent to which there's a handoff that
22 occurs for an acute episode and then a handoff occurs again.

1 And as you track attribution for the management of that
2 particular patient over that period of time, how does the
3 attribution rule work in that kind of a scenario, as
4 compared to folks that are seeing people out of the
5 hospital.

6 And I don't know how prevalent that is. It's
7 certainly limited to certain kinds of specialties. But I
8 wonder if that's an issue or one that lends a complexity to
9 this?

10 MR. BRENNAN: I think it might be potentially an
11 issue. The way it's done is that we look at E&M dollars on
12 physician fee schedule claims. So to the extent that a
13 hospitalist is submitting physician fee schedule claims, and
14 if they exceed the 35 percent threshold, then they would be
15 assigned to the episode. But to the extent that they're
16 not, they wouldn't. And a physician in the community
17 instead would be attributed that episode.

18 MS. BURKE: But if the goal over time is the
19 episode, this sort of full management of the patient
20 throughout the period of time that they're being treated,
21 arguably there are certain aspects that each of them can
22 control.

1 MR. BRENNAN: Absolutely. I didn't want to get
2 too much into it for the purposes of this presentation.
3 This is why you could have probably several multiple hour-
4 long presentations just on attribution and how you do it.
5 We picked 35 percent and we said let's just go with this and
6 generate some scores and see what they look like. But in
7 the report we said 35 percent might not be the right number.
8 You might need different thresholds for different
9 conditions. And for some things you might need multiple
10 attribution.

11 The only cautionary note there is that the more
12 approaches you take, the more complex it becomes and the
13 more --

14 MR. BERTKO: Niall, on that point, if I can add
15 for Sheila's benefit, only about 25 percent of Medicare
16 beneficiaries have one or more admissions during the year.
17 So while that's an issue to consider, we're also dealing
18 with the 80 percent of beneficiaries treated by physicians
19 who have no admissions.

20 MS. BURKE: [Inaudible.]

21 MR. BERTKO: Yes, of course.

22 MS. BURKE: You're absolutely right. The ratio is

1 clearly on the outpatient side but, in fact, the highest
2 cost drivers are on the inpatient.

3 DR. KANE: If the physician in the community
4 doesn't ever talk to the hospitalist and the hospitalist
5 never talks to the physician in the community, they might
6 well end up in the higher cost end. Just because you turn
7 over inpatient authority to a hospitalist doesn't mean your
8 responsibility ends in a good care system. In a poor care
9 system, the responsibility ends but that's when you start
10 losing information and losing the -- so I don't think the
11 hospitalist piece, anymore than turning them over to a
12 surgeon for the inpatient care, should necessarily absolve
13 the primary care person --

14 MS. BURKE: And I'm not arguing that it does. My
15 only question is how you -- One of the issues that Niall
16 very correctly points out and the paper correctly points out
17 is the whole point of this is how do you develop credible
18 information that you can then use to alter people's
19 behavior?

20 And the credibility will come with are you
21 reflecting what it is that I can do? You're absolutely
22 right, there ought to be a relationship that exists. The

1 whole concept of turning somebody over in and then saying
2 not my problem, come see me when you're done, is crazy. But
3 it is a question of can you accurately reflect decision
4 points and then reflect are you, in fact. talking? Are you,
5 in fact, managing this patient appropriately? That's really
6 the question.

7 MR. BERTKO: Naturally, I have a thousand things
8 to say, so I'll limit it to 10.

9 First of all, I wanted to congratulate Niall and
10 Cristina for doing a lot of good work. I'd like them to go
11 back to slide five. I think they've answered one of the
12 questions at least to my satisfaction.

13 Is it worth doing this? That 4.6 billion is a lot
14 of money. Cristina, I need to ask, is that Part B only or
15 Part A and B?

16 MS. BOCCUTI: It's Part B only.

17 MR. BERTKO: So then I would suggest doubling it,
18 as a rule of thumb, because the Part A stuff is generally 50
19 to 60 percent of total Medicare costs and at least on the
20 private sector side, for under-65 people, we've found that
21 relationship continues to hold.

22 Next, I guess I'd like to say that there's good

1 news here. Look on the left side of the graph. 70 percent
2 to 80 percent of doctors practice in a very tight band
3 around the mean. That's great news. The folks that we
4 should be concerned about are the ones in the outlier region
5 over there.

6 And then to add to that, I would suggest -- only
7 this editorial opinion -- somewhere between the first and
8 second deviations might be the right cutoff point. It
9 varies by specialty. We seem to think it's 20 percent to 30
10 percent of physicians are the ones that you should try to be
11 looking at. So the numbers there are quite large.

12 The third point I'd make is that I'm really happy
13 that you validated with public sector data with a more or
14 less transparent practice what the private sector has been
15 doing. Your data here more or less matches what we're
16 seeing. And I think it's important that we do that in a
17 transparent way so that it be understandable to physicians
18 whether or not they are agreeable to it.

19 So Glenn, your skepticism is certainly well
20 deserved. And when you go to the next step, which perhaps
21 was what Sheila and Bob were asking about in the last one,
22 you can conceive of a scorecard based on this kind of data

1 that can be relatively simple. We've used this particular
2 approach, we've had our Ph.D. stand out in front of groups
3 of doctors and say here it is, by the way, we can give you a
4 scorecard showing the reason for your score is you used 200
5 percent of the average lab use compared to your peers in Big
6 City, Texas, in cardiology or dermatology.

7 That's the answer. And then the biggest question
8 of all is what Niall has put at the end here, is where do we
9 do that? So confidential to the docs.

10 I would suggest, and I think Arnie would agree
11 with me, that the moment this is done, there will be an
12 enormous demand from the employer side to say well, tell us
13 what the answers are. And we need to be ready to face that,
14 as well as from say the group physician practice managers,
15 the leadership group that Nancy's trying to train. And
16 Nancy, I hope you get every single potential leader.

17 I think I limited it to five.

18 DR. REISCHAUER: Thank you for leaving me five.

19 My basic question was going to be the one that
20 Ralph asked. I think this stuff is fascinating and where it
21 leads who knows, but we're getting a great education, I
22 think, on this trip.

1 I was thinking can you look at the standard
2 deviation of the range within any physician? Do people who
3 are on average, who practiced inefficiently, for a third of
4 their cases, they're very efficient. We've got a lot
5 stronger case if they're just generally inefficient for
6 virtually all of their cases.

7 The other thing is do we know anything about
8 looking over time? This does have a time element. But as
9 you expand the length of time, does the variance here go
10 down significantly or not?

11 And then I think what Sheila was getting at, it
12 would be interesting to look at the correlates of efficiency
13 and inefficiency, that the hospitals that are the most
14 inefficient or most efficient generally send their patients
15 to. Age, is this something that gets better over time? Are
16 they part of a multi-specialty group practice or not?

17 What it will do is sort of lead us to some ideas
18 about how to operationalize some of this, what other levers
19 should we be pushing on? Should it be having Nancy teach
20 them all? Should it be encouraging them to get into multi-
21 practice group specialties? What?

22 DR. CROSSON: Just a couple of comments on the

1 sizing of this. I'm not sure I agree completely with John
2 here. I think if you look here on slide five, it's 4.6
3 billion and you can multiply that if you add other parts of
4 Medicare payment. But that's only assuming you make it
5 disappear.

6 MR. BERTKO: No, return it to the mean.

7 DR. CROSSON: If you look at the next page, if you
8 look at page six, I guess if I were drawing this I would
9 have assumed that you would be aiming to take it back to the
10 second standard deviation.

11 MR. BERTKO: No.

12 DR. CROSSON: I guess that's the issue. But even
13 if you decide that we should take it back to a place between
14 the first and second standard deviation, I think the number
15 is going to be less than 4.6.

16 The last point I would make is however valuable
17 this is, and I'm sure it has value, I believe the value
18 would pale beside moving the whole curve to the left. I
19 think a lot of the other thoughts that we we're engaged in
20 are fundamentally that.

21 MR. BERTKO: I obviously need to reply. You're
22 right on this, the 3.6 billion starts at double it to get

1 the Part A stuff in, so you have 7 billion of potential.

2 One way to do it, the way that most health plans do it, is
3 you don't have those doctors available. So they go to the
4 rest.

5 There is no reason to be satisfied with having the
6 same appropriate amount of care, no stinting, but moving the
7 cost of that care to the mean.

8 DR. REISCHAUER: Just to reemphasize that, when
9 you look at Phoenix, the most inefficient area in your data,
10 but then see that the 10th percentile is down at 50 percent
11 of their mean, you realize whoa, there's a lot of room here
12 if we can be comfortable that the care they're providing is
13 high quality care.

14 MR. BERTKO: Right.

15 DR. CASTELLANOS: As a practicing physician, I
16 really like this proposal. I think it holds a lot of
17 promise, especially using the episodic groupers or whatever
18 method to provide the physician with confidential data that
19 allows him to compare himself to other people.

20 I'll be honest, I bet you some of those outliers,
21 that 1.9 percent, don't even know they're outliers. They're
22 out there thinking they're doing the best job in the world

1 and don't really recognize that perhaps they're not using
2 resources appropriately. So I think this really has a lot,
3 a lot of potential.

4 We need to make sure that the data that's provided
5 to them is accurate. My only suggestion is you need to get
6 the physician community involved right from the get-go to
7 get this data together.

8 I think this is important, rather than applying
9 targets. What Nick said earlier, and I would hope MedPAC
10 would reaffirm their 2001 recommendation to replace the SGR
11 using the expenditure targets with perhaps an updated
12 process based on physician costs. We're not asking you to
13 do anything different than what you do to other providers.

14 I'm concerned with the here and now rather than
15 we're talking about potential things and when this is all
16 going to get implemented. I'm very concerned over the here
17 and now.

18 On the forefront, we have a 5.1 percent cut,
19 together with all the other cuts. And there's been a lot of
20 communication in the physician community that there may be
21 an access to care to the Medicare recipient. I think it's
22 real, that threat. And I think the cost of doing nothing

1 now or doing nothing at this time is very great.

2 DR. MILSTEIN: I wanted to speak in support of
3 Ralph's point and a point made by several others that we
4 shouldn't even remotely consider this being the single basis
5 for any kind of a formula for SGR escape. It needs to be
6 balanced, include quality, and from my perspective include
7 some of the high potency ingredients outlined in the prior
8 presentation, like credible means of care coordination,
9 credible IT system to support longitudinal management. I'm
10 not sure there's much disagreement on that point but that's
11 my sense of what might work.

12 Secondly, we are going to, out of respect for
13 physicians in smaller practices, we do need to begin to
14 think about if this is an escape route from SGR for making
15 sure that on a specialty specific basis the minimum number
16 of episodes per -- I'll call it escaped physician unit,
17 whether it's a single doctor or 10 doctors -- be what
18 current research suggest is the number of episodes you need
19 for statistical stability. I think the evolving research
20 suggests that it's specialty specific. It isn't just 20.
21 It might be 20 for some, it might be 40 20 some. There's
22 other specialties.

1 So we have to understand what the current research
2 indicates is a statistically stable minimum number of
3 episodes per unit and make sure that on a specialty specific
4 basis we've assured that for doctors so that we're not
5 holding them accountable for noise, that we're holding them
6 accountable for signal.

7 And last, as I look at this number and again go
8 back to this issue of what's the job that beneficiaries need
9 physicians to lead in this country, I want to reinforce some
10 of the earlier points. It's not about getting all doctors
11 who are in the tail and for which there's no good reason for
12 them to be in the tail to stop being in the tail. It's
13 basically to begin to set a mark for excellence such as top
14 quartile performance, and then begin to think about
15 rewarding physicians, whether it's through escape from SGR
16 or P4P or both for physicians who can bring their quality
17 and their resource use scores up to a point where their
18 scores are not statistically different than, for example,
19 the top quartile.

20 And that's my vision for how you could get to this
21 very tight distribution. And from the beneficiaries point
22 of view, a distribution that continuously shifts to the

1 left, if we're going to offset the cost additive effect of
2 the biotech pipeline which is coming at us at apparently a
3 higher rate in terms of its cost additive impact.

4 DR. KANE: One was a technical question and then a
5 comment. The technical question is when you end up dropping
6 out 30 to 40 percent of physicians to get them into the 20
7 episode threshold, how many outliers do you drop out?
8 What's the correlation between that and are you going to
9 lose all of your outliers because they don't do that many
10 episodes? And have you checked that yet? I don't know.

11 And then I have a comment.

12 MR. BRENNAN: I'll give you a partial answer. All
13 of the episodes have been already trimmed for outliers by
14 the time we get there, on an episode-specific basis. So we
15 look at all the diabetes episodes and we take off diabetes
16 episode outliers, hypertension episode outliers.

17 Now some people think that instead of eliminating
18 them from the analysis you should just -- I think it's
19 called winds rising -- and take them down to the 95th
20 percentile or whatever. Again, this is not set in stone.

21 It's possible that some of the physicians who
22 don't meet the threshold are outlier physicians. But then

1 you get into the measurement and precision issues that I
2 talked about. And even after excluding those you still have
3 a pretty -- for most specialities it seems to go from 0.5 to
4 1.5 or 0.6 to 1.5.

5 So you're still getting a reasonable distribution,
6 I think.

7 DR. KANE: Although you may well be missing those
8 outliers that we were focusing on in the other study. I'm
9 just wondering if you can tag those people and say in which
10 episodes are we capturing them or not? By virtue of the
11 rules we've created to create episode-based evaluation, are
12 we automatically eliminating the 4.6 billion people? I
13 don't know.

14 MR. BRENNAN: Also, we should make it clear that
15 these were two separate analyses and Cristina's was focusing
16 just on Part B, whereas the episode analysis was focusing on
17 all dollars.

18 DR. KANE: I would just want to be assured that
19 we're still capturing the outliers.

20 The other comment goes back a little bit to
21 something that Karen mentioned, that the beneficiaries
22 should also be part of this equation, and not just on the

1 basis of information. But once -- I noticed on the last
2 slide the options for addressing SGR. Might we want to
3 consider tiering and copay differentials to steer
4 beneficiaries in the fee-for-service system towards the
5 physicians who are going to be more cost effective and
6 quality -- that's not even on the list right now, the
7 beneficiary piece of it. But I think it should be at least
8 talked about, even if we decide to back off because we don't
9 know enough.

10 But if we were going to go after -- I mean, having
11 parents in Florida who are, I just think physicians are in
12 feeding frenzies for fee-for-service Medicare patients with
13 good secondary. And it would be helpful for them to know,
14 for instance, who to avoid. And so maybe a tiering
15 structure and a copay structure that helps inform the
16 beneficiaries and drive them more towards the physicians who
17 are better profiled would be something to think about,
18 sooner rather than later.

19 DR. BORMAN: Just a very quick comment. I think
20 this is fascinating work and I think it's really well done.
21 I understand all of the concerns. I'm a physician. I'm a
22 surgeon. I'm trained to take things apart, and hopefully

1 put them back together, too. And yes, you can anticipate
2 that you provide this information, and one of the things
3 that many physicians are going to do is say well, tell me
4 how you did it and let me pick apart your model and that
5 kind of stuff.

6 But I also would tell you, I would not
7 underestimate the power of right now taking this analysis at
8 the level of precision that we have, albeit imperfect, and
9 starting to provide that information confidentially. You
10 don't have to tie it to anything. It is not, in and of
11 itself, clearly the answer to SGR.

12 But is this something practical that could be put
13 in place fairly quickly, fairly immediately and say we
14 understand all the disclaimers, we've got lots of
15 disclaimers about the nature of the information here, but
16 here you go. Here's comparative information.

17 I think that would be huge step forward to endorse
18 some short-term implementation of this kind of strategy.

19 MR. HACKBARTH: Let me to just leap in and pick up
20 on that. I generally agree with that.

21 In this conversation we've heard multiple
22 different uses mentioned. One is education of physicians.

1 Second is education of patients. A third is identification
2 of outliers with some consequences attached to that
3 exclusion, tiering or whatever. Potentially as an overall
4 performance assessment, presumably attached with some
5 opportunity for gainsharing.

6 As you move down that list I think the level of
7 precision required increases. If we're talking about
8 confidential disclosure to physicians, I think you're
9 talking about a very different game than if we're paying out
10 trust fund dollars based on presumed savings where I think
11 there would be -- or financial punishment if you're in the
12 high end of the distribution. I think when you're down at
13 that end of the continuum, the standard of proof is much,
14 much higher.

15 So just to be clear, despite my earlier comments
16 to Arnie, I think that this is a promising area particularly
17 with regard to education of physicians and confidential
18 disclosure. It's when you get to the other end of the
19 continuum that I'm not sure whether it works or not. That's
20 not an answer that it doesn't, it's just that I've got some
21 unresolved questions and anxiety about it.

22 I also think that when you move from the private

1 payer setting to the Medicare setting there's a different
2 dynamic. In part, that's just perhaps attributable to more
3 dollars being involved based on the decision for many
4 physicians because Medicare is a bigger share of their
5 practice. But you also get into that this is a political
6 process. It's more vulnerable to legal challenges of
7 various sorts. The decision making mechanisms are just much
8 more difficult and cumbersome than they are for private
9 payers.

10 So I think this is potentially promising and we
11 ought to keep pushing ahead. I feel perfectly comfortable
12 with the recommendation we've already made that CMS ought to
13 develop these tools for confidential education of
14 physicians. It's just how far and how quickly we can move
15 down that continuum. That's where my questions are.

16 DR. SCANLON: This comment relates very strongly
17 to what you said. As we've been hearing about different
18 potential applications, I think we do go along a scale in
19 terms of what we really need to demand above the measures.
20 The dimension that I would add to this is the issue of
21 timely, that if we're talking about payment in particular,
22 people are not going to be very happy if their payment is

1 based upon experience several years back. I think we need
2 to, as we think of other applications, think about when will
3 we have the capacity to be able to give this kind of
4 feedback and use it for other purposes besides the
5 confidential feedback that can be a bit remote? When will
6 we have the capacity to do it on a timely enough basis? I
7 don't know what the timely enough basis is, whether a year's
8 lag is fine or a year-and-a-half or something like that.

9 But right now we really do have this problem of
10 assembling data and being able to say what's actually
11 happened within Medicare.

12 DR. HOLTZ-EAKIN: I wanted to just say thank you
13 for all the good work and to echo that I agreed with your
14 five, John, and your five, Bob. Especially the idea of
15 looking within the physicians to see if they're uniformly
16 good guys or not.

17 The other question I have, and I confess my
18 feelings as a commissioner, I can't keep track of all the
19 demos and pilots that exist in the universe. I think it
20 would be fascinating if there was some live data and actual
21 claims out of one of the good care demos, pay for
22 performance or group practice or anything, and you ran this

1 on that. Do you get the same distributions? Do you get the
2 same behaviors that we're finding in the broad pool in these
3 things which are targeted to provide better care?

4 I don't know the answer but I think it would be
5 interesting if you could do it.

6 DR. WOLTER: I'm certainly fine with this and I
7 have no doubt there are areas where attribution to
8 individual physicians and comparative data coming back can
9 make a big difference.

10 The part of this, though, that interests me the
11 most is how do we connect it to the larger issue of tackling
12 high volume high cost areas in the program? And in those
13 areas more often than not the care of patients is a team
14 sport. And that's, I think, a challenge in terms of how do
15 we take this information and connect it back to some of the
16 other themes that we've been talking about today? But
17 there's so much opportunity there if we can find a way to
18 it.

19 MR. HACKBARTH: What I imagine would happen or the
20 goal would be that if you feed this back to individual
21 physicians, focusing initially on the high volume very
22 costly things that if a physician sees that they're

1 consistently at the high end, costly end of the
2 distribution, the question you want them to ask is am I
3 using the right specialist consults? Is the hospital doing
4 something wrong? And you try to get them to engage in a
5 conversation.

6 So this is an analytic tool for trying to impose
7 some order on what is often a chaotic set of relationships.
8 And by using the analytic tool I assume the goal is to get
9 people to think more systematically about their
10 relationships with other providers.

11 Now that's a stretch. That's not a cinch to make
12 happen. But I assume that's the goal here.

13 DR. WOLTER: I was even thinking that if we do try
14 to create some incentives around virtual groups or units
15 coming together to take better care in terms of coordination
16 costs, quality measures, this information could be
17 invaluable when you have those units that have come
18 together. Because then you can connect the hospitalists
19 with the outpatient physicians. Some organizations can even
20 break their data down in terms of how many x-rays are being
21 ordered for a certain episode and they can really start to
22 work with the data. So I think there's a lot of value

1 there.

2 The other thing I forgot to mention, and of course
3 this is the thing that's so hard and I don't know how we get our
4 arms around it, but the issue of appropriateness and
5 utilization in volume is so hard to analyze in all this.
6 Even if we can start to deal with the episode and the
7 quality measures and the cost of an episode, which of those
8 episodes could have maybe been prevented? Which are
9 inappropriate because of care that was delivered that maybe
10 wasn't necessary? And we kind of saw that a little bit in
11 the Minneapolis/Miami example last month. That
12 appropriateness issue is very hard to analyze.

13 MR. HACKBARTH: What I'm wrestling with, I take
14 Arnie's point back in the earlier discussion very seriously
15 about we don't want to lock people into particular organizational
16 models. We want to identify great care and reward it,
17 whatever organizational form.

18 Instinctively though, I can more readily see this
19 information being used by an organized delivery system of
20 some sort for self-improvement than individual physicians in
21 an atomized, unorganized delivery context taking it and say
22 I'm going to get my specialists to behave differently or I'm

1 going to get the hospital to behave differently. If there's
2 an organizational context for it, it just seems like it's a
3 much cleaner shot to me.

4 DR. WOLTER: I think that's especially true again
5 for these complex illnesses and the more complicated
6 episodes. Of course, since that tends to be where the cost
7 is, it would be a great place to put some emphasis as we try
8 to find ways to use this information.

9 DR. MILSTEIN: On this point, I agree with the
10 point that you're making and I think that additionally we
11 need to consider the reality that across other industries
12 smaller units of aggregation tend to be more agile and more
13 innovative. So we're balancing two very valid points. And
14 I very much accept the validity of what Nick and you were
15 saying.

16 MR. HACKBARTH: All right, we're finished with
17 this.

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

20 MS. MARRONE: I'm Barbara Marrone from the
21 Emergency Physicians.

22 I've been following this discussion over the last

1 few months, along with the demos from CMS and some of the
2 other efforts. And one of the things that's difficult is if
3 you're in a specialty that's not really going to fit into
4 this model of attribution, it would be helpful if at least
5 the heterogeneity of physician practice was recognized
6 somewhere along the reports and the analysis because I'm not
7 sure how emergency physicians and some of the other
8 specialists that don't fit into the models, which is
9 rightfully focused on high-cost high-frequency high-volume
10 conditions, how they're going to escape from the SGR. Are
11 they just going to sort of sail along on the proverbial
12 coattails of other docs who learn how to handle this better?

13

14 I'm just not sure and it would be helpful if we'd
15 get a little guidance for other types of specialists.

16 Thank you.

17 MR. HACKBARTH: Okay, we'll adjourn for lunch and
18 reconvene at 1:15.

19 [Whereupon, at 12:01 p.m., the meeting was
20 recessed, to reconvene at 1:15 p.m. this same day.]

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AFTERNOON SESSION

[1:17 p.m.]

MR. HACKBARTH: Next up is the mandated report on payment changes for Part B drugs.

DR. SOKOLOVSKY: Good afternoon. Beginning in 2005 Medicare implemented a completely new way of paying for physician administered drugs based on the average sales price. This new system not only reversed the trend in spending for these drugs, which had been growing at a rate of more than 20 percent annually, but actually resulted in a decrease in Medicare spending. Congress directed MedPAC to evaluate the effects of this new system on beneficiaries and physicians. Today we are presenting results from our second congressionally mandated report on the impact of these changes.

For this presentation, I will first present our analysis of changes in volume and expenditures for Part B drugs in 2006. Next we'll look at how physicians from different specialties reacted to the payment changes as well as more general changes in physician practices. We'll then return to an issue which some commissioners had expressed interest in, shifts in where beneficiaries are receiving care.

1 Commissioners also expressed interest in two drug
2 payment issues, how discounts are allocated in ASP
3 calculations when products are bundled together and the use
4 of least costly alternative to determine payment rates for
5 some prostate cancer drugs. And we will discuss these
6 issues, as well

7 Last year we studied the effects of the payment
8 changes on chemotherapy services for Medicare beneficiaries.
9 As you may recall, we found that access to chemotherapy
10 remained good but that some beneficiaries without
11 supplemental insurance were more likely to be sent to the
12 hospital outpatient department to receive chemotherapy.

13 This year we have been asked to study the effects
14 of the changes on other specialties that provide physician
15 administered drugs. We have focused on the experiences of
16 urologists, rheumatologists, and infectious disease
17 specialists.

18 We have also continued to meet with oncologists
19 and beneficiary advocates to continue to track access to
20 care for beneficiaries needing chemotherapy, and our
21 analyses have combined claims analysis with interviews with
22 physicians, practice managers, hospital administrators,

1 specialty group associations, wholesalers, manufactures, and
2 other stakeholders.

3 As you can see from this slide, Part B drug
4 spending is concentrated in a few specialties. Oncologists
5 who provide chemotherapy to cancer patients account for more
6 than 50 percent of all Part B drug spending. On the other
7 hand, infectious disease specialists account for less than 1
8 percent. Much of what's included under the rubric of other
9 are drugs that go through pharmacies and DME suppliers. In
10 general, most specialties except for oncology use a small
11 array of drugs. For example, rheumatologists are the main
12 suppliers of infliximab for treatment of rheumatoid
13 arthritis, and urologists provide more than 80 percent of
14 drugs used to treat prostate cancer.

15 Total spending for each of these specialties on
16 all services, which includes visits, drug administration,
17 other procedures and tests, increased for all of the
18 specialties but drug spending fell for each one of them.

19 The decline for drug spending ranged from only 1
20 percent for rheumatologists to 52 percent for urologists. A
21 large part of the reduction in spending was attributable to
22 lower prices under the ASP payment method. That is, ASP

1 resulted in substantial price savings for Medicare on nearly
2 all drugs and these payment rate changes drove decreased
3 spending. Part B drug spending fell from \$10.9 billion in
4 2004 to \$10.1 billion in 2005, which was the lowest amount
5 since 2002.

6 In the last slide I showed you what happened to
7 expenditures. Now I want to shift to the amount of drugs
8 provided to beneficiaries. Here we talk about volume which
9 is measured by spending with prices held constant.

10 for most specialties, the volume of drugs provided
11 to beneficiaries from 2003 to 2005 increased. The exception
12 was drugs provided by urologists. Here volume fell 15
13 percent. Although infectious disease specialists provided
14 more drugs in 2005 than in 2003, the volume declined from
15 2004 to 2005. However, because the total amount of drugs
16 they provide is so small, small volume changes appear as
17 large percentage fluctuations.

18 In last year's study, we found that much of the
19 volume increase for oncologists reflected the substitution
20 of newer more expensive drugs for older therapies.

21 Urologists provided 16 percent less drugs in 2005
22 than in the 2004. The decline was in the number of

1 beneficiaries getting drug treatment for prostate cancer.
2 This decrease did not result in more drug administrations in
3 the hospital outpatient department. And declines were
4 greatest in practices that had been providing the most drugs
5 previously.

6 There are a number of possible explanations for
7 the decline, including changes in physician practice
8 patterns and lower payment rates for the drugs making them
9 less profitable.

10 Hormone suppressing drugs are used for the
11 treatment of advanced prostate cancer. However, early
12 screening in the past decade or so has led to more early
13 detection and treatment of low-risk cancer patients and
14 these people may never progress to the advanced stage.
15 However, rather than use a watchful waiting approach, many
16 patients with localized prostate cancer have chosen to
17 undergo hormone therapy. In fact, the percent of patients
18 with any kind of prostate cancer undergoing hormonal therapy
19 increased from 12 percent in 1991 to 41 percent in 1999.

20 In recent years however, more research has shown
21 that the drugs increase risk for heart disease and other
22 conditions. These findings may have discouraged some use

1 where benefits have yet to be proven for low-risk patients.
2 Also, some physicians have recommended that patients take a
3 break from the therapy both to maintain the drug's
4 effectiveness and to improve patient's quality of life.

5 Finally, physicians may have been discouraged by
6 the lower profit on the drug from prescribing the drug for
7 patients in cases where the benefits have not yet been
8 proven.

9 In 2006, for which we still have no claims data,
10 some physicians have told us that they've begun asking
11 patients to get drugs -- not just prostate cancer drugs but
12 also bladder cancer drugs -- at pharmacies using their Part
13 D benefit and then have the physician administer it in the
14 office.

15 Rheumatologists provide a small number of Part B
16 drugs in their offices, mainly to treat rheumatoid
17 arthritis. They continued to increase the volume of drugs
18 they provided for this purpose and spending on their most
19 important drug, infliximab, was constant. Most
20 rheumatologists continue to provide the infusions in their
21 offices. There are some self-administered drugs, now
22 covered under Part D, that can substitute for infliximab,

1 which is an infusion covered under Part B.

2 Rheumatologists generally told us that these drugs
3 are interchangeable for the conditions that they treat,
4 although individual patients may do better on one product
5 than another. Before Part D nearly all Medicare patients
6 without drug coverage received infliximab because of Part B
7 coverage. Now physicians may work with the patient to
8 determine whether it makes more sense for them to start with
9 a Part D or a Part B drug based on the patient's drug
10 spending in relation to the coverage gap and the out-of-
11 pocket limit.

12 Finally, infectious disease specialists provide
13 far fewer drugs in their offices than do the other
14 specialists we've discussed today. Additionally, they are
15 never the main purchaser for anyone drug and the antibiotics
16 that they use most frequently are used more often in
17 hospitals. Thus, they never seem to have the market power
18 to get the best price for any drug that they use.

19 Typically, infectious disease doctors practice in
20 facilities -- for example hospitals, nursing homes and long-
21 term care hospitals -- and only the largest practices have
22 opened outpatient infusion centers. However, the model of

1 the outpatient infusion center provides some advantages to
2 patients with infections and compromised immune systems who
3 would otherwise be hospitalized and exposed to more
4 infections.

5 The 2005 decline in the volume of drugs provided
6 to patients in their offices suggests that once the
7 provision of drugs became financially unattractive more
8 practices shifted at least some services back to facilities
9 where they had typically been provided.

10 In our interviews with urologists,
11 rheumatologists, and infectious disease specialists we found
12 that physicians had made many changes to their practices in
13 order to become more efficient. Efficiencies included
14 constantly monitoring drug prices, reducing drug
15 inventories, paying quickly to get prompt pay discounts from
16 wholesalers, scheduling patients to ensure that there was
17 little downtime when practices were open, and reducing staff
18 or staff benefits or sometimes changing personnel mix.

19 These changes are similar to those that we talked
20 about last year for oncologists. However, because of the
21 greater relative importance of drugs to the practice of
22 oncology, oncologists have most affected by the payment

1 changes and much of what they told us this year is similar
2 to last year, but efficient management practices have become
3 even more important to them.

4 We found that larger practices were more likely to
5 achieve economies of scale both for drug purchasing and
6 overhead for their infusion centers. So for example, more
7 infusion chairs keeps the costs per infusion lower. Large
8 practices also were more likely to be able to employ
9 specialists in drug purchasing, and individuals to help
10 patients secure funding for their treatments if they
11 couldn't pay their copayments.

12 One consultant told us about helping some small
13 practices form a virtual network to accomplish some of these
14 efficiencies of the larger practices, particularly for drug
15 purchasing. Although we were not able to speak to solo
16 practitioners, physicians in different parts of the country
17 told us that they had heard of small practices that were no
18 longer able to provide drugs in their office.

19 We also continued to hear about patients without
20 supplemental insurance being shifted to the hospital
21 outpatient department and this is an issue that the
22 Commission expressed concern about last year. Sarah is

1 going to discuss it in greater detail.

2 MS. FRIEDMAN: In our interviews, we heard that
3 more physicians had either started sending their patients
4 without supplemental insurance to the HOPD to receive their
5 infusions or were shifting the site of care for more of
6 their patients.

7 We examined the associated costs of this shift to
8 Medicare and beneficiaries by comparing the payments in
9 doctors offices to the payments in the HOPD for high-volume
10 drug regimens in each of these specialties. Our estimates
11 are only a snapshot of the prices in 2006 and will change in
12 2007.

13 We found that neither setting is consistently more
14 expensive. The difference in costs for the two settings
15 ranged from \$1 to \$40. The small difference we calculated
16 does not take into account two ways extra cost to Medicare
17 may be incurred when patients are moved to the HOPD. The
18 first is through the 70 percent of aggregate patient bad
19 debt that Medicare pays. Second, duplicate lab tests and
20 physician visits result when patients are moved.

21 DR. SOKOLOVSKY: To sum up our key findings, we
22 found that the payment changes resulted in savings for both

1 Medicare and beneficiaries. Beneficiaries continued to have
2 access to drugs and the volume of drugs provided in general
3 has continued to rise. However, fewer beneficiaries
4 received drug treatment for prostate cancer in 2005 compared
5 to 2004.

6 The payment changes have had an effect on where
7 some beneficiaries receive care. As Sarah said,
8 beneficiaries without supplemental insurance are more likely
9 to be treated in the hospital than other beneficiaries. As
10 we said last month, we found that few common measures are
11 available to determine if quality of care has been affected
12 by the payment changes.

13 As you know, last month we discussed some issues
14 related to drug payments and I'd like to review one issue
15 here and also discuss another drug payment issue.

16 Last month we talked about a particular issue
17 connected to ASP. Some manufacturers make certain discounts
18 for one of their products contingent on the purchase of one
19 or more other products. Many oncologists spoke about a
20 particular example of this kind of bundling that created a
21 problem for them.

22 Let me remind you: product A and product B are

1 similar products that compete for private share. The
2 manufacturer of product A also makes product C, which is a
3 single source drug. All oncologists must provide at least
4 some of this drug to their patients.

5 It's very unusual to get a large discount on a
6 drug that has no competition. In this case, the
7 manufacturer provides a significant additional discount on
8 product C to purchasers who buy product A instead of product
9 B. These discounts result in a lower ASP for product C and
10 a lower payment rate.

11 Let me illustrate. And I just want to say again
12 these numbers are entirely for illustrative purposes and
13 don't represent any actual transactions. Let's say the list
14 price for product A and product B is \$100 and the list price
15 for product C is \$300. If the physician gets the bundled
16 discount, which again for this illustrative purposes is 10
17 percent for A and 30 percent for C, they have no trouble
18 purchasing either product at the Medicare payment rate. As
19 you can see here, that would be the left side of the slide.
20 However, if they prefer product B, they will lose money
21 every time they buy product C.

22 In the short term, this bundling arrangement has

1 resulted in lower Medicare payment rates for all three
2 products. In the longer term, it could drive product B out
3 of the market, leading to higher prices for A and C.
4 Further, some physicians believe that the practice is
5 hurting their ability to choose a product based on clinical
6 decisions.

7 Finally, other manufacturers of single source
8 products could also use this method to increase their sales.
9 If this happened, the integrity of the ASP payment system
10 could be affected.

11 So here we have a draft recommendation which
12 reads: the Secretary should clarify ASP reporting
13 requirements for bundled products to ensure that ASP
14 calculations reflect the true transaction prices for drugs.

15 In this draft recommendation we do not argue for
16 or against bundling or propose any specific allocation
17 method. In the text of the report we would look at
18 different allocation methods. The goal here is to ensure
19 the integrity of the ASP system. Discounts should be
20 allocated in a way that does not create inappropriate
21 financial incentives for clinicians as they treat patients
22 and ensures that ASP reflects the true average transaction

1 price for drugs.

2 The spending implications here are indeterminate.
3 Reallocation of bundled discounts could increase the payment
4 rates for some drugs and decrease it for others. In the
5 future, however, it would help to preserve access to care
6 for providers and beneficiaries by ensuring again the
7 integrity of the ASP payment system.

8 Last month one of the commissioners asked us to
9 look into inconsistencies in the application of least costly
10 alternatives, or LCAs, to hormone suppressing therapy for
11 advanced prostate cancer.

12 LCA policies say that Medicare won't pay the
13 additional cost for a more expensive product if a clinically
14 comparable product exists. Virtually all local carriers
15 apply this policy to hormone suppressing drugs to treat
16 advanced prostate cancer.

17 When the policy was first implemented it covered
18 two drugs, but now there are six products in this drug class
19 ranging in modes of administration from monthly injections
20 to annual implants. The clinicians that we spoke to agreed
21 that the drugs were clinically equivalent, although
22 physicians may favor one over another for a number of

1 reasons including quality-of-life issues.

2 Interviewees said that the policy is applied
3 inconsistently across carriers and changes frequently. For
4 example, in some areas all products are covered under one
5 LCA policy whether dosage and unit are comparable.

6 Since ASP changes quarterly, LCA may vary from
7 quarter to quarter and payments again then have to be
8 adjusted for dosage. Some carriers may determine
9 retrospectively which drug is least costly and ask for
10 return of overpayments, sometimes going back for several
11 years.

12 Some products are grandfathered in and others are
13 not. So if you start on one product, Medicare will continue
14 to pay for at the ASP plus 6 payment rate in the following
15 quarters. For other products they will not.

16 The inconsistencies in the way that the policies
17 are implemented are troubling and deserve further study.

18 In addition, urologists have remarked that
19 although there are other drug classes which may have
20 clinical alternatives these drugs are among the only drugs
21 to which an LCA policy is applied. This could be an issue
22 to look into in the future, to see whether there are other

1 drugs or drug classes to which an LCA policy could be
2 applied.

3 This concludes our presentation. Commissioners
4 will want to consider the draft recommendation and we would
5 be happy to hear any additional comments you may have. I
6 just want to remind you this report is due January 1st, so
7 next month is the last time you'll be able to see a draft.

8 DR. CASTELLANOS: Joan, I think you did a good
9 job. I think there are some issues that I'd kind of like to
10 bring up a little different than you did.

11 The volume thing, I think, is important. In your
12 slide that you showed, there was a 50 to 60 percent decrease
13 in volume going from year 2003 to 2005. As we talked and I
14 showed you data, actually that decrease started back in
15 2000.

16 From a clinical viewpoint I think we can explain
17 it. Quite honestly, I congratulate you and MedPAC for
18 bringing this to the clinicians' attention. Prior to this,
19 the urologists in this community, or for this matter in the
20 country or the AUA, had no idea that this was a clinical
21 fact.

22 I think what's happened is treatment changes have

1 changed. We're not giving this drug to anybody except
2 people with end-stage disease. We're picking up that
3 disease a lot earlier so we're not having as many patients
4 in the end-stage disease.

5 The other point that you mentioned about the
6 holiday is a very, very true. We're often holding treatment
7 because of the side effect profile, the complications as you
8 mentioned, but also we found that the patient doesn't
9 develop the resistance or hormonal refractiveness to the
10 drug, so the efficacy lasts longer. So I think we can
11 probably explain it on that reason.

12 That's not to say some doctors may have stopped
13 giving it for financial reasons, but I don't think that was
14 the main reason.

15 I think the two issues of bundling and LCA I'd
16 like to comment on. Quite honestly, I think they're pretty
17 the same from a physician viewpoint. What this does, it
18 ties the treatment to the cost of the drug and not to the
19 benefit of the patient. As you very aptly pointed out,
20 under bundling some drugs are not available. They're
21 underwater, so to speak. In other words, for the physician
22 to give the drug he feels or she feels is most appropriate

1 will cost that physician because he's paying the bill for
2 that drug a certain amount of money. So he's restricted in
3 what he can do.

4 And the same with LCA. It changes from quarter to
5 quarter. And as I said last time, these may be chemically
6 or pharmacologically equal but they're not equal to the
7 patient. The patient who's having a change in his or her
8 treatment, it's emotionally upsetting, it's financially
9 perhaps even upsetting. But more important, it disrupts the
10 physician relationship with the patient. In other words,
11 what's happening again is this ties treatment to cost.

12 Under LCA, again my recommendation is that it's
13 not compatible with MMA. It doesn't let market forces
14 dictate the price. The carriers have such a wide variety of
15 how they implement that.

16 My suggestion on LCA is that we follow MMA's
17 recommendations and get rid of MMA. CMS will not do it
18 because it's not a national carrier decision. It's a local
19 carrier decision and the local carriers, in my opinion, are
20 not doing a very good job.

21 Again, what I'd like to say is that both LCA and
22 bundling are in the same issue. If we're going to deal with

1 bundling, we need to deal with LCA because both of these
2 issues ties treatment to the cost, not to the benefit of the
3 patient.

4 Thank you.

5 MS. BEHROOZI: Thanks. This is really thorough.
6 You've gleaned a lot of information and I really appreciate
7 that you spent a lot of time talking with the providers.

8 I'm going to take note of something that you
9 included under the heading that the providers with whom you
10 spoke, I guess, reported that they need to carefully manage
11 their business practices. I guess that's as a result of the
12 lower level of profit that they're able to derive from the
13 Part B drugs.

14 And the last note is reduced staff or staff
15 benefits. You're saying say that some of the practices
16 reported that they had lowered their personnel costs by
17 reducing the size of their staffs, offering fewer benefits,
18 freezing salaries or delaying raises. I really wouldn't
19 want the Commission to be on record to say that that's
20 efficient provision of medical services, is to make it so
21 that the staffs who work for these providers end up not
22 having medical benefits or raises.

1 MS. HANSEN: This was really interesting to look
2 at the earlier conversation we had in the previous meeting
3 about some of the shifting that's going on for people who
4 don't have the supplemental insurance.

5 But a little bit related to Ron's comments I
6 wonder if, in the course of all of these different pieces
7 about some of the changes relative to the pharmaceuticals,
8 whether we would be in the position to kind of coordinate
9 the comments? I'm thinking about what Medicare's
10 pharmaceutical policies or drug policies are, especially now
11 that we have Part D added on.

12 You mentioned the impact to the beneficiary. But
13 I just wonder if we could do an overarching piece on
14 Medicare kind of pharmaceutical policy with the coverage.

15 DR. SOKOLOVSKY: I just want to say that's exactly
16 what we hope to do in the spring, to look at the issues
17 between Part B and Part D drugs.

18 DR. SCANLON: First I have a question and then a
19 couple of comments.

20 In part it relates to what Jennie just raised with
21 respect to the shifting. I think it's important because one
22 of the things we'd like is the payment policy not to have a

1 negative impact upon patients and beneficiaries. And it's
2 also because -- this is from our last meeting, I noticed but
3 in the trade press it got picked up in terms of MedPAC's
4 reporting that the shifting is occurring.

5 What I wanted to ask you about was in the meeting
6 materials we talk about the claims analysis and saying that
7 there is no discernible trend. I guess there's a question
8 of which evidence should we really put more store in? I
9 didn't know what you meant by a discernible trend versus
10 that there is really sort of a problem here.

11 Because it could be that yes, there are instances
12 that this is happening. But just as the way when we're
13 doing updates we look at what's going on over all and we try
14 to get as much comprehensive data as we can. I wanted to
15 see how we should weigh the claims results versus the
16 interview results.

17 DR. SOKOLOVSKY: In terms of the shift to the
18 outpatient department, certainly we've heard it everywhere
19 but we have not been able to pick it up. Our claims
20 analysis only goes as far as 2005 but that is when ASP takes
21 effect. We don't see a spike. There is continued growth in
22 the use of outpatient infusion centers but it doesn't

1 increase at a more rapid rate and it continues to increase
2 for most specialties in physician offices. And Duke
3 University recently came out with a study which found the
4 same thing.

5 DR. SCANLON: I guess I'm wondering if we should
6 be more tentative about that conclusion.

7 MR. HACKBARTH: Can you think of any potential way
8 to rationalize, connect those two pieces of information, the
9 anecdotal reports with the claims data?

10 DR. SOKOLOVSKY: I think that when you think about
11 the number of beneficiaries that don't have supplemental
12 insurance, it's under 10 percent anyway and that's assuming
13 that they all have chemotherapy. So we wouldn't expect a
14 huge increase to show up when we eventually -- you all know
15 about data lags and so on. But when MCBS finally comes out
16 and we know who are the people without supplemental
17 insurance, we might be able to look at this more clearly.
18 But now all we can look at is gross aggregate, do we see a
19 real spike? And we just don't see it at this point.

20 DR. SCANLON: In terms of other points, both last
21 month and this month the issue of access has come up and
22 partly physicians' access to drugs at something less than

1 ASP plus 6. I wanted to raise the issue of the competitive
2 acquisition program because it was meant to be the safety
3 valve for physicians that were not able to get a drug at ASP
4 plus 6 or below ASP plus 6.

5 I understand, in some ways, introducing it with
6 some restrictions. It's required that physicians get all of
7 their drugs through the program, that a whole practice
8 participate. Those rules may be too strong though some
9 rules, in terms of restricting this program, may be
10 important so that you don't create a situation where
11 physicians are not incented to try and get the best deal on
12 drugs. We don't want to do that.

13 But at the same time, we maybe should have a
14 functioning safety valve so that when the isolated instances
15 occur that there is a mechanism by which physicians can get
16 drugs at the price that Medicare is willing to pay.

17 Also related to this issue of access, I think, is
18 the issue of the ASP and the bundling. I'm supportive of
19 the recommendation. I think that we really should reflect
20 transaction prices in the marketplace. I don't know what
21 true transaction prices might mean and I don't know how to
22 exactly do this because I think that there is a variety of

1 arrangements that you can have in contracts that won't look
2 the same but end up having the same effect.

3 One of the realities is that even when we do this,
4 even though the prices of individual drugs may change
5 significantly because of a reallocation -- not the price
6 from the manufacturer but the price that Medicare is paying
7 -- the advantage to buying a bundle still may be there
8 because Medicare is, in some respects, paying you 6 percent
9 more than the drug manufacturer's revenue. And so if you
10 can get it for less, then you're going to be interested in
11 doing that.

12 So I think that it's an issue that needs to be
13 resolved because not reflecting an appropriate allocation is
14 something that is problematic.

15 Let me just end by mentioning about the LCA. I
16 think it's something we do need to explore some more in a
17 number of contexts. One is this issue of local carriers and
18 what discretion they should have. In one of the last
19 reports that I worked on a GAO we actually recommended that
20 we eliminate local carrier medical policy because physiology
21 is not local. And so the science of medicine shouldn't be
22 dictated by local medical boards or medical groups making

1 decisions. And when they actually are agreeing, spending
2 resources to make the same decision one after another, and
3 then some of them not arriving at that same point. It
4 doesn't make sense.

5 The other thing that I think that's important for
6 us in thinking about this for the future is this very much
7 relates to what we've been talking about in the context of
8 controlling Medicare costs and the cost-effective
9 alternative. It's got to be a part of that. To the extent
10 that we've got it here, we should be asking ourselves what's
11 wrong with the way it's being applied? How can it be more
12 effectively applied as appropriate for the future?

13 MR. HACKBARTH: Bill, can I just ask about your
14 comments on the bundling issue? What I thought I heard you
15 say was that you agree with the thrust of the draft
16 recommendation but you're cautioning us that the solution
17 may not be easy to find, that it's a complex issue. Is that
18 your basic message?

19 DR. SCANLON: Yes. I think that what CMS will
20 find -- and actually they're in the press now of trying to
21 work this through for Medicaid as well with respect to
22 average manufacturing price. What I think they will find is

1 there's a variety of arrangements under which drugs are
2 bought. And the question is what are the set of rules that
3 you want to have to apply to that variety that you can
4 identify today, and then hopefully in some respects deal
5 with the ones that develop in the future? Because these
6 contractual arrangements can be structured in all kinds of
7 different ways. We're talking about individual
8 relationships between manufacturers and their customers.
9 And they don't have necessarily a set of rules that will
10 correspond to what Medicare dictates. They can do different
11 things. They're going to influence the results that we get.

12 The numbers that Joan said are just illustrative.
13 It does matter in terms of a how big of a shift there's
14 going to be and how big of a difference there is in terms of
15 the incentive you have to use drug A or drug B. It in terms
16 of the numbers.

17 So how they're going to work out in actual
18 practice is going to affect things.

19 MR. HACKBARTH: So it's complex, but do you think
20 it's important to try to do it to preserve the integrity of
21 the ASP system?

22 DR. SCANLON: I think it's important to do.

1 Preserve integrity of the ASP system sounds like such a
2 lofty goal. I hate to go that far.

3 MR. HACKBARTH: That's why I used those words.

4 DR. SCANLON: I think it's important to do from
5 the perspective of doing the best job we can and getting a
6 ASP that's not too distorting, because ASP is flawed. This
7 idea that we're not interfering with the marketplace when we
8 use it in order to pay for drugs. I mean, let's be
9 realistic to ourselves.

10 MS. DePARLE: I'm smiling because I think that
11 when you were at GAO and I was at HCFA, now CMS, you guys
12 recommended ASP as a solution to our terrible problems then
13 of not only did we not have a lofty goal, but we didn't
14 really have much of an idea. And we were paying what we
15 called average wholesale price.

16 I can still remember your testimony, which is that
17 it's not average, it's not wholesale and it's not a price.
18 But other than that, it's a great way of doing it.

19 DR. SCANLON: And I still stand behind it as a
20 step in the right direction. It is not something that takes
21 us to nirvana.

22 MS. DePARLE: I agree with that and I guess I

1 wanted to speak in favor of the recommendation. I would
2 even support going further, although as I sit here looking
3 at this what is true transaction price? I think this is
4 among the more difficult issues that we and those at CMS who
5 are trying to get this right face. It will constantly be
6 morphing and it will be very fluid in this marketplace, I
7 think, for drugs. But I think it's really important that we
8 acknowledge this issue now as the first that we've
9 identified and that we keep monitoring it. Because it will
10 be something else next month and it does distort not only
11 what Medicare pays but what troubles me the most, and I know
12 troubles many here, is it distorts what happens to
13 beneficiaries, to patients, and the treatment that they
14 might get.

15 And so we have to be very careful about that and
16 make sure that we try to set forth the proper incentives, as
17 I think everyone here agrees.

18 So I would support this.

19 DR. HOLTZ-EAKIN: I also wanted to speak in favor
20 of the recommendation. There have been a large variety of
21 issues raised regarding this, at least to me, many of which
22 I think are ones we shouldn't worry about. And we should

1 put aside issues associated with the legality of the
2 contracts. That's been raised with me. I think that's not
3 our portfolio and not an issue.

4 I think bundling is a pervasive element of the
5 commercial market in medicine and elsewhere, and bundling
6 per se should not be perceived as the problem. Instead, I
7 think what is at the heart of the issue is correctly
8 matching discounts for agreement to use particular products.
9 The proposal targets that, targets it effectively. And I
10 think that's important within the context of the sub-nirvana
11 ASP system -- do I have the current lingo -- because for
12 this market one of the important elements of getting good
13 outcomes is getting new products to enter and to compete
14 effectively at the point of entry. The remainder of the
15 incentives we can debate. But certainly at the point of
16 entry, I think we want to make sure we get people in. And
17 this, I think, is a step in the right direction in that
18 regard.

19 We shouldn't pretend that it's a big cost saver.
20 The recommendation said indeterminate. My instincts are
21 actually worse than that. But I think it's the right thing
22 to do regardless because of the long run properties. I

1 think we should make the recommendation for that reason.

2 The caveats I'd put are the ones I'm worried about
3 on outstanding administrative issues in feasibility and
4 doing this in a timely fashion and the awful fear of a
5 precedent that we may come back to regret later. I don't
6 know if there are other examples that people can point out
7 where this is a bad precedent. I haven't found any. But
8 these are the two issues, administrative feasibility and
9 unintended precedence.

10 MS. BURKE: I want to draw on comments both by Ron
11 and by Bill in the following sense, and this is specifically
12 with respect to the bundling issue. I think Bill's point
13 that, at best, we are trying to negotiate what is an
14 ordinarily complex environment where there are, in fact, a
15 variety of circumstances and a variety of arrangements,
16 similar to what Doug has suggested, that exist in the market
17 today. And our intention is not to wholesale either reject
18 them out of hand or accept them all out of hand.

19 But I think while our goal, and I certainly
20 support the tone of what it is we're trying to suggest in
21 terms of the ASP system, while our goal ought to be for
22 reasonable purchasing and taking the opportunity to take

1 advantage of lower cost in a rational way, I am very
2 concerned at the extent to which it interferes with the
3 practice of medicine. There is no question that there are
4 decisions made on a variety of bases, in terms of the choice
5 of pharmaceuticals that are chosen by a physician at any
6 point in time for particular circumstances.

7 But when an issue arises because of the nature of
8 the way we have structured the payment that leads to a
9 specific outcome that is not, in fact, one that's balanced
10 by the clinical issues -- which at least in this case seem
11 to have arisen, perhaps not often, in many cases it's simply
12 a choice of A versus B, they're both clinically similar,
13 they both have the same result. In fact, we ought not
14 interfere with the market in that case.

15 But in a case where it essentially allows a market
16 practice that alters the decision solely on the basis of
17 that, I am troubled.

18 And as Bill suggested, there are lots of different
19 arrangements that exist. But ones that really interfere
20 with this decision that is based on a clinical issue concern
21 me. It's not clear to me, looking at the recommendation,
22 what you anticipate to be the outcome of this as it relates

1 to that issue. Theoretically, I think going in this
2 direction makes absolute sense.

3 But to Bill's point, I'm not sure practically what
4 this means. Does it mean, in fact, that there ought to be a
5 system that's developed that essentially, in assigning the
6 cost in this case that our materials very nicely, John, you
7 did a terrific job of laying out what are a whole set of
8 complex issues. But this choice of Drugs A, B or C, when A
9 and B are loaded on one side and C is on the other, and
10 essentially the market practice is to essentially under
11 price one of those in order to avoid essentially a market
12 challenge by drug C, and essentially move the between two
13 products, I'm not certain I fully understand how you would
14 address it in this context.

15 Again, to Glenn's point, I don't ever want to get
16 to the point where we are, in fact, interfering in market
17 forces that ought to exist in honest market moves. But to
18 the extent to which it begins to radically alter a decision
19 that is a clinical decision based on what drug makes the
20 most amount of sense because it is inherently different, and
21 they have taken the opportunity in the structure of the
22 bundling to essentially overprice that piece, I'm troubled.

1 And I'm not sure I fully appreciate or understand how this
2 begins to get up at that, nor what is the message that we're
3 sending in terms of our concerns about this practice.

4 DR. SOKOLOVSKY: I guess what I would say was that
5 I didn't hear enough consensus here on a particular
6 allocation method. And so this is put in there as to say
7 this is something that we are concerned about. And then in
8 the text discuss, for example, how Medicaid, how the
9 discounts are allocated there, discuss a number of different
10 ways in which it could be allocated and not come down on any
11 particular one.

12 MS. BURKE: And the presumption in that case then
13 is the allocation method ultimately, if in fact this is a
14 practice that essentially loads the discount so that it
15 disadvantages a particular product, under pricing it by the
16 value of the discount on the other side, that the
17 allocation, if corrected, will in fact result in a more
18 equitable balance in the market between those two drugs.
19 That's the presumption, I presume?

20 MR. HACKBARTH: That would be the goal.

21 MS. BURKE: I think if that's our goal, I think
22 that's terrific. Again I think theoretically I'm quite

1 comfortable. But I guess I would argue that only to the
2 extent there's consensus, that a statement that suggests
3 that markets ought to work. But at the point at which it
4 interferes with a clinical decision-making process is where,
5 in fact, there ought to be an intervention, even if it's a
6 market intervention. But that one piece I'm not certain. I
7 think you've laid out a very terrific sort of look at but I
8 don't know whether we've said that sufficiently, clearly.

9 DR. HOLTZ-EAKIN: I had a reaction. In
10 particular, because I think there's some words in there, and
11 even in some of the presentation, that I don't think we A,
12 should engage in using and are really not our portfolio.

13 So in particular, I think this issue has nothing
14 to do with a dominant product or a sole source product,
15 which is I think the term you used, somehow the notion that
16 there's just one thing out there. That may not be even be
17 the facts in this case.

18 The issue is the correct attribution of discounts
19 for purchases.

20 MS. BURKE: That's a way to get at the issue.

21 DR. HOLTZ-EAKIN: That's the heart of the issue.
22 If there's a competition policies issue, a tying issue where

1 you are inappropriately using one product to get more power
2 than another, sue them. Not job.

3 MS. BURKE: Well, it is our job if our payment
4 policy --

5 DR. HOLTZ-EAKIN: If our payment policy produces
6 it. But we're fixing --

7 MS. BURKE: -- disadvantages a clinical decision-
8 making process.

9 DR. HOLTZ-EAKIN: My point is we should focus on
10 fixing the payment policy. Will it be the case that payment
11 policies affect clinical decisions? Every day. We want
12 people to be cognizant of what things cost when they make
13 care decisions.

14 MS. BURKE: Of course we do.

15 DR. HOLTZ-EAKIN: So I don't know where that line
16 begins.

17 MS. BURKE: I don't disagree with your premise
18 that, in fact, part of this is how you pay, that part of
19 this in fact involves a decision-making process that happens
20 every day. You choose one device versus another device.
21 One is more or less expensive than the other.

22 But in this particular instance, at least as I

1 perhaps poorly understand, there is a particular practice in
2 bundling as it relates to pharmaceuticals that, in fact, it
3 is a direct intervention into a clinical decision-making
4 process because it puts someone clearly at a disadvantage
5 around a price issue when, in fact, if given all things
6 being equal if they had a clinical decision to make the
7 decision would be made to purchase X versus Y.

8 But the way we've structured the payment system is
9 so dominant in terms of the ability to price A and B that
10 essentially you don't really legitimately have a choice of
11 C. That's what concerns me, unless I misunderstand the
12 issue.

13 DR. REISCHAUER: I guess I'm going to side -- the
14 economists are going to stick together on this one.

15 MS. BURKE: Of course. God knows.

16 [Laughter.]

17 DR. REISCHAUER: What Bill said was very true,
18 we're a long way from perfection and we can never reach
19 perfection and this is a step in the right direction. But
20 just to provide an example for Doug's point, in a case where
21 we aren't really looking at prices, the DRG is set for an
22 artificial knee, an artificial hip, and one company has all

1 of these products and one of the products isn't exactly as
2 good as the alternative is, but it says I'll give you a
3 discount on the volume of sales to the hospital and the
4 hospital will say we're buying the cheapest package
5 altogether. It's affecting clinical decisions all the time.

6 It's sort of a boundary and we don't go there and
7 can't go there. But where we can help things along we
8 should.

9 MS. BURKE: In that case, essentially, it's an
10 array of all of their products that they're discounting.
11 And so you're forced to take a product that, in fact, is not
12 the product you want.

13 DR. REISCHAUER: Is clinically inferior to the
14 competitors --

15 MS. BURKE: Because it's part of a much broader
16 range of products.

17 DR. REISCHAUER: Right.

18 MS. BURKE: Not a product-to-product comparison.
19 It's a much bigger grouping. Yes, I think that's
20 troublesome.

21 MR. HACKBARTH: So payment systems like the DRG
22 system, where we bundle services together and pay a lump sum

1 price, inherent in those systems is potentially an effect on
2 clinical decision-making. Indeed, some would say that's
3 their intended purpose.

4 In the case of this particular payment system,
5 ASP, this is a narrow payment system not a bundled one.
6 We're paying unit prices. And generally when you use those
7 payment systems, the effect on clinical decision-making in
8 general would be less because there's no bundling going on,
9 unless you've got prices that are really out of whack. And
10 so they're so far out of whack that clinicians can't buy the
11 drug and that interferes with their decision-making.

12 The way I look at this particular issue is this is
13 a narrow unit price payment system and what we're trying to
14 do through this draft recommendation, as Doug says, is get
15 the prices we pay as accurate as possible. In that way, we
16 have the maximum likelihood of neutrality in clinical
17 decision-making. But as Bill says, we should have no
18 illusions about our ever getting to perfection.

19 So I like the way Doug characterizes this with the
20 narrowest possible rationale. Let's try to make the system
21 work as accurately as best it can. And by doing so, we'll
22 achieve your goal of greater neutrality and clinical

1 decision-making.

2 MS. BURKE: The difficulty, in part, I'm the last
3 one to argue against the principles behind DRGs or PPS. I
4 understand. But it is a much bigger averaging. Yes, we do
5 pay for a bundle of things. But it is an on average. This,
6 as Glenn just pointed out, is a very narrow, very limited
7 range of things where that kind of averaging doesn't play.
8 That's the difference here, is the narrower we get, the
9 smaller the unit, the less ability there is to -- no
10 question. What you choose in terms of your pacemaker or
11 your joint replacement, it's the point I was making. It's
12 in a large grouping of things that, on average, it works.

13 This becomes a very narrow band and there is less
14 opportunity for that to occur. And that concerns me. But I
15 don't disagree at all with what you've said.

16 DR. REISCHAUER: We all agreed, although we want
17 to continue arguing.

18 [Laughter.]

19 MR. DURENBERGER: Well, I'm not going to continue
20 arguing. I want to make an additional point. I want to
21 thank Sheila for the comments that she made because I think
22 the therapeutic value is the issue. And we spend our time

1 on the pricing because we have been denied legitimate
2 pricing information for so long by a variety of these drug
3 companies that it is a policy effort to try to get at it and
4 we're trying to supplement that policy.

5 But I must say what bothers me, having not been
6 here last time and just read the report, is that we're not
7 talking widgets. Just trying to amplify on her argument, we
8 are not talking widgets. This is not Adam Smith.

9 This is a government-granted monopoly to one
10 inventor, through a patent system, which has some
11 accountability that goes with it. And while the legislature
12 may not have carefully crafted what that accountability
13 should be, I would argue as a patient or as a beneficiary
14 the potential that either costs are going to deprive me of
15 access or they're going to, in one way or another, affect my
16 surgeon or physician's judgment, that gets at the
17 accountability that a monopoly-granted privilege has to us
18 as a society.

19 That's what I think I find most offensive about
20 the particular monopolistic -- I don't have a problem with
21 the bundling. I'd love to see somebody, not us, investigate
22 bundling more in a wide variety of technology areas to see

1 how much money we're in effect losing or care quality is
2 being diminished.

3 But on this one, I really just want to add the
4 dimension to Sheila's argument. I think there is
5 accountability and responsibility that goes with the grant
6 of that patent monopoly. And I'm not sure that it's being
7 exercised appropriately in this case.

8 MR. HACKBARTH: Let me ask about draft
9 recommendation one. Is there anybody who has fundamental
10 reservations? I'm not asking for a vote at this point.
11 We'll vote in December. But if people have fundamental
12 reservations about draft recommendation one, I'd like to
13 hear them now so we can potentially address them.

14 DR. MILLER: Bill, you made your point that the
15 word true -- and you guys might want to put this up -- you
16 made the point, Bill, that you wanted the word true out of
17 there. Certainly, if that comes out, it doesn't change --

18 DR. SCANLON: I wouldn't know how to define it if
19 you asked me to.

20 MR. HACKBARTH: So we'll drop true from the draft.

21 DR. KANE: Do you want to say something about the
22 way the price is set, if when in doubt should favor enhanced

1 competition?

2 Isn't that what we were just getting at was that -
3 - well, there is no true transaction price in a bundle.
4 It's an arbitrary decision. Unless you accept that there is
5 a market out there for the competitive product, and then
6 there is theoretically a market-based price. There's no
7 cost build up you can do to get to that.

8 So what's a transaction price for a bundled
9 product? That doesn't get you anything. You have to say
10 with some kind of goal in mind, or it's up to that
11 manufacturer to make up the price.

12 DR. MILLER: The way I've been hearing this
13 conversation and trying to balance the notion of whether
14 we're -- the concern about clinical and competition, but
15 we're administering a price here. And so can we get the
16 price right and then hope that downstream or upstream,
17 whichever way this works, that it has an impact on these
18 other things that we're concerned about.

19 That the way this would work, the way I'm hearing
20 it is we make a statement like this -- and you also asked
21 the question, what are we accomplishing here?

22 So the way I would try and articulate this, CMS is

1 grappling with this issue. We've made a statement here with
2 this recommendation that says we think there's an issue
3 here, there's a problem, and that we think a fix needs to be
4 investigated.

5 In the text, I would see us, for example, laying
6 out as clearly as we can the notion that the incremental
7 difference in that discount, the way Joan went through her
8 example, is one of -- and the presumption here is, and I
9 think there's some support for this, that those kinds of
10 arrangements are reflected in contracts. And that that
11 incremental difference needs to be allocated back to the
12 drug in question. And that the enforcement mechanism for
13 this, which we mentioned last time but not again this time,
14 is that we're not envisioning CMS going through item-by-item
15 and looking at these agreements. There would just be a
16 random look-behind on the part of an inspector general or
17 someone like that to be sure that the manufacturer is
18 reporting the ASP following those rules.

19 We would also lay out that that is not the only
20 way that one could think about allocating it. We would give
21 other examples for how someone could allocate that
22 difference.

1 DR. KANE: So you're going to say the transaction
2 price definition is, for example, for this particular
3 arrangement, here is how it should be? Or are you going to
4 say we have principle behind which price transaction prices
5 should be evaluated?

6 DR. MILLER: I think our principle is that if the
7 discount gets triggered by the drug, then that discount
8 should be allocated to that drug.

9 DR. KANE: That's what you mean by true?

10 DR. MILLER: We took true out.

11 DR. KANE: I'm just saying I think you need a
12 principle or otherwise there is no true. It's whatever the
13 manufacturer wants it to be.

14 MR. HACKBARTH: The principle is the draft
15 recommendation, and then Mark is providing a specific
16 illustration of what that might mean in the example case.
17 So you allocate the incremental discount to the second drug.

18 DR. KANE: But in these more complex situations
19 what does the inspector general do, or whoever is auditing?
20 Prices come from two places. They either come from a
21 competitive marketplace or they come from a monopoly
22 manufacturer setting something. So which one is the true

1 one?

2 And if you're going to set that one example, is
3 that supposed to be the one that there's a principle behind
4 it that should apply across the board as best as one can
5 apply? Is that what you're trying to get at? And that
6 principle seems to be that you are fostering the competitive
7 pricing model whenever possible, that when there's
8 competition for a drug then it's the noncompetitive drug
9 that you put the discount on?

10 Is that what the principle is or not? I'm just
11 trying to get a sense of what do you mean by...

12 DR. MILLER: Certainly to the first half of your
13 comment, we're saying that this applies to all situations.
14 So it's not picking a situation and saying you allocate in
15 this instance and you don't. Where you have these
16 contractual arrangements that say a discount is dependent on
17 two drugs being together, you take the difference, for
18 example, and allocate.

19 The thing I am purposely navigating around here is
20 that there is, only in a matter of degree, slightly
21 different opinions expressed about whether this is price
22 only that we're playing with and the concerns over clinical

1 and promotion of competition.

2 So I think that we're trying to say here is we
3 should get the price right, and I've given you an example of
4 how -- you, CMS -- of how to think about this. And there
5 may be other examples. Our hope is, our expectation is, as
6 best as we can understand it, is that it will, in fact,
7 foster better clinical conditions and competition.

8 What I'm afraid of is if you put the word in that
9 says you should do this to promote competition, it raises
10 questions about well then what is the definition of
11 competition?

12 DR. KANE: There's two sources of what are prices.
13 There's either a competitive market or in a monopoly that's
14 whatever the manufacturer makes it, or a negotiation between
15 the manufacturer.

16 MR. HACKBARTH: We have a mixture of each.

17 DR. REISCHAUER: That's what we have now.

18 [Simultaneous discussion.]

19 MR. HACKBARTH: We've got some monopoly drugs and
20 some competitive.

21 DR. KANE: But you're worried about bundling.

22 DR. REISCHAUER: It's conceivable that you could

1 have two monopoly drugs and the manufacturer could say if
2 you buy the second one where you bought the first one, I'll
3 give you an incremental discount. And then the question is
4 where do you put that incremental discount? It's with the
5 behavioral change that brought about the discount.

6 MR. HACKBARTH: Buying the second drug.

7 DR. REISCHAUER: It's the buying of the second
8 drug, so it should go on the second drug.

9 DR. KANE: So you want an outsider to figure out
10 which drug the manufacturer was trying to sell when they
11 applied the bundled discount?

12 MR. HACKBARTH: Well, you know. It's in the
13 contract. It says you only get this if you do this. So you
14 assign it to that.

15 DR. KANE: So the principle here is going to be
16 whichever drug you're trying to sell...

17 MR. HACKBARTH: That's where the discount is
18 assigned. If you only get the discount if you do this, you
19 assign it to that, the incremental discount.

20 DR. KANE: You only get the discount on this drug
21 if you buy that drug. So the that drug is the one that gets
22 the discount.

1 So what principle is that?

2 MR. HACKBARTH: That you try to get accurate
3 prices that reflect -- yes. I know you're resisting that,
4 but that is the principle.

5 then that has secondary effects on making the
6 decisions neutral for clinical decision-making, and that's a
7 good thing. But the guiding star for the policy is trying
8 to get the transaction prices as accurate as we can within
9 the inherent limits of these systems.

10 DR. SCANLON: I guess I have concern that I don't
11 know what accurate means. If I pick up the newspaper and it
12 says buy one get one free, is there really one that's free?
13 Or am I paying 50 percent of the list price? And if I say
14 I'm paying 50 percent of the list price, that's one
15 allocation rule. There's another allocation rule which says
16 I got one free and I paid full price for this other one.

17 Well, that's where we are on this.

18 The issue about our example, we talk about
19 competition but we've got three different ASPs in that
20 example. We don't combine drug A and B and do one ASP,
21 because they're not the same drug. They're competitive but
22 they're not competitive enough to have the same ASP, which

1 is another issue that's involved here.

2 I think there needs to be some allocation and my
3 extreme of buy one get one free is kind of the absurd case
4 but I think we could get close to that if we're not careful.

5 I think Sheila's concern is extremely valid, and
6 this is in terms of not being able to do something that's
7 perfect. Because we're talking about allocation of price
8 rules here. We're not even thinking about the clinical side
9 of this, and that would complicate this much more it.

10 That's why I'd like to make another plug for the
11 competitive acquisition or some other safety valve that says
12 when -- sort of the best price rules that can possibly
13 imagine, we've still got a problem, we've got a way of
14 dealing with that problem.

15 MR. HACKBARTH: Could I just pick up on a piece of
16 that?

17 The reason that I'm fixated on trying to couch
18 this in terms of accurate pricing, despite all of the
19 difficulties, is that I think having level playing field for
20 clinical decision-making or fair competition, they're way
21 more difficult to define and operationalize as your
22 guidepost for policy. This one is hard. Those are way

1 harder.

2 So let's stay focused on what we can most
3 manageably do. I think the secondary effects on clinical
4 decision-making are desirable.

5 With regard to the CAP program, the Competitive
6 Acquisition Program, I'd like to hear some more reactions on
7 that.

8 DR. MILLER: Let me just say one thing to deal
9 with Bill. Bill, first of all, I don't think we have any
10 problem within the chapter talking about the CAP program.

11 MR. HACKBARTH: Describe it so people know what it
12 is.

13 DR. MILLER: I'll get Joan to do that in just one
14 second. I just want to say one thing.

15 Also, cast your mind back. We made
16 recommendations the last time we dealt with this issue in
17 which we tried to improve the CAP program. And assuming
18 everybody's in the same place, I don't think there's any
19 problem with inserting language if it will help you that
20 says and by the way, we really need to be working on this.

21 You and I had some conversations where you
22 suggested ideas. We can throw those out, put that on the

1 agenda and work towards it just as a process thing. So
2 decidedly, that can be dealt with.

3 MR. HACKBARTH: Joan, would you give us the 30-
4 second reminder on CAP.

5 DR. SOKOLOVSKY: The MMA included an alternate way
6 for physicians to get drugs, and that would be that vendors
7 would compete for contracts with CMS to purchase all the
8 drugs that a physician would need under Part B and supply it
9 the physician, and the vendor would bill both Medicare and
10 the patient for the drugs. And the physician would not be
11 involved in any monetary transaction, at all.

12 However, I think we talked a little bit about this
13 last year. Many of the actual way in which it was set up
14 were not attractive to either physicians or vendors. So
15 right now there is one vendor, very few physicians, and the
16 vendor does not supply all drugs under Part B. So it
17 started, but it's not full blown as of yet.

18 MR. HACKBARTH: But what I hear Bill saying is
19 that it has not taken off because of the specific rules and
20 restrictions that were added onto it, but the core idea
21 still has merit as a safety valve, to use Bill's term. I
22 find that appealing myself.

1 DR. MILSTEIN: More of a question.

2 As I heard articulated how these so-called true
3 transaction price might be arrived at, it sounded to me like
4 we were saying that in the event that the price of any drug
5 is made contingent on the purchase of another drug, the
6 incremental discount associated with that drug should be
7 attributed back to the contingent drug. So maybe contingent
8 drug, I think would be a helpful part of the vocabulary in
9 articulating this particular solution.

10 DR. CASTELLANOS: Maybe I'm missing something but
11 I don't see any recommendation or any discussion on LCA and
12 I think that's an important issue, also.

13 MR. HACKBARTH: I wanted to come back to that. I
14 think I'm in a similar place to Bill on that. The notion
15 that this policy varies significantly across the country
16 troubles me. A long time ago now, five or six years ago
17 now, MedPAC did a report on how the programs run in response
18 to a Congressional mandate. One of the general thrusts of
19 that was there's way too much variation in some of these
20 policies where, as Bill says, the physiology doesn't vary,
21 it's just sort of random variations. It's not even
22 constrained discretion, it's just random variation.

1 So I'm definitely sympathetic on more uniformity
2 in things like this.

3 The thing that troubles me about closing the door
4 to LCA altogether is that I can imagine that the concept is
5 potentially a useful one to deal with new technology and
6 basically setting up payment systems where we say these are
7 clinically equivalent. We're not going to say to people you
8 can't have the new thing. But if you want it, there's some
9 additional cost to be paid. You've got to pay something out
10 of your own pocket to get that. We think that they're
11 essentially the same.

12 I'd hate to see, given the long-term issues that
13 Medicare faces with the growth technology and the associated
14 costs, our saying no, that's a door that should never be
15 opened.

16 So more uniformity and care in the administration
17 without closing the door for the long-term, is where I would
18 be on LCA.

19 DR. CASTELLANOS: I don't know what if that's
20 going to answer the problems that I'm dealing with from a
21 clinical viewpoint. Again, I'm going to be forced to use a
22 drug based on cost. And I don't think it's fair to the

1 patient and it's not fair to me.

2 I understand your concerns about closing the door
3 on that whole LCA picture, but I think we need to look at it
4 from what's practical to the physician also and to the
5 patient. We're not doing that. We're looking at it just
6 from, again I'm wearing a different hat but I should be
7 where my Medicare hat. But I think we also have to think of
8 the beneficiary.

9 MR. HACKBARTH: What I hear you saying -- correct
10 me if I'm wrong, Ron -- is that at the patient level you
11 don't see the drugs as being equivalent, that they're
12 looking at one notion of equivalency that's incomplete and
13 it doesn't take into account the full range of clinical
14 considerations including the impact on the patient. So you
15 really don't see these as equivalent at all?

16 DR. CASTELLANOS: That's correct.

17 DR. REISCHAUER: It strikes me there's two very
18 different issues here. One is it's being applied
19 inconsistently across geographic carriers, the carriers
20 areas. And another is that because of the way we do this
21 with quarters, referencing quarters, you can find yourself
22 on the short end of the stick, which seems to be unfair.

1 And then there's the issue that you two guys have been
2 talking about.

3 I think we can clean up the other two and make
4 things better.

5 DR. MILLER: I think actually there's a third
6 issue. You're seeing variation across carriers and you're
7 seeing within the LCA categories things with very different
8 dosage and administration properties being put together in
9 the same category. I think that is at least two of the
10 things that you're reacting to.

11 I think what Glenn said and better execution of
12 it, that if we can speak to the process in getting less
13 variability across the country that's simply the product of
14 the carrier and much cleaner categories of saying these two
15 are comparable to substitute for one another. I think that
16 begins to address the clinical issues without closing the
17 door on the concept entirely.

18 DR. CASTELLANOS: That's correct. but there's one
19 other issue where the price is changing on a quarterly
20 basis. And the problem is based on that I'm forced to make
21 different clinical decisions, whether I give X or Y drug.
22 As I said last time, one's an abdominal wall injection and

1 one is an injection in the hip. And I don't think it's fair
2 to the patient.

3 MR. HACKBARTH: Other comments on the LCA issue?

4 MS. BURKE: So do we have a LCA recommendation?

5 MR. HACKBARTH: Not at this point.

6 MS. BURKE: Do we anticipate developing one
7 relating to carriers or the issues that have risen?

8 MR. HACKBARTH: That's the question on the table.

9 MS. BURKE: Is the question shall we develop a
10 recommendation?

11 MR. HACKBARTH: Would you favor that?

12 MS. BURKE: I certain think, as you identified the
13 three different issues, whether we can come to an agreement
14 on what we would say about similarity of application,
15 whether getting rid of the variation --

16 DR. REISCHAUER: We do the true application.

17 MS. BURKE: Yes, it would be the big T.

18 If we can figure out how to articulate that, one
19 of the concerns is that, of course, is true across Medicare,
20 is that the carriers have wide discretion on a whole variety
21 of things.

22 Query whether in this case -- I mean, I don't

1 disagree this is where we want to go. The question is do we
2 want to pull this one out, compared to every other decision
3 the carriers make that vary, whether you're having a good
4 day or not.

5 DR. MILLER: That's exactly right. And the reason
6 that we are here at this juncture is Joan looked at this and
7 there is a level of complexity here on the very specific
8 issue that's being raised and the question of why this? Why
9 not think about this more broadly.

10 And so what we did is we put this on the table to
11 see what your reaction is, which is what we do a lot. The
12 question is whether if we pursue this do we want to think
13 about this issue more broadly and address some of the issues
14 of not closing the door and thinking about the categories
15 and the rest of it?

16 And if that's the direction people want to go, I
17 am reluctant to say that by three weeks from now we will be
18 back in the room with a hard case recommendation that people
19 go I understand it and I'm ready to go.

20 I do believe that, given what I've heard here,
21 everybody would at least agree that this is something that
22 should be discussed in the chapter and said that this is an

1 issue that we're going to pursue. I think that much there
2 seems to be agreement on. And then we could discuss that.

3 MR. HACKBARTH: Reactions to that proposed
4 approach, which is to lay out in the text the concerns and
5 the different facets of it but not do a boldface
6 recommendation at this point?

7 MS. DePARLE: I would agree with that approach and
8 I find myself in the somewhat surprising position of
9 defending the carrier medical policies and this particular
10 policy, the least costly alternative, because I was
11 frustrated when I was running Medicare often by some of the
12 variation out there.

13 But I became convinced over time, in part after
14 discussions with clinicians, Ron and others, who said to me
15 there is really a -- there are some negative examples you
16 can identify, some anecdotes that you might not like.

17 On the positive side, there are examples where
18 that flexibility allows Medicare to defuse new technology
19 more quickly than it might otherwise do so and test it out,
20 let local clinicians who are either believers in it, have
21 used it, understand it, test it out.

22 So there's a lot of complexity to all of this.

1 And I would really hate to make a quick decision here that
2 would constrain that flexibility.

3 My view was what, Ron, you said, that Medicare
4 should be the same for everybody. It shouldn't matter
5 whether you're in Mississippi or whether you're in upstate
6 New York. The problem is it's very difficult to do that
7 with the kind of staffing that Medicare currently has. You
8 have to use the kindness of strangers, I guess, to get this
9 program administered.

10 So I became convinced that you really needed
11 something like that and I would hate to, in one fell swoop,
12 say that that's the wrong way to go.

13 MR. HACKBARTH: The experimentation argument, I
14 think, is a very legitimate one, that this is an opportunity
15 to see how these things work in practice.

16 The only reservation I have about that is if we're
17 going to do an experiment, let's do it in an orderly way and
18 say okay, we're going to allow it in this particular area
19 where we've got some experienced clinicians. And we're
20 going to hold off in other places and do an experiment and
21 see how it works and then apply it.

22 But to me it's not experimentation to just say

1 everybody do what they want. That's just chaos.

2 MS. DePARLE: I don't know that it's everybody do
3 what they want. It certainly is loose.

4 One of the reasons why that occurs, though, I
5 think, is because at least heretofore the Agency has been
6 constrained by the need to go through a rather formal
7 process, at least informal rulemaking, before doing
8 something like that.

9 Now recently I've noticed they seem to be more
10 flexible about making those sorts of changes and doing
11 demonstrations without going through that process. But in
12 the past to do something like this policy, the least costly
13 alternative, to do it nationwide -- which is what I think
14 Ron would argue, if you're going to do it, do it nationwide
15 -- that would have taken a rulemaking that could take two
16 years. And so we have to weigh the timely administration of
17 the program in here, too. And I understand that there are
18 people here who disagree with that particular policy.

19 But I do think if you want them to have some
20 ability to react to things, this is part of why it ends up
21 being done by local carriers as opposed to the Agency itself
22 doing it the way you said.

1 DR. SCANLON: I do think there's an intermediate
2 step, which is that local carriers can pay for things
3 without having a coverage policy. By the time you reach a
4 coverage policy, there's been enough experience that a
5 carrier is making a decision and feels they can actually
6 promulgate a policy.

7 I guess I would argue that we should be doing that
8 at the national level. We still can give some carrier's
9 discretion to allow some experimentation and that there be
10 sort of a formal learning process.

11 The other thing I'd underscore what Nancy-Ann
12 said, which is we've got to start running Medicare on the
13 cheap. You can't have a Medicare program that's done right
14 by borrowing on the goodwill of your friends.

15 MR. HACKBARTH: We are going to have to move
16 ahead. We are running behind.

17 I think what this discussion says to me is that
18 we're not ready for a boldface recommendation on this. I
19 think we can/should have the discussion in the text both on
20 the more consistent administration and truly trying to find
21 equal equivalency from all standpoints. But boldface would
22 be a bridge too far at this point on LCA.

1 Thank you very much.

2 Now we're on to rural hospital payment systems and
3 the mandated report.

4 DR. ZABINSKI: The Congress has mandated MedPAC to
5 study the effects of certain policies in the MMA that adjust
6 payments for rural hospitals. Today we'll take our final
7 opportunity to discuss the results of our analysis of this
8 rural report.

9 We'll start by discussing a recommendation that
10 affects payments in the outpatient PPS and then after that
11 we'll open up for discussion on the whole report.

12 In the previous two Commission meetings we
13 discussed two current policies that supplement outpatient
14 PPS payments for rural hospitals. The first of these is a
15 redistribution that takes about 0.4 percent of the
16 outpatient PPS payments from all hospitals to increase
17 outpatient PPS payments going to rural sole community
18 hospitals by 7.1 percent. This policy transfers about \$90
19 million to the SCHs, with most of the money coming from
20 urban hospitals.

21 Secondly, there's a hold-harmless policy that adds
22 about \$50 million to the outpatient PPS payments to small

1 rural hospitals that are not SCHs. This policy is set to
2 sunset at the end of 2008.

3 In the previous two meetings, we estimated that
4 the hold-harmless payments would add \$70 million to the
5 rural hospitals, but now we estimate the lower amount of \$50
6 million because our earlier sample included some hospitals
7 that are now critical access hospitals. Some of these CAHs
8 had received hold-harmless payments but they cannot receive
9 them any longer because they're exempt from the outpatient
10 PPS and they currently receive cost-based payments.

11 Also in previous meetings, we stated that our
12 primary issue with the existing policies, the hold-harmless
13 payments and the redistribution to the SCHs, the problem is
14 that neither policy efficiently targets hospitals that are
15 in need or are important to beneficiaries' access to
16 outpatient services.

17 So in response, we proposed a policy that would
18 give low-volume hospitals a percentage increase over their
19 standard outpatient PPS payments instead of either the hold-
20 harmless policy or the redistribution to the SCHs. We
21 proposed this low volume adjustment to replace the current
22 policies because the data show that hospitals exhibit

1 economies of scale in their outpatient departments and
2 consequently smaller hospitals are at a competitive
3 disadvantage relative to larger hospitals.

4 Also, the data show that rural hospitals tend to
5 have lower outpatient service volumes than urban hospitals,
6 so the rural hospitals have lower scale economies.

7 The advantage of the low-volume adjustment is that
8 it would be more efficient than either the hold-harmless
9 policy or the redistribution going to the SCHs. In
10 particular, if designed properly a low-volume adjustment can
11 more efficiently target hospitals that are important to
12 beneficiaries' access to outpatient services. Also, it can
13 directly target a factor that affects hospital financial
14 performance and is typically beyond the control of isolated
15 hospitals, that being whether the hospital is low volume or
16 high volume.

17 In an example of how a low-volume adjustment can
18 be advantageous to either of the existing policies, consider
19 a situation where two hospitals are in close proximity and
20 they get into a medical arms race. These hospitals could
21 receive higher hold-harmless payments because of their
22 rising costs due to the arms race. But under a low-volume

1 adjustment, their increased spending from the arms race
2 would not lead to higher payments. The only way they could
3 receive higher payments is if they are isolated low-volume
4 hospitals.

5 The features of this proposed volume adjustment
6 would be the following: first, hospitals would have to be a
7 minimum distance from any other hospital in order to receive
8 low-volume assistance. Also, the adjustment rates would
9 decline as hospital volume increases. That way the lowest
10 volume hospitals would receive the highest adjustment rates.
11 Finally, the policy would not begin until 2009, after the
12 hold-harmless payments sunset at the end of 2008.

13 In this slide we talk about the primary effects of
14 the low-volume adjustment. These include first, that it
15 would restore most or all of the dollars to the system that
16 would be lost when the hold-harmless payments sunset. In
17 particular, we have developed two alternative draft
18 recommendations for the Commission's consideration today.
19 One of these alternatives would add about \$35 million to the
20 outpatient PPS payments going to rural hospitals and the
21 other would add about \$55 million, where the \$55 million is
22 about equal to the amount of money that hospitals currently

1 receive from hold-harmless payments. Our intent is to have
2 the Commission consider these two alternatives and select
3 one if they so choose.

4 A second effect of the proposed low-volume
5 adjustment is that it would redistribute dollars towards
6 low-volume hospitals which tend to have lower outpatient
7 margins than larger hospitals. This would end the
8 redistribution that favors sole community hospitals and
9 instead low-volume hospitals, including low-volume SCHs,
10 would receive low-volume adjustments.

11 On this slide we show the effects on specific
12 categories of hospitals of moving from current laws that
13 would be in 2009 that would include the SCH redistribution
14 but would not have a low-volume adjustment to the proposed
15 policy that would include a low-volume adjustment but there
16 would be no SCH redistribution.

17 On the first line we have low-volume small rural
18 hospitals that are not SCHs. On this slide, this is the
19 group that would benefit the most from going to a low-volume
20 adjustment because they would receive the low-volume
21 adjustment and they would no longer have to fund the SCH
22 redistribution. This group encompasses about 200 to 220

1 hospitals.

2 In the second row you have larger small rural
3 hospitals. In other words, these are non-SCH small rural
4 hospitals that would not receive a low-volume adjustment.
5 These hospitals would benefit a little from moving from
6 current law to a low-volume adjustment because they would no
7 longer have to fund the SCH redistribution. This group
8 would also encompass about 200 to 220 hospitals.

9 In the third row you have relatively small SCHs
10 that would receive a low-volume adjustment. These hospitals
11 would lose their current redistribution but they would get
12 the low-volume adjustment. They would be about equally
13 well-off under current law or under the proposed policy.
14 This group encompasses about 250 to 280 hospitals.

15 Then, on the final row is a group of hospitals
16 would be the only clear losers from moving to a low-volume
17 adjustment. These are the relatively large sole community
18 hospitals would not receive a low-volume adjustment.
19 However, because of their size, their expected outpatient
20 margins under the proposed policy would be roughly equal to
21 that of the margins of the low-volume hospitals. This is
22 the smallest group of the four and it encompasses about 130

1 to 160 hospitals.

2 I'd like to give the commissioners their final
3 opportunity to view a draft recommendation that you will
4 vote on today. Today we actually have two alternative
5 versions, as I discussed earlier, of this recommendation.

6 The first version is the draft recommendation that
7 you saw at the last meet Commission meeting. However, some
8 commissioners were concerned that this first version
9 returned less money to the outpatient PPS system than the
10 sunsetting hold-harmless policy. So we have the second
11 alternative that is identical to the first, except it
12 returns to the system about the same amount of money as does
13 the hold-harmless payments. In particular, the specific
14 differences are that the second policy would set the cutoff
15 for getting low-volume adjustments at about 125,000
16 outpatient services, while the first alternative set it at
17 about 100,000 outpatient services.

18 Secondly, additional payment for rural hospitals
19 be about \$55 million under the second alternative versus \$35
20 million under the first alternative.

21 The recommendation itself reads as follows: After
22 the scheduled sunset of the hold-harmless policy, the

1 Congress should replace the SCH redistribution policy with a
2 graduated low-volume adjustment to the outpatient PPS. This
3 adjustment should apply only to hospitals with fewer than
4 125,000 outpatient services and that are more than no more
5 than 15 road miles from another hospital.

6 The implications of this policy is that it would
7 increase budgetary spending by between \$50 million and \$200
8 million. And also, because the hold-harmless policy sunsets
9 at the end of 2008, this recommendation would help maintain
10 the financial circumstances of rural hospitals and help
11 assure beneficiaries' access to outpatient services.

12 That concludes our discussion and I turn it over
13 to the Commission for consideration of the draft
14 recommendation and discussion of any issues on the rural
15 report.

16 MR. DURENBERGER: By going from the \$50 million to
17 the \$200 million, do they affect the hospital beneficiary at
18 all? You're not buying votes from the large rurals --

19 DR. ZABINSKI: No, the \$50 million to \$200
20 million, that's sort of a required bucket. The estimated
21 amount of this particular recommendation is \$55 million and
22 we have a bucket of \$50 million to \$200 million that it fits

1 into. That's the idea there.

2 DR. REISCHAUER: Just the categories that we
3 established for the cost of these things, the range. That's
4 all.

5 DR. MILLER: You're asking a different --

6 [Simultaneous discussion.]

7 MR. DURENBERGER: That's what I assumed when I
8 read the 125,000, we were getting into the larger hospitals.

9 DR. ZABINSKI: Yes, you get slightly larger
10 hospitals under the second alternative.

11 DR. STENSLAND: But it does two things. One, it
12 gives a little bit more money to the smaller hospitals and
13 it gives more money to hospitals, when we go up to \$55
14 million.

15 MR. DURENBERGER: [Inaudible.]

16 DR. WOLTER: I guess I'll start by saying I think
17 that the policy shifting to a low-volume adjustment from
18 hold-harmless probably does make a lot of sense from a
19 policy standpoint. And I did appreciate the chance, Glenn,
20 to talk to about this, which really got me thinking about
21 it.

22 I guess I do have a number of concerns about where

1 we stand with this. The first concern I have is that
2 generally speaking across-the-board outpatient PPS margins
3 are quite negative. That would be true in larger hospitals,
4 as well. I've really been worried about our direction in
5 the last few years of lumping that with the inpatient
6 margins as we make our decisions, because I think over time
7 there can be distortions in behavior if we have a separate
8 payment system that continues to run margins in the negative
9 10 to 12 percent range on a consistent basis.

10 I honestly don't think that's very good policy, in
11 and of itself. And I find what we're doing here, in some
12 ways, is we're targeting that margin and we're trying to
13 stay consistent with it. That would be the summary I would
14 have.

15 You didn't show these charts today, but last month
16 you showed under proposed policy that 2009 outpatient low-
17 volume eligible margins would be, for outpatient minus 18
18 percent and for overall minus 4.5 percent. You showed a
19 chart that showed the proposed policy -- and this, I think,
20 would be at the 100,000 services -- for the not low-volume
21 eligible, they would have outpatient margins of minus 16
22 percent and overall margins of minus 6.4 percent.

1 My concern is that we've moved a long ways away
2 from the days when we were targeting payment policy to
3 covering the costs of an efficient provider. I think that
4 what we have here is extremely negative margins. And even
5 the overall negative margins are more negative than the
6 average overall hospital Medicare margins.

7 I'm really worried about the changes if you look
8 at the bigger picture. And I think we are overdue to have a
9 look at outpatient prospective payment policy in general,
10 just to make sure that it's set right because I think we're
11 in trouble.

12 I'm also a little troubled by the argument that
13 this is taking money away from urban hospitals, current
14 policy, because after all my assumption is -- although we
15 didn't have the data in this chapter -- this is not likely
16 our DSH and IME group of hospitals. This is not a group
17 with wage index that was favorable relatively speaking. And
18 so this is a group that is kind of caught without some of
19 the other variables in Medicare payment policy that help
20 them, and I'm very concerned about the average overall
21 Medicare margins that we're dealing with here.

22 Those are my worries. Some other issues have been

1 raised about what is a service? Can we really do all-payer
2 service counts that easily? When we made this
3 recommendation about inpatient low-volume adjustment, it got
4 translated in a way that really didn't have any impact, and
5 we talked about that, Glenn.

6 Those are the worries I have about this
7 recommendation.

8 DR. STENSLAND: Maybe I can shed just a little
9 light on who the winners and the losers are. I don't want
10 people to be confused and think this is a take from the rich
11 and give to the poor, this SCH redistribution. The overall
12 Medicare margin for the SCHs in 2004 was, I think, negative
13 3.9, which is a little lower than the negative 3, which was
14 the average for all hospitals.

15 But of course, to fund that 7.1 percent add-on to
16 the SCHs, you're taking money from everybody. So it's kind
17 of take a little bit from everybody, stack it up, and then
18 give it to this one group that's really, on average, about
19 average. So we're taking some money from some people would
20 have negative 7, 8, or 9 percent margins and some people who
21 have positive 7, 8 or 9 percent margins and giving it to
22 this SCH group.

1 MS. BURKE: If I could just follow with a question
2 specific to that, as I think I understand the numbers that
3 you've suggested, I see essentially 400 hospitals lose to
4 gain for 200. That's how these numbers play out for me,
5 unless I'm misunderstanding. Let me walk you through my
6 math and tell me if I'm right.

7 Just to the point that's being made, and maybe I
8 just misunderstood. I understood in the categories that you
9 have on page six, in the first category essentially folks
10 that currently get nothing under current law, there are
11 about 200 hospitals who would gain from a low-volume
12 adjustment.

13 In the second category the small rurals that get
14 nothing and nothing, they get nothing. And there's about
15 200 hospitals there; correct?

16 The folks in the third category get something now
17 and will get something comparable? And there are about 200-
18 plus hospitals there.

19 And the last category that get something and are
20 losing something, there's about 200. So I guess it's the
21 200 to 400 -- reverse, because the second category gets
22 nothing now and would lose nothing. Lose nothing/gain

1 nothing, that's 200 hospitals.

2 So essentially, you've got 400 hospitals, 200 of
3 whom are essentially going to -- well, 250 will gain plus
4 200, so 400 gain. So a loss of 200. Is that right?

5 You've got the last category lose. They get
6 nothing.

7 DR. ZABINSKI: The last category lose and there's
8 like --

9 MS. BURKE: That's around 160.

10 DR. ZABINSKI: There's about 130 to 160, depending
11 on how you set the parameters.

12 MS. BURKE: The first and the third categories
13 gain; correct?

14 DR. ZABINSKI: The first category gains. The
15 middle two categories are about break even, and the bottom
16 loses. The bottom one is the smallest of the four.

17 MS. BURKE: You have a slight gain then. That
18 assumes the hold-harmless. So you have essentially a net.
19 It's just who essentially gains?

20 DR. ZABINSKI: Right.

21 MS. BURKE: Thank you.

22 DR. WOLTER: Another question I had, just quickly,

1 was I guess CMS was asked -- this was in the paper -- to
2 calculate what they thought the cost differences were for
3 the sole community hospitals and that's how they came up
4 with a 7.1 percent. I guess the first part of the question,
5 was that all based on outpatient cost?

6 DR. ZABINSKI: Yes.

7 DR. WOLTER: Secondly, what would be the
8 difference in their logic from hours, to choose 7.1 percent?
9 I think, in a way, we're looking at redistributing 0.9
10 percent.

11 DR. STENSLAND: Just to go along the timeline,
12 Congress said CMS, tell us, do rural hospitals have higher
13 costs? CMS says no, not on average. But what if we look at
14 a subset of these hospitals? If we look just at SCHs, on
15 average, yes, they do have higher costs.

16 Then we kind of took it a step further and said
17 let's look within the SCHs. Who in the SCHs have higher
18 costs per unit of service? It looks like only really the
19 low-volume SCHs are the ones that have the higher cost unit
20 of service, not the higher volume SCHs.

21 So I kind of think of the SCH add-on has being
22 kind of a poor proxy for low-volume.

1 Also, they did things a little bit differently in
2 their econometrics, but that's probably the easiest way to
3 look at it.

4 The other thing that we do that's a little
5 different from what they did is we say that as you start to
6 get really low volume, we think volume becomes more
7 important. So say for the hospital with 15,000 visits or
8 20,000 visits, that one extra patient in our model is given
9 a lot more weight that it would be for a hospital that has
10 300,000 or 400,000 visits. That one extra patient wouldn't
11 be so important for them. But the way the CMS did the
12 modeling, they said that one extra patient is equally as
13 important, no matter what your volume is. It's basically
14 they had a linear function where we had this spline
15 function, with a steeper slope.

16 DR. WOLTER: I think where we are in agreement is
17 that the low-volume adjuster might be a much better proxy,
18 in terms of how to deal with the issues. I'm just concerned
19 that the proposed policy leaves us with outpatient margins
20 of 6 to 8 percent worse in this group of institutions than
21 it does for the overall hospital average around the country,
22 16 to 18 percent negative, and that the overall Medicare

1 margin of negative 4.5 to negative 6.3 percent is another 2
2 percent to 4 percent worse than what we see in the larger
3 institutions.

4 That seems disadvantaged to me when I look at
5 those numbers.

6 DR. STENSLAND: The numbers are a little bit
7 better than that. I think those are the members from the
8 \$35 million adjustment. So the numbers are a little bit
9 better if we go to the \$55 million adjustment. So
10 essentially, the outpatient margins are little bit worse
11 than average, but not much when we move to the \$55 million.

12 DR. WOLTER: It's hard to imagine that that small
13 change is going to take the negative 18 percent low-volume
14 eligible margin to negative 10 or 12 percent. But it would
15 be nice to see the numbers.

16 DR. ZABINSKI: It takes it to minus 14.

17 DR. REISCHAUER: Aren't we just redistributing? I
18 mean, if we take the second option here, we're
19 redistributing the money that's there now. No?

20 DR. WOLTER: No, because the sole community
21 hospital's 7.1 percent is just gone. So what we're
22 redistributing is only the dollars in the hold-harmless --

1 DR. REISCHAUER: That's the law; right?

2 DR. WOLTER: The law has it expiring. I thought
3 we were trying to ascertain appropriate policy going
4 forward.

5 MR. HACKBARTH: We're doing a mandated report here
6 and I just want to get clear what the mandate is. The
7 mandate is just to report on the impact of the various
8 provisions in MMA on rural hospitals, is that right? As
9 opposed to make policy recommendations on the outpatient
10 department payment system, for example? So it's report on
11 the impacts.

12 Then we said we may go beyond the mandate in this
13 particular case and suggest a more rational way to target
14 assistance within the rural outpatient department system.

15 You've raised some concerns, Nick, that go way
16 beyond this particular recommendation to the overall
17 financial situation of rural hospitals, both inpatient and
18 outpatient.

19 It feels like to get into recommendations on those
20 at this point, this might not be the right vehicle. The
21 right vehicle for that, I suppose, is the discussion on
22 updates of we'll have next month.

1 Maybe what we ought to be doing here, if you have
2 reservations about the specific draft recommendations here,
3 is just drop them and just go strictly with a report on the
4 impacts, as required by the mandate.

5 Those, to me, seem to be the two basic paths and
6 then we can look at the broader financing issues of all
7 types of hospitals next month in the update recommendation.

8 What are your thoughts?

9 DR. WOLTER: I think one of the points I'm raising
10 is when you look at proposed policy margins, which I have
11 not seen the recalculations except for what you just said,
12 would we have any appetite to try to get this group of
13 institutions at least in the same ballpark as other
14 hospitals and outpatient PPS? We're still a point or two
15 away in terms of our recommendations.

16 MR. HACKBARTH: In the aggregate you're talking
17 about all rural hospitals?

18 DR. WOLTER: Yes. We had an appetite for
19 redistributing a small amount of money from one negative
20 group to another, I suppose you might say.

21 It stands out to me when I look at this margin
22 data that we have a group here that seems to be in a

1 different place than larger institutions.

2 DR. STENSLAND: I just had a little bit on the
3 data part of it. I want to be clear that the margins we're
4 showing here are margins from 2004 data which we have, which
5 is our most recent data. And then we make some adjustments
6 for these policy changes. When we move to the 2005 data,
7 which I think is what we'll be discussing next month, that
8 baseline may change and rurals may look a little better next
9 month than they do now, the reason being that some of these
10 MMA policies that we're estimating the effects on hadn't
11 fully come through in the 2004 data. So some of these extra
12 money that we're talking about here, this 2.3 percent
13 increase in rural payments overall, might be moving through
14 the system -- it was only partially through the system in
15 2004 and we'll see more of it in 2005. so the differential
16 between urban and rural might shrink between 2004 and 2005
17 data. So just bearing that in mind.

18 MR. DURENBERGER: Trying to be responsive to your
19 question, Nick, and trying to think about what that part of
20 the Congress, which has posed this particular question,
21 would like by way of a response. I think when they say
22 impact, they are also asking for our recommendation for what

1 to do about whatever we say the impact may be. So that
2 attracted me to the policy solution that the staff has come
3 up with, or everybody has come up with, however we got it.
4 But I like that.

5 I'd leave it to Nick's recommendation as to, if
6 there's a flaw in this formula that we need to change that
7 might be appropriate. But I do believe we shouldn't just
8 send up the impact information without adding what we think
9 is an appropriate alternative on the issue of what is access
10 in rural America.

11 DR. BORMAN: I'd like just to support some of the
12 concern that Nick has outlined. I think that a lot of these
13 hospitals have a reduced ability by comparison to all
14 hospitals of a higher commercial fraction through which to
15 move moneys around. And I think that they are skating at
16 the very thinnest of the ice here.

17 And there is a bigger issue here of do we move
18 them to the still thin ice but somewhat thicker that other
19 folks are sailing on? And also with an idea of trying to
20 just kind of hang on, white knuckled, from year-to-year, to
21 be able to make some plans over a several year period of
22 stability.

1 What I hear from these folks, at least in my
2 region, is that this is a very difficult thing to look
3 forward toward any kind of meaningful future, to take
4 forward some of the initiatives that have come out here in
5 terms of quality, in terms of IT, including all of those
6 kinds of things just move -- they're at such a negative end
7 of the margin here that they can't begin to think about
8 those things.

9 And so I think there would be some good -- I don't
10 know if there's a way to soften this or to say we think it's
11 hugely important to have a look at the bigger picture at
12 some point. I'm not enormously uncomfortable with this but
13 I do think it begs the big issue.

14 DR. CROSSON: I just wonder, based on what Dan
15 said a couple of minutes ago, whether we may not actually be
16 doing an interim report here. If the impact of the MMA
17 provisions is likely to change the baseline data from 2004
18 to 2005, it might be a little premature to make
19 recommendations at this particular point, but rather
20 actually make comments about what the impact is and that
21 it's not clear yet and outline in the text that there may be
22 recommendations needed. And then when the data comes in

1 clearer, I think the basis for the recommendation might be
2 more solid.

3 Is that an implication of what you were saying?

4 DR. STENSLAND: Yes.

5 MS. BEHROOZI: Ultimately, I think I'm going to
6 ask a question of Nick. I enjoyed reading this paper
7 because it offered a resolution or a proposal that was easy
8 for me to understand, which is maybe too low a threshold for
9 what should be a MedPAC recommendation, but it certainly was
10 a more elegant solution which I think we're always in search
11 of to matching the payment policy to what it's supposed to
12 be addressing.

13 So if it's a matter of what the result is, Nick,
14 what I wanted to ask is is your concern specifically related
15 to those 130 to 160 losers, as Sheila helped us break it
16 out, in particular? Or is it overall?

17 Because of its overall, then it's a matter of the
18 size of the pot I think, as both Dan and Jeff said. If you
19 put more money into it, then you could address those
20 margins. If you're starting from a different baseline, the
21 margins will look different.

22 But is it about the shift or is it about there

1 just not being enough in the pot?

2 DR. WOLTER: I think it's about -- I wish we had
3 the chart from last month that protected what the proposed
4 policy would do for the low-volume eligible and for the not
5 low-volume eligible. And it gives both the outpatient
6 margins and then the overall Medicare margins there. It
7 seems to me we're targeting very negative margins,
8 recognizing -- I think that was a good point, Jay -- if
9 we're going to see some changes that still flow through,
10 that in and of themselves that might change this -- is that
11 what you were suggesting -- it might be that we'd be looking
12 at different numbers at this point in time next year.

13 But it may be that we don't have enough in the
14 pipeline to put these institutions at least on some kind of
15 level playing field with what else is going on.

16 The bigger question I'm raising is are we really
17 happy with the outpatient prospective payment system and are
18 negative 10 to 12 percent margins across the board for
19 everybody, is that a good place to be? And that's a much
20 bigger discussion for down the road.

21 DR. STENSLAND: If I could just make a quick
22 clarification, and that's that we're talking about what's

1 going to happen between 2004 and 2005. Essentially, all the
2 extra money that's going to be coming in that hasn't already
3 shown up in our 2004 figures is inpatient money because
4 almost all of those increases in payments that we talked
5 about in the first page or so of the report are inpatient.

6 So we really won't be seeing much change unless
7 there was some underlying change in general in profitability
8 of outpatient. We won't see any change in the outpatient
9 margins due to Medicare policy from 2004 to 2005. We should
10 see some change in the inpatient and overall margins due to
11 those changes.

12 DR. WOLTER: I think the overall is part of what
13 we've been trying to look at for others.

14 MR. HACKBARTH: Here's where I think we are. The
15 proposal on the table is a redistributive proposal to better
16 target the money. What I hear you saying, Nick, is in the
17 abstract it sounds like a sensible approach. But you're
18 worried about redistributing money from institutions that
19 have negative margins to other institutions. You're worried
20 about the level of payments that underlie the whole system.

21 We often talk separately about distributive
22 policies, redistributive policies, and base rate policies

1 that affect the level of rates. It may be that this is a
2 case where we should not be doing that separately. I guess
3 I would be inclined to drop the draft recommendation. I
4 think the proper place to address your concerns about the
5 base rates paid to rural hospitals, both for outpatient and
6 inpatient services, is in the update discussion.

7 I have no illusions that it's going to be any
8 easier there but at least it's properly placed, that's the
9 right forum for it.

10 I think it just makes sense to go with a report
11 that focuses on assessing the impact of the MMA system.

12 DR. HOLTZ-EAKIN: Does that mean that we would
13 have in the text anything that looks like recommendation 1A?

14 MR. HACKBARTH: We can discuss it in the text. In
15 fact, we've discussed it in the text, I think, in a rural
16 report last year. Actually --

17 DR. ZABINSKI: We had it in the March chapter last
18 year.

19 DR. HOLTZ-EAKIN: I don't think you can remind
20 people what good policy is too often. And I would hate to
21 lose that.

22 MR. HACKBARTH: That's fine with me, if there's no

1 objection to putting it in the text.

2 MS. BURKE: I was going to say that it seems to
3 me, to Doug's point, I think that while we probably aren't
4 ready to go with the recommendation, I think noting this,
5 because in fact we are going to, at some point, address the
6 issue that there's a sunset, that going forward we might
7 want to think about better targeting. But we need to look
8 at this overall question.

9 Arguably one of the big issues that potentially
10 could complicate this further is if we get into DSH and you
11 start making radical changes in terms of DSH as it relates
12 to rural -- I mean, the overall impact on rural hospitals, a
13 variety of policy changes, as well as the outpatient margin
14 issue.

15 But I do think, to Doug's point, saying that as we
16 go forward this will be one thing we'll want to think about
17 as that sunset occurs. But also the broader question of
18 reimbursement strategies for rural hospitals is going to
19 have to come up in a broader context.

20 DR. KANE: I find this very confusing, and this
21 goes back to is there anything here to recommend at this
22 point.

1 One thing is there's a sunset provision that's a
2 \$50 million value. The other thing is a sole community
3 hospital add-on that actually doesn't start, according to
4 your thing, until 2006, according to your paper.

5 I'm confused as to why we're taking away something
6 that hasn't started yet to replace something that hasn't
7 sunsetted yet. It says beginning in 2006, CMS is adjusting
8 upward by 7.1 percent payments to SCHs for outpatient PPS.
9 And what's sunsetting is this old hold-harmless provision.

10 Can we just address the sunsetting and say we
11 think there should be an outpatient volume adjuster to
12 replace that, and leave SCH to when we get a better
13 understanding of what's going on in the hole?

14 You've combined -- the hold-harmless is different
15 than the SCH adjustment?

16 DR. ZABINSKI: Yes.

17 DR. KANE: Hold-harmless disappears pretty soon,
18 in a couple of years?

19 DR. ZABINSKI: Yes.

20 DR. KANE: One thing you found is that the ones
21 who really need that are the low-volume hospitals. Then
22 somehow SCH got combined into that, that \$90 million dollar

1 value that hasn't started yet. And now you're trying to
2 throw that into this how to fix the hold-harmless piece.

3 DR. WOLTER: If I understand this right, it's
4 because they're linked in the sense that the sole community
5 hospital payments are related to their outpatient costs.
6 It's just that CMS came up with a different number in terms
7 of the add-on they give.

8 And then what I think I heard is that within that
9 group some are much more costly because of low-volume than
10 others. So the goal here was -- I thought that was a good
11 word -- an elegant solution that would try to be a better
12 way to target where the issues really are, which I am fine
13 with, I think, in concept.

14 I'm just so uncomfortable with were these margins
15 are. And I would hope we could include the margin data if
16 the chapter, also. That would be a request, if that would
17 be possible.

18 DR. KANE: I think I'm with Mitra. I think that
19 this is sort of past comprehensive then, because I don't
20 understand this recommendation, and why the SCHs add-on is
21 included in the resolution of the hold-harmless
22 disappearing? Because they looked like they were too

1 separate --

2 MR. HACKBARTH: I'm going to resolve it by getting
3 rid of the recommendation. That's the most efficient way to
4 do it.

5 We'll have a discussion of this in the text, and
6 then when we talk about updates and base level payments we
7 can talk about the broader issue of the financial status of
8 rural hospitals, inpatient and outpatient.

9 DR. MILLER: I just want to do one thing in terms
10 of managing expectations. Nick and I had had some
11 conversation on this, so just to give you all the benefit of
12 it.

13 Nick is raising issues about the broader equity
14 and how well the OPD system is functioning broadly. There
15 has been a desire among the staff to get to this issue,
16 build a model and do an analysis not unlike we did on the
17 inpatient side where we tried to look at the equity of the
18 payment system of the inpatient side.

19 We've been given some fairly large mandates in the
20 last couple of years, specialty hospital report, SGR report,
21 as you guys are all aware of. And we haven't been able to
22 get to that. But to manage both the distribution and the

1 level we probably really need some of that work done. And
2 so we are trying to get to it. I think we can look at this
3 issue more broadly in how the OPD is functioning.

4 MR. HACKBARTH: Okay. Thank you.

5 Next is IME and disproportionate share.

6 MR. ASHBY: Okay, we will start today's
7 presentation by briefly reviewing some key findings from our
8 September and October presentations. And then we'll present
9 some data on the impact of options for reducing the IME
10 adjustment and distributing the savings among all hospitals
11 by raising the base rates.

12 Lastly, we'll discuss policy options and present a
13 draft recommendation related to uncompensated care and DSH
14 payments. You may also want to continue a discussion of IME
15 policy options based on the information that we present
16 today and that we presented at earlier meetings.

17 First, some descriptive findings. Spending on IME
18 is \$5.5 billion and DSH \$7.7 billion, together accounting
19 for 14 percent of all inpatient payments. About three-
20 quarters of all hospitals get DSH payments, 30 percent get
21 IME, and about a quarter get both adjustments.

22 Hospitals getting both IME and DSH, as a group,

1 have the highest Medicare margins, although we should note
2 here that this will inevitably be so, given that the
3 denominator of this calculation is the cost of treating
4 Medicare patients and the numerator includes the extra
5 payments related to Medicare patients.

6 Hospitals getting neither adjustment then have the
7 lowest margins and the gap between these two, those getting
8 both, those getting neither, has been steadily growing over
9 the last decade.

10 In terms of analytical findings, our analysis
11 documented the size of the IME and DSH subsidy, that is the
12 portion of payments that is not explained by the impact of
13 teaching or low income patient care, on the cost of treating
14 Medicare patients. We found that the IME adjustment
15 includes \$3 billion in subsidy which is 60 percent of the
16 payment. This finding is based on a regression model, which
17 documented that Medicare costs per case rise 2.2 percent for
18 every 10 percent increment of teaching intensity.

19 Then we found that the DSH adjustment includes \$6
20 billion in subsidy, which is 84 percent of the payment. The
21 regression finding in this case was that for urban hospitals
22 with at least 100 beds Medicare costs rise 1.4 percent for

1 every 10 percent increment of the low income share.

2 We found no relationship, though, between costs
3 and low income share for all other hospitals.

4 Finally, our analysis found little evidence of any
5 relationship between hospitals' uncompensated care measured
6 as a share of their total expenses, and the IME and DSH
7 payments they receive. That finding, you'll recall, was
8 based on data from the mandated reporting systems of five
9 states.

10 MR. LISK: So let's move on and discuss our
11 analysis of the potential impact on providers of changes in
12 IME payment levels under different scenarios.

13 In our analysis, we simulate the potential impact
14 of different changes to IME payments on Medicare margins and
15 the distribution of Medicare payments. For this analysis we
16 have simulated a base case margin using 2004 data that
17 adjusts payments to reflect certain policy changes that have
18 taken place since 2004. These include reflecting MMA DSH
19 policies that raise the DSH cap for rural hospitals and
20 urban hospitals under 100 beds, an IME adjustment of 5.5
21 percent which is the adjustment that will be in place
22 starting in the 2008 period and beyond. This is lower than

1 the adjustment that was in place in 2004 but is higher than
2 the current your adjustment for 2007, which we are in now,
3 which is set at 5.35 percent.

4 We also adjusted the fixed loss threshold for
5 outlier payment cases so that the full 5.1 percent outlier
6 pool was paid out to hospitals. As a reminder, in 2004 the
7 fixed-loss threshold was set too high, so only 3.5 percent
8 of the pool was paid out to hospitals. This change has the
9 effect of increasing our base margin from what you might
10 have seen for 2004 in the past.

11 We were not able to include in our analysis the
12 effect of the shift over to cost-based weights from the
13 charge-based weights that were in place in 2004. Taking
14 account of these policy changes, our simulated base market
15 is a little higher than what we actually observed in 2004.

16 This next chart shows the overall Medicare margins
17 by teaching status under three different scenarios. First,
18 is the baseline margin which I just discussed. Next is the
19 margin if the IME adjustment were reduced by one percentage
20 point with the savings returned to the base. The second
21 scenario we show is what happens to the margin if the IME
22 adjustment is reduced to the empirical level of 2.2 percent,

1 again with the savings returned to the base.

2 As you can see, as we move from the baseline
3 margin reducing the IME to the empirical level, the margins
4 start to converge and the differences in the hospitals'
5 performance narrows.

6 If we look to the left at the baseline margin, we
7 see the major teaching hospitals' overall margins are about
8 12 percentage points higher than for non-teaching hospitals.
9 If the IME adjustment reduced by one point to 4.5 percent,
10 the difference in the overall Medicare margins between major
11 teaching and non-teaching hospitals would narrow to 10
12 percentage points. And if the IME adjustment were brought
13 to its empirical level of 2.2 percent, overall Medicare
14 margins for major teaching hospitals would still remain 5.5
15 percentage points above non-teaching hospitals.

16 Although we don't show it on the slide, the gap in
17 the aggregate financial performance between major teaching
18 and non-teaching hospitals would narrow further to 3.4
19 percentage points if both IME and DSH payments were brought
20 to the empirical level. So that just gives you an idea of
21 what happens when we take everything to the empirical level
22 in terms of the differences in performance at those

1 hospitals.

2 This next slide shows the same information, only
3 for inpatient margins. Remember that it is the inpatient
4 payment system that the DSH and IME adjustments apply to.
5 So this slide shows the effect on the inpatient margin.

6 Here again, we show a similar narrowing of the
7 gaps between major teaching and other teaching hospitals as
8 we move from the baseline policy to a one percentage point
9 reduction in the IME adjustment and reducing the IME
10 adjustment to the empirical level, although the differences
11 are larger than we saw for the overall margin.

12 For the inpatient margin we see a 17 percentage
13 point difference in the base case compared to major teaching
14 and non-teaching hospitals. And this difference is cut in
15 half when the IME adjustment is reduced to the empirical
16 level.

17 On this chart yo can also see that the margin for
18 other teaching hospitals actually goes up slightly. And
19 this happens because base payments for this group in
20 aggregate would go up more than they would go down from
21 their reduction in IME payments.

22 This next slide shows the distribution of

1 inpatient payment changes if the IME adjustment were reduced
2 by one point to 4.5 percent. The blue bars show the
3 distribution for teaching hospitals and the green bars shows
4 the distribution of payment change for non-teaching
5 hospital. And in this chart we combined major teaching and
6 other teaching hospitals into the teaching hospital group.

7 If the IME adjustment were reduced to 4.5 percent
8 from 5.5 percent, 7 percent of teaching hospitals would have
9 Medicare inpatient payments fall between 2 percent and 4
10 percent. Another 38 percent would see payments go down less
11 than 2 percent.

12 52 percent of teaching hospitals, those are the
13 smaller teaching hospitals, however would see payments
14 increase. These are hospitals with small teaching programs,
15 less than eight residents per 100 beds.

16 87 percent of non-teaching hospitals would
17 actually see payments increase. In this group, the group
18 that sees no change -- that you see there in the middle --
19 are basically sole community hospitals who are paid on the
20 basis of hospital-specific rates. So from putting the money
21 back into the base, they would not get an increase in
22 payments and see no change.

1 In this next slide, we show the distribution
2 payment changes for reducing the IME adjustment to the
3 empirical level. And here we see a wider spread in the
4 distribution of payment changes. Hospitals with higher
5 resident-to-bed ratios will see the largest reduction in
6 Medicare payments but would still receive the highest IME
7 add-ons. 19 percent of teaching hospitals would see
8 Medicare inpatient payments fall by 4 percent or more.
9 That's the accumulation of the three leftmost bars.

10 Over 85 percent of non-teaching hospitals would
11 see payments increase between 2 percent and 4 percent.
12 Teaching hospitals with less than eight residents per 100
13 beds would actually see a slight increase in payments.
14 Again, this happens because the increase in base payments
15 offset their decrease from the IME.

16 Now Jack will talk about collecting uncompensated
17 care data and some other issues dealing with uncompensated
18 care.

19 MR. ASHBY: To support development of a mechanism
20 for offsetting hospitals' uncompensated care, Congress, in
21 the BBRA, back in 2000, directed CMS to begin collecting the
22 necessary data from all PPS hospitals. CMS, in fact, did

1 add an uncompensated care schedule to the Medicare cost
2 report in 2003. But there has been widespread recognition
3 that the form has not resulted in accurate or consistent
4 data.

5 In this next slide, we show some of the problems
6 with the current S-10. We probably don't want to get into
7 much detail here, but I'll summarize by saying that we think
8 it's critical to have separate reporting of bad debts and
9 charity care, and also to have separate reporting of
10 Medicare and other payers bad debt, since there is a
11 mechanism already in place for Medicare to reimburse
12 hospitals for the unpaid copayments of beneficiaries.
13 Perhaps most importantly, hospitals need guidance on what
14 they can and cannot include in bad debts and charity.

15 Based on input from several accounting and
16 financial management experts, we have already provided CMS
17 with detailed suggestions on the form and accompanying
18 instructions. Your briefing books provide some additional
19 detail on the improvements that we think are necessary. And
20 if you have any questions on that material, I'd be glad to
21 respond to that after the meeting.

22 A related issue is that there currently is no

1 federal requirement that hospitals maintain a formal written
2 charity care policy. Although as an aside here, we now have
3 a California law going into effect on January 1 of 2007 that
4 will require it for California hospitals.

5 Most hospitals have developed a policy which
6 typically defines eligibility for charity care on the basis
7 of the patients and their family's income, assets and
8 financial obligations for Medicare. But CMS's data
9 collection instrument asks hospitals about this and some
10 hospitals, particularly rural facilities, have reported
11 voluntarily that they do not have a written policy.

12 CMS might consider requiring hospitals to maintain
13 a charity care policy, perhaps as a condition of
14 participation, because without it CMS would be unable to
15 conduct a complete audit of the data that hospitals report
16 on their S-10.

17 This leads to our draft recommendation, and that
18 is that: The Secretary should improve the form and
19 accompanying instructions for collecting data on
20 uncompensated care in the Medicare cost report and require
21 hospitals to report using the revised form as soon as
22 possible.

1 The recommendation pretty much speaks for itself
2 but I would add that we stand ready to work closely with CMS
3 on this and we'd like to get started quickly because it will
4 take about two years to obtain useful data, even assuming
5 that the instrument can be finalized in the next few months.

6 This recommendation would have no implication on
7 Medicare spending and it would bring about a small increase
8 in hospitals' reporting burden.

9 Perhaps the optimal way for the federal government
10 to finance a social good is through a broad-based revenue
11 source. Medicare is probably not the best vehicle for an
12 uncompensated care payment as a social good for at least
13 three reasons. First, that the impact of uncompensated care
14 on the cost of treating Medicare beneficiaries is probably
15 small, like the impact of Medicaid or SSI patients, as our
16 analysis has shown.

17 Second, that uncompensated care comes from all
18 patient groups.

19 And third, that a payment to offset uncompensated
20 care costs would protect access to care, again for all
21 patient groups.

22 The concept of a separate federal program to pay

1 for a portion of hospitals' uncompensated care has been
2 proposed in the past. Financing could come from general
3 revenues, either as a direct appropriation -- as was done,
4 incidentally, to implement an IME payment for children's
5 hospitals -- or through a mandatory entitlement structure to
6 mitigate the uncertainty of the appropriations process.
7 General revenues are less regressive than the payroll tax
8 financing the Part A trust fund, and of course the trust
9 fund is scheduled to be exhausted in 2018.

10 An alternative approach, though, would be to fund
11 the uncompensated care payment through a broad-based tax on
12 the revenue of health care organizations such as hospitals
13 or insurance companies, as several states have done to
14 finance their own charity care pool.

15 If the Commission would like to retain the
16 uncompensated care payment within Medicare, we would turn to
17 the current DSH payments, \$7.7 billion in 2004 you recall,
18 to provide the funding. The Commission would have to decide
19 whether to recommend using all of the DSH funds for the
20 uncompensated care payment or using some of the money for
21 that purpose and retaining some within the PPS to improve
22 payment equity among all hospitals.

1 This policy direction would represent a way for
2 Medicare to make its contribution to offsetting hospitals'
3 uncompensated care costs and perhaps other payers would
4 follow suit.

5 Once the amount of funds is established in
6 relation to DSH funding, the next question would be how to
7 distribute the payment. It could be paid in the same form
8 as the DSH adjustment, a percentage add-on to the Medicare
9 payment rate. But that wouldn't work well because hospitals
10 with small shares of Medicare patients would have a lesser
11 proportion of their total uncompensated care costs paid, and
12 we already have evidence that some of hospitals providing
13 the most uncompensated care do indeed have below average
14 shares of Medicare patients.

15 A better option would be to break the link to per
16 case payment by distributing payment based on each
17 hospitals' total uncompensated care costs. Once the funding
18 level is fixed, policy would articulate the allocation among
19 hospitals. Basically, each hospital would be entitled to a
20 share of the budget corresponding to its uncompensated care
21 costs as a share of national uncompensated care cost.

22 Even with Medicare's uncompensated care payment

1 limited to paying out a fixed amount of money, the payment
2 would probably still lead to significant political pressure
3 to increase funding over time. One way to address that
4 pressure, as well as to target the payments to the hospitals
5 doing the most for patients of limited means, would be to
6 limit the payment to hospitals' charity care in contrast to
7 its total uncompensated care or charity care plus bad debts.
8 And then the payment could be further narrowed by limiting
9 it to the charity care provided to patients whose family
10 income is below a certain threshold, such as -- just as a
11 example -- twice the federal poverty level.

12 Although it imposes an additional recordkeeping
13 and reporting burden on hospitals, some states have taken
14 this approach for their charity care pools, and hospitals
15 have been willing to provide the necessary data.

16 Finally, targeting at the hospital level might be
17 improved by limiting payment to charity care exceeding a
18 certain threshold share such as a 5 percent of a hospitals'
19 total patient care costs.

20 In this last slide, we present several principles
21 for developing a payment to offset hospitals uncompensated
22 care. First, such a payment is predicated on CMS revising

1 the S-10 and collecting the first round of data, probably
2 doing some initial auditing and analyzing the data.

3 Second, the payment could be organized as either a
4 separate payment funded by some type of broad revenue
5 source, or within Medicare funded from the Part A trust
6 fund. You will want to discuss whether to be more specific
7 on this issue.

8 Third, the payments should have a fixed budget.
9 Of course, policymakers would need to devise some way to
10 increase that budget appropriately over time.

11 Fourth, the allocation of the payments should not
12 be linked to hospitals' volume of Medicare cases.

13 And fifth, the payments should target hospitals
14 playing the largest role in meeting the needs of patients
15 unable to pay their bills, using one or more of the
16 mechanisms that we saw on the last slide.

17 So that's our presentation and we open it up for
18 discussion.

19 MR. HACKBARTH: What I'd propose we do is discuss
20 these one at a time. Let's start with IME.

21 MR. MULLER: The Medicare program has a long
22 history of supporting IME, explicitly since at least '83,

1 and I would argue implicitly really going back to 1966,
2 because from 1966 to 1983 we had a cost-base system and the
3 costs of teaching hospitals were incorporated inside that.
4 As the chapter indicates, the DSH payments came in '86.

5 Part of what IME is for is something that people
6 have different opinions on. It's at least there for the
7 higher costs that a teaching hospital incurs from training
8 the future generation of physicians and other caregivers,
9 largely by having residents and medical students.

10 As we know from the chapter and our previous work
11 on this, the more residents that a teaching hospital has the
12 higher the margin. So in a sense the more it needs the
13 social mission for which IME payments are set, those having
14 more residents, providing more physicians of the future, the
15 higher margin it has.

16 Secondly, as we point out, in the DSH program, the
17 payments from the DSH program include both for Medicare
18 beneficiaries that are low-income, and also for Medicaid
19 beneficiaries. That's how we determine the DSH payments.
20 As Jack noted there briefly in his introduction, therefore
21 just as an arithmetic calculation, DSH margins are going to
22 be high in the Medicare program because the payments are

1 being made on behalf of patients -- that is Medicaid
2 patients -- who are not Medicaid beneficiaries. So you're
3 going to have high margins.

4 So the more a teaching hospital meets it's social
5 function of training future physicians, that is having more
6 residents, the higher the margin it has. The more it takes
7 care of people who are poor by taking care of Medicaid
8 beneficiaries, the higher the market it has. And then we
9 act surprised.

10 This reminds me of the scene from the movie
11 Casablanca, where the police inspector comes into Rick's
12 Café, which is also a casino, and all of a sudden notices
13 after a turn of events that there's gambling going on and
14 proceeds to try to close the casino when a courier comes up,
15 "Your winnings, sir", as if this is some kind of shock.

16 The point here is that the social policy here is
17 to have more residents being trained and also take care of
18 people in the Medicaid program, which increases the Medicare
19 margin. And then we shouldn't be surprised at all that
20 there's a high Medicare margins in teaching hospitals when
21 they have a big teaching program and when they have a big
22 program in DSH.

1 I would argue we've known this for a while. That
2 is a social mission. And that mission is to cover those
3 costs.

4 Furthermore, it came up earlier in the discussion
5 of rural hospitals, the high inpatient margin is used in
6 part and at other times to cross-subsidize a very high
7 negative outpatient margin, which obviously -- and teaching
8 hospitals in general have very large outpatient programs,
9 given the scale of their programs.

10 Also, we don't have the IME payments in some of
11 the rehab component, in the skilled nursing home components,
12 and in the psych components. So we have negative margins in
13 teaching hospitals in those programs that also are covered
14 by these large inpatient margins in Part A. So that's one
15 of the reasons we like to look at total Medicare margins and
16 not just focus on the inpatient margins.

17 We also know that we have difficulties in the DRG
18 system. This commission dealt with that in the specialty
19 hospital report a year and a half ago. And some parts of
20 our recommendations at that time to modify the DRG system
21 have been implemented in part. But our recommendations on
22 severity adjustment have not yet been implemented. I think

1 it's the feeling of many people that once there's a better
2 severity adjustment system, that might better reflect some
3 of the costs of teaching hospitals as well.

4 Having seen what happened with our recommendations
5 on how to better capture hospital cost-to-charge ratios and
6 see how it was first proposed by CMS to be implemented,
7 which is different than we had interpreted, I would first
8 like to see how CMS implements any severity adjustments we
9 ever come up with. But certainly, if we had better severity
10 adjustment inside the system, we could probably have a
11 better reflection as well of the true acuity of costs inside
12 teaching hospitals.

13 Jack and Craig, I'm a little concerned about how
14 we did our simulation here, as well. Because, for example,
15 you note that you look at these high margins and obviously
16 the high margins then become a target for people looking at
17 where monies can be looked at in the Medicare program.

18 But for example, to put the outlier payments in at
19 a simulated level rather than at the level that they're at
20 just overstates the margins. I don't quite understand why
21 we don't put them at the level at which we're paying the
22 payments rather than at the level at which they should be

1 paid. In other areas we look at the payments that are being
2 made, not what the payments could be.

3 Furthermore, I'm also concerned on the DSH side,
4 in a sample of five states in terms of uncompensated care
5 and how we did that calculation. I must say the findings
6 here that the DSH payments are almost randomly correlated
7 with levels of uncompensated really surprised me. That has
8 not been my experience in looking at hospitals. I don't
9 have the whole database memorized the way this report
10 purports to do. But I think we need to look at more than
11 just those five states because those findings were so
12 surprising to me. I think we all would have concern if DSH
13 payments are randomly correlated with levels of
14 uncompensated care.

15 Obviously, since the calculation is not on
16 uncompensated care per se, but on Medicare and Medicaid SSI,
17 and as we pointed out that is probably not the best proxy in
18 the world for uncompensated care. But to have it randomly
19 associated, as our chapter indicates, is very surprising to
20 me. So I would like a little bit more analysis of how
21 representative those five states are and what a national
22 sample would look like, because that finding just totally

1 perplexed me that it was that far off.

2 In summary, I feel we've had this discussion for a
3 couple of years that obviously it's easy to see and the
4 empirical evidence indicates that teaching hospitals have
5 higher Medicare margins than other hospitals. But I would
6 say it's a direct result of the programmatic design that
7 says the more teaching you do, the higher the inpatient
8 margin you have. The more uncompensated care, or as we
9 define it the more Medicare patients you treat, the higher
10 the inpatient margin. Those are policy decisions that go
11 back at least 23 to 20 years. I think they're well built
12 into the system.

13 And then given the fact that these hospitals also
14 provide other services on which they lose an awful lot --
15 I'm trying to remember from last year, but I think the SNF
16 margins for teaching hospitals are well beyond the
17 negativity that Nick referred to for outpatient programs. I
18 seem to remember they're north of minus 50 percent.

19 So when you think of the fact that we have to
20 cross-subsidize all these other programs within those
21 inpatient margins, it doesn't bother me as much, obviously,
22 that these inpatient margins can support the enormous social

1 goal that teaching hospitals provide.

2 MR. ASHBY: Can we respond to those two points?

3 We'll do in order, Craig will take on the outlier one.

4 MR. LISK: One thing, just to clarify on IRF and
5 psych PPS's, there are IME adjustments on those payments
6 systems, just to clarify that.

7 On the outlier payment system, and the reason why
8 we modified things to put it at 5.1 percent, because that is
9 what, in theory, is supposed to be paid out by CMS. CMS
10 doesn't always hit the target. So sometimes it's 3.5. It
11 was 3.5 in 2004, but in theory CMS should hit the target.
12 Sometimes they over hit the target. And so that's what we
13 are doing, and our policies are just comparable, assuming
14 5.1 percent outlier pool throughout the options that were
15 consistent across that.

16 One other point though to say, in terms of how we
17 were conservative in our estimate of the IME adjustment of
18 2.2 percent, 2.1 percent if we look at the actual policy
19 that was in place in 2004. If we actually corrected that
20 for outliers, the actual empirical level, the IME adjustment
21 would be 1.9 percent. Instead, it would actually be a
22 little bit lower. So I just wanted to give you that little

1 piece of information.

2 The other thing, in terms of when you look at the
3 outcomes of our margins and when we actually take out the
4 DSH subsidies, it's to give you an idea of also our
5 empirical simulations that we are being, I guess,
6 conservative in our estimates and how we're approaching
7 this. Because otherwise they may have narrowed right to
8 zero if we accounted for absolutely everything. We're still
9 seeing the margins higher in the teaching hospitals versus
10 other hospitals.

11 DR. MILLER: Can I just make one point on that?
12 The pattern of narrowing the differences between the three
13 categories of hospitals would still be present whether you
14 modeled it at the 5.1 level or the actual level.

15 MR. LISK: And that's absolutely correct. That
16 pattern would really be the same if we did that, yes.

17 MR. ASHBY: On the pattern of relationship between
18 uncompensated care and IME and DSH payments, we were
19 concerned too that five states might not be totally
20 representative of the nation, even though the states have
21 the best data systems for an analysis like this. So we
22 actually replicated the entire analysis on uncompensated

1 care data from the AHA annual survey.

2 It was really rather interesting how similar the
3 results were. We recreated the same graph that we have in
4 the report and it looks almost exactly the same. So
5 evidently what we found is fairly representative of the
6 nation and GAO did a good job of picking states for the
7 analysis.

8 DR. MILLER: I would just be a little careful
9 about representative of the nation. We've have had some
10 issues with the national AHA data. So we ran it both ways
11 just to sort of see what two datasets with different sets of
12 flaws would produce in a sense. We think the five state
13 data is probably the best that's available at the moment.
14 The reason that there's only five states is because that's
15 whose basically collecting it at this point.

16 The other thing I would say on that comment, the
17 characterization was that it's randomly associated. Do we
18 feel like it was randomly associated or just not
19 particularly one-to-one?

20 MR. ASHBY: Randomly associated might be a little
21 strong. You can see at the top of the distribution that
22 there are indeed some hospitals with large DSH payments that

1 do have large uncompensated care. But you'll also see many
2 examples on both ends where they have large uncompensated
3 care, low DSH, and vice versa.

4 So there is some relationship but it's a rather
5 limited one.

6 MR. MULLER: I want to come back on the DSH
7 statement, because Glenn asked that we talk about the IME
8 first.

9 Let me just make one more point on the teaching
10 hospital that just comes from this morning's discussion
11 about both the organization of physician groups and
12 potential options on the SGR. And that is in so far as we
13 have some slight policy preference for more organized groups
14 and more accountable units, the teaching hospitals with
15 their employed medical staffs and larger multi-specialty
16 groups become a natural setting in which one has multi-
17 specialty and accountable units.

18 I don't want to pretend that they're anywhere near
19 as organized as a true group practice, as Jay represents. I
20 don't want to stretch it that far. But they do have a
21 multi-specialty nature. But more importantly they are truly
22 accountable units because you do have 500, 1,000, 1,500

1 physicians under one organized governance process and they
2 can be, in that sense, an accountable unit.

3 If one of our real objectives in terms of the
4 long-term overall reform of the Medicare system is to have
5 more accountable units, especially that link both the -- to
6 use Medicare jargon, Part A and Part B, or to use more
7 natural terms as linking physician and hospital policies --
8 I think they become a good natural setting for that kind of
9 effort.

10 MR. HACKBARTH: The topic for the next 15 minutes
11 or so it's going to be IME.

12 DR. CROSSON: On the IME discussion, I just want
13 to get a couple of quantitative things straight.

14 With respect to the two options that we had there,
15 a one point reduction or reduction all the way to the
16 empirically justified amount, I think that's about one-third
17 of the way. Is that right? The difference is about three
18 points, between 2.2 and 5.1; is that right?

19 MR. LISK: It's 5.5 to 2.2, so 1.1.

20 DR. CROSSON: So it's somewhere between a quarter
21 and a third.

22 The second one is this issue of the likely impact

1 of severity adjustment, the severity adjustment part of the
2 recommendations that we made previously. Any idea
3 quantitatively what impact that would likely -- I realize it
4 depends -- but what impact that would likely have on
5 increasing margins for large teaching hospitals?

6 DR. MILLER: This is what we were talking about in
7 the hallway last night; right?

8 MR. LISK: Yes.

9 DR. MILLER: Craig caught me in the hallway at the
10 end of the night and we were talking about this. This is
11 fairly complex. You arrive at it by if all of this and not
12 this, and if all this and not this, and you have to do it a
13 couple of different ways.

14 My takeaway from the conversation, and I'm not
15 sure about the answer to the margin question, it's about in
16 the neighborhood of a point; right?

17 MR. LISK: Severity adjustment itself, APR-DRGs,
18 brings down the empirical level of the IME adjustment by a
19 little less than a point, about a point. But the other
20 things on top of that, the cost-based weights and those
21 things, raise it back up to pretty close that it's a wash
22 between the current system and the APRs in terms of what the

1 empirical level is for IME. But severity adjustment, by
2 itself, lowers it by about a point.

3 DR. MILLER: You understand that the different
4 adjustments in the DRGs cut in different directions on the
5 teaching hospitals, the severity adjustments help it, some
6 of the other don't.

7 DR. CROSSON: So the net is up, down, or nothing?

8 MR. LISK: The net, the empirical level goes up a
9 tiny bit when you do everything, all the refinements,
10 together. It's pretty close to what the current system is,
11 in terms of defining the empirical level for the IME.

12 MR. HACKBARTH: I think what Jay is asking is how
13 much money does the severity adjustment shift towards
14 teaching hospitals? How does that compare to the won
15 percent reduction in IME?

16 MR. LISK: And that's pretty close.

17 DR. BORMAN: Just a couple of things to clarify.
18 In the paper we say that 20 percent of teaching hospitals
19 roughly receive only IME, so roughly one in five. And that
20 particularly institutions that receive both in large amounts
21 are tightly concentrated, one might even say 90th percentile
22 and up is a pretty huge chunk of the pot, people who are at

1 the 90th percentile and up.

2 If I heard you right on slide at number nine, that
3 was the distribution of reducing to the empirical level
4 inpatient payment changes, it was roughly 20 percent -- I
5 think you actually said 19 -- that go from minus four or
6 potentially more negative. Right?

7 MR. LISK: In terms of change of payments.

8 DR. BORMAN: Out of that group of folks, this
9 minus 19 percent, how much of that is represented by those
10 really high-end recipients?

11 MR. LISK: The above 8 percent is roughly the
12 hospitals that have a resident-to-bed ratio of greater than
13 0.5, so 50 residents per 100 beds or more.

14 DR. BORMAN: Because I think one of the things
15 that I'm interested in this is a bit what might be lost in
16 looking at the aggregate that you learn by looking at the
17 distribution here. Because I'm a little concerned,
18 particularly when we've collectively now have thought about
19 these issues together and discussed them together, that we
20 keep banging on -- there is a small subset group that's
21 getting a fair amount of money here, there's no doubt about
22 it. And my sense is that that's where some folks here have

1 their biggest concerns.

2 So I just want to be clear on things that
3 redistribute, one would hope redistribute more away from
4 those that we perceive that currently may be the most
5 unfairly advantaged.

6 Is that what you perceive as happening here?
7 You're familiar with the data. You see from whom to whom
8 we're talking about going here, because we're looking at
9 bringing people to a margin that's under 2 percent based on
10 some best guess scenarios about which there have been some
11 cogent concerns.

12 So is this a distribution that mostly takes from
13 richer to less rich or more poor to less poor, or whatever?
14 Is this a redistribution that benefits people who are at the
15 lower end of the spectrum within the community?

16 MR. LISK: Yes, in general that's the case. Of
17 course, there's a distribution among teaching hospitals and
18 their own performance but yes, generally we're taking money
19 from people were doing by far the best under the program and
20 giving it back to the people who aren't getting the
21 adjustments and would be increasing their margins in terms
22 of the non-teaching hospitals, for instance.

1 DR. BORMAN: I couldn't agree more with the
2 importance of the recommendation to get data and get better
3 data and get it fast. To move these things around with the
4 implications for the future in a non-data-driven matter
5 really is a default of everyone's responsibility that's a
6 party to all of this, not just the folks in the room. I
7 certainly have banged on my folks at home, which is about
8 where all I can do that. But I think it's hugely important
9 to do this in a data-driven way.

10 I would just reiterate Ralph's comment that most
11 academic medical centers, certainly most university ones,
12 are very much closed staff models and offer the perfect
13 opportunity for some of the demonstrations and taking
14 ownership of some of those issues and perhaps some of us
15 have not done as good job of that as we can. But I think
16 going forward we certainly represent a big chunk of that
17 community in the direction that we believe there may be good
18 opportunity to go.

19 MS. HANSEN: I'd like to come at this perhaps as
20 the going forward comment that, Karen, you just ended with
21 of having Medicare be a value purchaser for IME. I think
22 Ralph, with the comment of the fact that the payments have

1 been going on in this format for training residence for the
2 past 20 or 30 years.

3 The value purchasing equation I'd love to see
4 inserted on a go forward basis is a comment relative to the
5 expectation of knowledge of Medicare recipients; i.e.,
6 geriatric types of content or evidence-based protocols,
7 teamwork processes that could really ultimately affect the
8 quality of care.

9 I know oftentimes this has been indicated that
10 this may be a little bit more on the graduate medical
11 education side, the GME side. But it seems like these
12 components are linked frankly to treating a beneficiary. So
13 the outcome I definitely would love to see is that
14 opportunity to have a product for the money that's given to
15 the institutions that receive them.

16 DR. HOLTZ-EAKIN: I just want to make sure I'm
17 thinking about this right. The way this seems to me is that
18 the empirically derived level actually solves the targeting
19 problem, and you've now got the money matching the social
20 mission of compensating for the cost of having these folks
21 around.

22 And then the question is what do you do with the

1 rest of the money? One thing I hear people saying is well,
2 you could fix the worst of the targeting stuff by trimming
3 the upper end of the distribution or something like that.
4 But that doesn't solve the question of what are we getting
5 for this money that doesn't match the mission?

6 So what I heard you say that I thought was
7 appealing was there ought to be some accountability groups
8 or something. So take that money, make it available to
9 hospitals, but make sure they deliver something for it.
10 Have a fund that's an enhanced pay-for- performance or
11 something. But you don't just hand it out just because they
12 happen to have people walking the halls with labels on their
13 heads that say student. I think you have to get something
14 for this.

15 I think you should put a lower priority on
16 arguments that say that we don't know if CMS will implement
17 the recommendation right. I worked for Congress and the
18 White House for six years. That shouldn't enter the
19 equation. You're not going to be able to guarantee that.

20 I'm also less sympathetic to the idea that doing
21 this right somehow doesn't solve all the problems. I think
22 we have to get this right. This is about these monies, this

1 is a lot of money, and we ought to get something for it.
2 That seems to me the right way to frame up the problem.

3 DR. KANE: I'm just going to, first of all, repeat
4 what I said in the last meeting because Ralph wasn't there
5 then. I think if you look at page six that shows the
6 overall margins, overall Medicare margins, major, other, and
7 non.

8 I come from a state where we have a lot of major
9 teaching hospitals. And what this has really meant is that
10 the major teaching hospitals are able to be in a much better
11 competitive position.

12 Nick was concerned about low margins in the rural
13 hospitals. And if I were Nick, I would be speaking up and
14 saying why do we have this baseline case? What is the
15 social -- again what Doug said, what's the social benefit of
16 that?

17 Congress, I know back in 1984, I was around
18 actually for that, I thought part of the reason they doubled
19 the empirical value was to make sure teaching hospitals
20 supported the implementation of DRGs. I think we can all
21 impute certain social goals here but we don't really know
22 what they are. And what's happened is what happened,

1 whether or not Congress intended it.

2 But I think if you look at where we are now, we
3 really do see a competitive disadvantage for community
4 hospitals, for non-teaching hospitals. The way that plays
5 out is actually going to affect who wins at pay-for-
6 performance and who wins at getting physicians into groups
7 that are actually manageable. Teaching hospitals have the
8 resources to buy up physician practices, to insert the IT,
9 to train the physicians to become more cost effective and
10 quality oriented. Community hospitals really have to get it
11 out of a different source. I think we really have to level
12 the playing field.

13 Most of our physicians are not affiliated with
14 teaching hospitals. They are in the community. And we want
15 these community hospitals to start doing more of the role of
16 leadership in helping doctors get the IT systems and the
17 infrastructure in place. We've given the teaching hospitals
18 a running head start on that, but I think it's really time
19 to think about what we've done to the community hospital
20 playing field.

21 One argument I've heard is well, the community
22 hospitals are better able to negotiate better rates with the

1 commercial sector. Well, I have not seen that in
2 Massachusetts. It's actually not the case in Massachusetts
3 in a truly competitive market.

4 But I think the other side of that is all it means
5 is they've been able to cost shift better than the private
6 sector. Is that a good social mission? Is that what we
7 really want to have Medicare policy encouraging?

8 So I would just encourage us to think very hard
9 about how to make this an equitable payment system and not
10 just pay for some kind of unfocused goal of better societal
11 goals that we haven't articulated?

12 And I support Jennie's idea that we should be
13 asking for more of the teaching hospitals in terms of who
14 they train and how they train the residence. That may well
15 fall into something more related to how we pay for the
16 residents, the direct medical education piece, who they
17 train and whether there are caps or limits, and whether we
18 maybe lift the limits on the caps if they'll train
19 gerontologists and primary care docs. That may be the
20 easiest way to get that kind of social policy made clear,
21 instead of some kind of vague add-on that we don't demand
22 accountability for.

1 So I guess just to reiterate, I think this chart
2 on page six suggests that we've created a fairly inequitable
3 system here for the non-teaching hospitals and that we
4 really have an obligation to try to level the playing field
5 and make community hospitals a little more whole so that
6 they're enabled to do the kind of things that we hope
7 everybody can do in pay-for-performance and quality
8 improvement.

9 DR. MILSTEIN: I support Ralph's suggestion of
10 linking the redistribution of these calculated overpayments
11 into the base payments, linking that to implementation of
12 our recommendations on severity adjustment. No? You didn't
13 say that? It wasn't sure.

14 Then I'll say that on my own.

15 Secondly, I also want to strongly reinforce a
16 number of comments made that irrespective of how this first
17 issue is resolved of doing much more to link these payments,
18 both direct and indirect, but today's topic is indirect, to
19 a more honed vision of what the social mission is of
20 training. As Jennie outlined, focus on aspects of training
21 to be much more valuable to beneficiaries.

22 My short list from the last two years of

1 discussion would have, in addition to geriatrics, medical
2 informatics/IT and the use of systems engineering to
3 improved efficiency and quality of services. I think if one
4 were to do an audit today of the number of full-time faculty
5 FTEs, faculty that are primarily expert in these three
6 areas, it would not be a happy result.

7 The speed at which this happens, obviously I would
8 look to leadership from AAMC and teaching hospitals to guide
9 us. But I think we've been through 40 years of no
10 conditions on both direct and indirect medical education
11 payment in terms of educational content and it's left us
12 with an equilibrium that -- if I can paraphrase Jay -- is a
13 situation where well run delivery systems keep telling us it
14 takes them a year or two to untrain and retrain the products
15 coming out of our medical schools. I think enough is
16 enough.

17 MR. HACKBARTH: Let me pick up on the Arnie's
18 proposal to link a change in IME to implementation of a
19 credible severity system. But before I go there let me just
20 go back one step.

21 When we started this conversation I think we
22 identified two broad categories of problems. One is

1 illustrated by this graph. Do we have a payment equity
2 problem among the different types of hospitals? And then
3 the second was an accountability issue. We're putting out
4 billions of dollars. What exactly are we buying for that?

5 We've talked a bit and thought a bit about whether
6 you can do anything on the accountability front after the
7 act. Can you go to hospitals once they've received the
8 money and say what did you use it for? And file reports on
9 that.

10 I have mixed feelings about that. On one level it
11 seems like a commonsensical thing to do. On the other hand
12 I'm concerned about the credibility of the information that
13 you would get. Because really the question you're asking
14 people is what would you drop if you didn't have this money?
15 And that's a hypothetical question to which people can
16 generate hypothetical answers and they're not real, hard
17 answers to the question.

18 So as I've thought about that track of after-the-
19 fact reporting, it doesn't seem useful or productive to me.
20 You've got to deal with this issue on the front end before
21 the dollars go out the door, not on the back end.

22 Now thinking about the payment equity piece of

1 this, MedPAC has recommended implementation of a severity
2 adjustment system. We talked a little bit about the
3 magnitude of the dollars that would be shifted by that
4 system towards teaching hospitals. It seems to me that it
5 may be an opportunity to say, rather than do that and shift
6 more money in this direction, let's use this as an
7 opportunity to do one of three things with the money. I
8 think there are three potential paths you might take.

9 One would be to say we'll take a piece of the IME
10 adjustment about the empirically justified amount when
11 severity is done and put it back in the base to be
12 redistributed to all hospitals, and address -- at least in a
13 small way -- the graph that's up on the screen.

14 A second path would be to say okay, let's take a
15 piece of that money and start tying it to performance and
16 get something specific for it and, for example, put it in a
17 pay-for-performance pool which would at least allow teaching
18 hospitals an opportunity to earn some of it back based on
19 superior performance, defined with these measures.

20 A third path would be the one that Arnie and
21 Jennie have suggested, which is to use these dollars to
22 begin promoting and encouraging supporting a change in how

1 we educate our medical students and residents and link it to
2 things like training more geriatricians and so on.

3 So I think those are the paths that at least seem
4 obvious to me.

5 Just one last point on this. I think that a
6 severity adjustment is a very good thing to do. I would
7 have liked to have seen it done in the initial package as
8 part of our overall DRG refinement recommendations. For a
9 variety of reasons that didn't happen.

10 Now I fear it's in jeopardy. It's become
11 isolated, if you will. And because it redistributes money
12 towards teaching hospitals and away from community hospitals
13 and rural hospitals, I think it's vulnerable. It's good
14 policy that's vulnerable because the politics don't look
15 very good, in view of this graph.

16 So I think that if we were to link a change in
17 IME to severity, in addition to good policy it may also be
18 good politics and increase the likelihood that we can
19 actually get a severity adjustment that targets the money to
20 the institutions that truly serve the sickest patients,
21 which I think is an important thing to do.

22 As for how to direct the dollars, whether to put

1 it in the base, pay-for-performance, or medical education, I
2 think there are pros and cons of each of those paths. For
3 myself, at least at this point in time, I don't have a
4 really strong feeling that one is right and the other is
5 wrong. We could try to reach consensus on that or we could
6 simply lay out the alternative paths and some pros and cons
7 to each.

8 So those are my thoughts and they are informed by
9 conversations with all of you. I would welcome reactions.

10 DR. REISCHAUER: Let me come to Ralph's defense
11 and then side with the opposite forces.

12 [Laughter.]

13 DR. REISCHAUER: The question was why pay more
14 than the empirical amount? And the empirical amount is
15 associated with the extra cost for services to Medicare
16 beneficiaries but presumably they're extra costs to serving
17 the general public, as well. And one could argue that this
18 is a broader social function of training people that are
19 going to serve the society as a whole, not just Medicare
20 patients, so give them more for that purpose.

21 The opposite argument or the counter argument
22 would be well, shouldn't private payers, Humana, Aetna, and

1 those people, belly up to the bar and pay their share? And
2 then Ralph, who runs the hospital, says yes, but they won't.
3 They'll just go somewhere else. They'll send their patients
4 somewhere else.

5 I think they should. And so I'm would actually
6 not succumb to that set of arguments.

7 Nancy said look at these disparities and margins
8 here. And we have to remember that these disparities and
9 margins also include the DSH payments as well. And before
10 we talked about how unlevel the playing field is, you would
11 want to see these without the DSH additions to them because
12 the DSH is for something else.

13 So this really gets into a horrendously
14 complicated set of considerations.

15 Glenn suggested where it could go if we took it
16 away into the base payments, medical education or pay-for-
17 performance. I would just say that pay-for-performance I
18 think it would be very hard to set up a separate pool for
19 teaching hospital pay-for-performance as opposed to pay-for-
20 performance in general. And if it were for everybody in
21 general, which is fine, I think it would hardly be
22 considered adequate by those who were involved with teaching

1 hospitals.

2 MR. HACKBARTH: Just to be clear, what I
3 envisioned was not a separate teaching hospital pool but it
4 would enhance the overall hospital pool and make it bigger
5 so it has more power. And then if teaching hospitals do
6 well on the measures they could earn back some of the money.

7

8 MS. HANSEN: I'd like to tie all of the three
9 thoughts you had, the severity adjustment, the pay-for-
10 performance, as well as the geriatric contact.

11 I like the idea of the severity adjustment or the
12 risk adjuster on the patient. My concern about the
13 complexity of taking that by isolation is the fact that
14 oftentimes older people inadvertently get into the situation
15 of receiving iatrogenic care. In other words, they go in
16 the hospital, something else gets worse, something else gets
17 worse. I think the New York Times article that was included
18 in our packet showed that.

19 So if we get paid for that complexity to the
20 fourth degree, then I don't know that we're incenting
21 incorrectly unless it's tied to an appropriate sense of
22 quality and pay-for-performance for this, which then is

1 implicit with knowing how to treat complex geriatric
2 patients.

3 If we do these things, I'd like to show how they
4 are actually interrelated. And I don't want to
5 inadvertently pay more for accidental care that creates more
6 severity.

7 DR. HOLTZ-EAKIN: I just want to say that I also
8 think they're all related and not related separate. My
9 vision is that the difference between those lines at the top
10 and toward the bottom is that those are harder cases and
11 they're genuinely better outcomes and the students learned
12 that that's what works, then teaching hospitals can get the
13 money and the lines can stay apart. I have no problem with
14 that. We just need to know that's what's going on.

15 MR. MULLER: Let me also just speak to the point
16 that Bob made, and Nancy, since a lot of this is driven by
17 the higher margins, a lot of that margin is driven by DSH.
18 So to just use the IME lever as a way of dealing with the
19 margin when half of it is DSH, we're just pounding a nail
20 because we have a hammer.

21 I think we should look at the interrelationship of
22 dish and IME, as Bob pointed out.

1 In our discussions in the past -- and I think
2 there's a lot of appropriate questions about the
3 distribution of DSH, as the chapter indicates. As usual, in
4 all our discussions over the years, we focus on IME even
5 when we say we're going to talk about IME and DSH.

6 MR. HACKBARTH: Yes. We are going to shift gears.

7 MR. MULLER: I do think we should not just look at
8 the IME. If we want to look at those margins in a different
9 way, we have to realize it's a combination, as Bob said, of
10 IME and DSH, not just IME.

11 MR. HACKBARTH: Any reaction, Ralph, to what I
12 said?

13 MR. MULLER: I think the severity adjustment is
14 something I was in favor of year-and-a-half ago. I'm still
15 in favor of it now. And insofar as it therefore changes the
16 funding for teaching hospitals in a positive way, I think
17 your suggestion on the IME is a fair one.

18 I think the question of how to -- on the pay-for-
19 performance and the target, I think there's a lot of
20 attraction to thinking about whether it's geriatrics or
21 informatics and so forth.

22 They're obviously, as Arnie indicated, if there

1 are, by his standard and other people's standards, too few
2 people doing this, there must be powerful signals in the
3 overall health care economy that keep people from going to
4 these fields, as opposed to being cardiologists or...

5 So I think whether one could have a sufficient
6 signal just within Medicare payment policy to overcome all
7 of those other signals, and those are signals that are not
8 just having to do with income, have to do with lifestyle,
9 have to do with so many other factors.

10 I am, on the one hand, persuaded by the fact that
11 it would be good to send some signals in that direction. My
12 sense is we wouldn't be able to send powerful enough signals
13 to overcome all those other ones. So we might feel good
14 about but I don't think the signals we could send are
15 powerful enough. There's real reasons why people don't go
16 into that. I, too, would wish more people went into it.
17 But I don't think we have enough to target in that
18 direction.

19 MR. HACKBARTH: A quick comment on this and then
20 we need to move on to DSH.

21 DR. BORMAN: Just regards to a piece that was in
22 the report, relative to the prevalence of certain services

1 such as burn care, trauma care, transplantation,
2 concentrated in major teaching hospitals.

3 I think that there may be others, and again I
4 think number one, one can say all of the things I've just
5 listed are not exclusive to Medicare beneficiaries. But
6 that we would all agree that probably they are a piece of
7 our health care system that we want. I think there's
8 probably some others that are concentrated in teaching
9 hospitals, in terms of neonatal care, in terms of
10 potentially some kinds of oncology care, bone marrow
11 transplant programs come to mind, some of those kinds of
12 things.

13 I would point out that I think preserving those
14 makes you want to be a little bit careful about just how low
15 you bring this margin, what you may be putting at risk. So
16 I would just remember those background services a little
17 bit.

18 MS. BURKE: Glenn, if I can just ask going
19 forward, I think we need, because I think the visual aids
20 lead one in a direction, I think we need to have charts that
21 show IME separate from DSH and what those margins look like.
22 Because I think this confuses the question.

1 To Karen's point, I think there are a variety of
2 issues, I would argue, in fact, that teaching hospitals do
3 do that are different. And we ought to at least understand
4 how much of a margin are we moving around? What's the
5 result of that? I think it is a much more complicated
6 question but this certainly masks and suggests that we're
7 going to have these wholesale shifts when I'm not sure
8 that's entirely the case, if I understand that these numbers
9 do include both in the margins. If they don't, that's one
10 thing. But if they do --

11 MR. ASHBY: Just to clarify, the DSH payments are
12 in all three of the numbers you see up there. You are
13 seeing the impact only of the teaching changes.

14 MS. BURKE: I understand.

15 MR. LISK: Although like I said, if we go to the
16 fourth thing that's not there and I mentioned is if you put
17 DSH to the empirical level, which is kind of treating it
18 differently, you still see the major teaching hospitals
19 having about a 3.5 percent overall margin that's higher than
20 the non-teaching hospitals. If you look on the inpatient
21 side, that difference is about 6 percentage points.

22 MS. BURKE: Again, as we look at DSH and we look

1 at its impact and what that distribution would look like as
2 we look at IME separately and its distribution, I think
3 those are important questions to keep in mind. And how the
4 money is used, to Karen's point, is an important question.

5 MR. HACKBARTH: Let's turn to DSH.

6 What I hear is a clear consensus that we ought to
7 again recommend collection of data on uncompensated care.
8 That's a repeat of a past MedPAC recommendation.

9 I also hear consensus that those data then ought
10 to be used to rewrite the formula, to direct the dollars to
11 the institutions that provide the uncompensated care.

12 Implicit, and I think needs to be explicit, is
13 that what we're talking about is a system that allocates a
14 finite pool of dollars. I'm not sure exactly off the top of
15 my head out to define that, as opposed to our saying that
16 the federal government should take on an open-ended
17 commitment to fund some percentage of uncompensated care

18 With regard to DSH, here again I hear some
19 different options that we need to grapple with a bit. And
20 these are options that have to do with the placement of this
21 revised payment adjustment. One option, of course, is to
22 leave it in Medicare, in which case it could be structured,

1 I guess, so that it's not payroll tax financed. Personally,
2 I don't have real strong feelings on that for reasons that
3 some other people I think have mentioned. The payroll tax
4 is not perfect by any stretch, but this payroll tax is
5 uncapped, unlike the Social Security payroll tax. And so it
6 has that element of progressivity in it.

7 I think more the issue about keeping it within
8 Medicare is an issue of stability and confidence in the
9 financing that it's going to be there, as opposed to an
10 appropriations process where it will be up against
11 competition with many other important worthy programs. At
12 least some of you have said to me that you draw some comfort
13 from it being within Medicare.

14 If it is within Medicare perhaps the most
15 important issue, from my perspective, is it really ought to
16 be unhooked from Medicare admissions so that the amount of
17 dollars flowing to an institution is not a function of its
18 Medicare volume, since many of the institutions that most
19 need the money for caring for uncompensated care patients
20 have low Medicare volumes, not high Medicare volume.

21 We thought a little bit about some other options
22 for placement, one being Medicaid where there is a

1 disproportionate share system. But I don't know a lot about
2 the Medicaid disproportionate share system, but what I've
3 heard doesn't inspire me to think that that's the best place
4 to get the dollars well allocated.

5 So to sum up, what I'm hearing is collect the
6 data, rewrite the formula, keep it in in Medicare, unhook it
7 from admissions, and whether it's financed with payroll
8 taxes or some other way probably isn't something where we've
9 got expertise. That's not a health policy judgment. That's
10 a federal fiscal judgment that we probably ought to just
11 leave to other people, namely the Congress.

12 Reactions to that summary?

13 DR. KANE: Just because I've been involved a lot
14 with state reform and DSH issues, a lot of uncompensated --
15 uncompensated care currently is very hospital-centric. And
16 yet, what you really would rather is that it was primary
17 care-centric, or at least included the physicians and had a
18 broader reach.

19 I think to be responsible, we really should think
20 a little bit about whether it should be hospital-centric if
21 you're going to pour \$7 billion into trying to support the
22 uninsured or the underinsured. Where would be the best

1 place to put those dollars?

2 And in part of the reporting in that supplemental
3 schedule 10, that hospital thing, we might want to add
4 something about community health centers that are supported
5 by you, or for physician -- a lot of teaching hospitals and
6 non-teaching hospitals have to pay the doctor to show up to
7 take care of the -- and I'm just trying to think, should we
8 just be hospital-centric about how this money gets
9 allocated? Or should we try to expand the way we think
10 about how \$7 billion ought to go to support the uninsured?

11 MR. HACKBARTH: Two quick reactions to that. One
12 is that given the press of other topics, all of the update
13 recommendations, the SGR report, et cetera, we don't have
14 the time or resources to invest a whole lot more in this.
15 Certainly, we could mention that in the text.

16 The second reaction is your comment reminds me of
17 a piece I saw in the New York Times I think about two weeks
18 ago. It focused on hospitals actually deciding well, the
19 way to deal with this from their own standpoint is to do
20 outreach to patients. And they focused on care for
21 diabetics on an outpatient basis. As opposed to waiting for
22 them to land in the hospital and become a very expensive

1 uncompensated care case, why don't we invest some dollars
2 further down the pipeline and try to get them better care on
3 an ongoing basis? Which would be very consistent with what
4 you said.

5 DR. HOLTZ-EAKIN: Given your summary, I may be in
6 the distinct minority but I think it's important to
7 recognize that this is not a Medicare problem. This is not
8 about serving the Medicare population at all. So I don't
9 think it belongs in Medicare.

10 I was the one who suggested Medicaid, not because
11 I wanted to trumpet the virtues of the Medicaid DSH payment.
12 I don't. It's an awful setup. But there are these two
13 disconnected systems, ostensibly under the same problem.

14 If you're going to keep this in Medicare for
15 reasons that are outside the standard objectives of Medicare
16 policy, they ought to at least be coordinated. It doesn't
17 make any sense to me to have two bad systems floating around
18 out there not hitting a problem that's very real.

19 So I'm not suggesting you put the money in
20 Medicaid, at all. I don't want that misunderstood.

21 Then there are two things that I think are
22 overstated. First of all, I think the financing issue is

1 irrelevant. Medicaid is general revenue. Medicare is
2 general and payroll taxes. The dollars flow back and forth.
3 So I wouldn't worry about that a bit.

4 And I don't think going forward, and this is pure
5 speculation, an enormous difference between the stability of
6 appropriated and mandatory programs. Everything is going to
7 be under fire and the Congress has shown a steady
8 willingness to fiddle with mandatory programs on an annual
9 basis. So that labeling is also, I think, largely illusory.

10 I think if you've got a poorly targeted program
11 that's costing money, you're a target. And it's better to
12 have a program that makes some sense somewhere, it's more
13 likely to be stable in a political environment if it makes
14 some sense. And that's what I think we should aim for.

15 DR. CROSSON: I would support the approach you
16 outlined.

17 I have one technical question, and it has to do
18 with the future accuracy of the data on uncompensated care
19 and sort of thinking about the problem we're going to look
20 at two or three years from now.

21 I couldn't tell from the information about the S-
22 10 form or the suggestions for improving it that you're

1 going to put in. Is the quantitation a function of hospital
2 charges or hospital costs?

3 MR. ASHBY: The hospitals would report charges and
4 they would be converted to costs with an RCC.

5 MR. BERTKO: I'm going to agree with you, Glenn,
6 on saying that whether it's payroll tax or general revenue
7 is outside of our domain. Other people are paid and elected
8 to do this.

9 But I'll disagree with Doug and say that I would
10 certainly want us to have some modest discussion because the
11 Part A trust fund will run out soonest of all of all of
12 these things and put some pressure on the payroll tax. I
13 think a general revenue source here is preferable over the
14 long run.

15 DR. SCANLON: Just to raise -- I think you have
16 set out some good objectives. But there's a question of how
17 far you go and whether you're trying to make an incremental
18 change to what we have now which might produce better
19 targeting versus trying to make a much better program and
20 meeting a lot of objectives and having Medicare as the
21 administrative of it. I think if we take everything that
22 you say we may be in that latter camp.

1 I could think about how I could improve targeting,
2 still use payments per Medicare admission, and take into
3 account the Medicare admissions relative to their
4 uncompensated care load, and get the money in the right
5 places. I don't know exactly how I'd do a finite pool in
6 terms of controlling that over time without some kind of a
7 new structure within Medicare.

8 And then as we start to move in that direction, if
9 we're to take Nancy's idea and say it's not just hospitals,
10 we're again moving and broadening the objectives, making it
11 harder to say we're doing this in the context of Medicare.

12 Just a comment on Medicaid. I think the problem
13 we would face on the Medicaid side is Medicaid is not
14 homogeneous. We've got 56 formulas out there. And it would
15 be this issue of how do we impose something that requires
16 rationality on the part of all 56 of the Medicaid programs
17 to coordinate with Medicare.

18 So that's why I think it's not someplace we can
19 go, or the Congress, even. The Congress has been reluctant
20 about too many mandates on states.

21 DR. HOLTZ-EAKIN: Just to make my point clear, my
22 point is not that we're going to impose anything on

1 Medicaid. I have no illusion about that. Tennessee doesn't
2 get any Medicaid DSH payments. Zero. They missed the boat
3 in 1997. So in designing anything you do in coordination
4 with Medicaid, you have to recognize that. That's all.

5 MR. DURENBERGER: I'll do this quickly. I didn't
6 want Dough to be the only one on the Commission aligned with
7 the theory of why are we in this business, and I only
8 reacted in response to what John said, if we are -- as we
9 should be -- really truly concerned about the bankruptcy of
10 Medicare then we should get out of both of these businesses,
11 IME and DSH.

12 I don't think we're prepared to say that, but I
13 think it is a reality that these are institutional support
14 payments in which it would be nice if everybody thought it
15 was a good idea, but they don't.

16 And so as a consequence of that, I just
17 philosophically wanted to be associated with the idea that
18 if we had a vote on pulling Medicare out of both of these
19 programs and building up our capacity to reimburse for
20 performance in the system, I'd like to be associated with
21 that.

22 MR. HACKBARTH: Okay. We need to move on.

1 DR. MILLER: A quick process thing. What I'm
2 hearing here is this conversation will be reflected in a
3 draft chapter. The only recommendation we've spoken to is
4 the data collection one. And from a process perspective,
5 hopefully we can come back in December and maybe just deal
6 with that in sort of a very narrow way, take a vote on the
7 data collection. And then meanwhile, you're reacting to
8 what's written in the chapter, trying to capture these
9 concepts that we've all been talking about.

10 So you get a sense of the process and how it will
11 play out. Everybody see that?

12 MR. HACKBARTH: Okay. Thank you Jack and Craig.
13 We are now to update on Medicare private plans.

14 Welcome, Carlos. This is your first time at the
15 table. Who's going first?

16 MR. ZARABOZO: I'll be going first.

17 The three of us will be talking about topics
18 related to private plans in Medicare. We'll give you an
19 update of enrollment figures for 2006, plan payments as they
20 compare to fee-for-service expenditure levels, and
21 beneficiary access in 2007 to MA plans. We'll also be
22 reviewing past recommendations that the Commission has made

1 related to Medicare Advantage and Part D.

2 As far as enrollment, this slide shows that
3 there's been a significant growth in enrollment in 2006. As
4 of July, overall enrollment in private plans stood at 7.4
5 million. This includes MA plan that participate in the
6 bidding process and other plans such as cost plans that do
7 not bid.

8 Between December 2005 and July 2006, the overall
9 enrollment grew by 1.2 million or 20 percent. As a result,
10 total penetration was at 17 percent as of July. That is 17
11 percent of the Medicare population is enrolled in private
12 plans through which the beneficiaries receive their Medicare
13 A and B benefits. This is very close to the historical high
14 of 18 percent in 1999.

15 Enrollment growth has been particularly strong in
16 rural areas where the rate of growth was 77 percent. We
17 should note, however, that 40 percent of the rural MA
18 enrollees are in private fee-for-service plans and in rural
19 areas over half of the enrollment growth, 52 percent, is
20 attributable to the increased enrollment in private fee-for-
21 service plans.

22 This next slide gives you an indication of what is

1 happening in private fee-for-service. The total enrollment
2 growth is 20 percent but in private fee-for-service between
3 December 2005 and July 2006 the enrollment growth was 270
4 percent, compared to 11 percent in local managed-care plans.

5 Regional PPOs, which had only 82,000 as of July,
6 they are not available in the previous year. And non-
7 bidding plans such as cost plans had a decline in
8 enrollment. As pointed out in the note there, nearly half
9 of the total enrollment increase is in private fee-for-
10 service plans in this time period.

11 To set the stage for the discussion of the MA
12 benchmarks and payments, this slide is a reminder of the
13 Commission's position with regard to payment neutrality and
14 payment of Medicare Advantage plans. The Commission
15 strongly supports private plans in Medicare and believes
16 that beneficiaries should be offered the choice of delivery
17 systems between Medicare fee-for-service and private plans.
18 However, the Medicare program should be financially neutral,
19 that is the program should not pay more for one choice
20 versus another. If beneficiaries are given this choice,
21 over time they will gravitate to either the fee-for-service
22 system or private plans, depending on what they view as the

1 most efficient and highest quality option for them.

2 In that context, we'll review now our updated
3 analysis of plan payments in relation to fee-for-service
4 levels.

5 Our analysis of MA benchmarks and payments is an
6 update of an earlier analysis that was published as an issue
7 brief in June of this year. The updated analysis is based
8 on July 2006 enrollment data whereas the earlier analysis
9 was based on the distribution of enrollment as of December
10 2005. The updated analysis has similar findings overall,
11 which are that enrollment weighted benchmarks are at 116
12 percent of fee-for-service expenditure levels across all
13 plans, which is very similar to the prior level of 115
14 percent, and that payments based on the plan bids are at 112
15 percent of fee-for-service costs for the counties where the
16 MA enrollees reside.

17 The change in the overall numbers, that is the 1
18 percentage point change, is primarily due to the effect of
19 the increase in private fee-for-service enrollment. The
20 next slide presents more detailed information by plan type.

21 Here we repeat the overall numbers of 116 and 112
22 along with the overall enrollment, but we're looking at

1 individual plan types except that we have not included
2 500,000 enrollees in special needs plans.

3 The HMOs have the lion's share of enrollment among
4 these four types of plans and therefore constitute the major
5 component of the overall numbers. For the HMOs, plan
6 payment levels are closer to fee-for-service expenditures
7 compared to the other two major plans in terms of
8 enrollment.

9 For the next category, local PPOs, they're bid-
10 based payments are close to the benchmark levels. The local
11 PPOs are drawing enrollment from counties where benchmarks
12 are high in relation to fee-for-service expenditures for
13 those counties at 120 percent. Enrollment in local PPOs is
14 not very high, at about 4 percent of the overall enrollment.

15 Similarly, for regional PPOs, enrollment is very
16 low and payment is very close to the benchmark. Benchmarks
17 are 112 percent of fee-for-service in part because of the
18 way the benchmarks are computed for regional plans, which is
19 based on the weighting of local county level benchmarks
20 weighted by the population in those counties.

21 The last category shown here are the private fee-
22 for-service plans. The payments for these plans at 119

1 percent of fee-for-service are the highest of any plan
2 category. Compared to other plan types, the benchmark
3 levels for these types of plans are also the highest in
4 relation to fee-for-service. Almost 90 percent of the
5 private fee-for-service enrollees are in floor counties,
6 that is in counties in which there was legislation
7 establishing a minimum private plan payment level.

8 The next slide discusses benchmarks and bids as
9 they relate to rebates.

10 As you are aware, the MA program is a bidding
11 program. The law specifies county level and region level
12 benchmarks against which plans bid. If a plan bids above
13 the benchmark, the plan is paid the benchmark level and
14 beneficiaries would pay a premium representing the
15 difference between the benchmark and the bid. The benchmark
16 represents the maximum Medicare program payment to the
17 health plan.

18 for a plan that bids below the benchmark, 25
19 percent of the difference is retained in the trust funds and
20 the remainder, 75 percent, are rebate dollars that plans use
21 to provide lower premiums, including lower Part D premiums,
22 lower cost-sharing, or extra benefits to their enrollees.

1 So total payments to the plan, in that case, consist of the
2 bid base payment plus the rebate amount.

3 The rebate amounts vary among plan types with the
4 highest rate of rebates, expressed as a percentage of fee-
5 for-service expenditures, being among HMO plans and the
6 lowest level being among regional PPOs.

7 Scott will now discuss plan availability.

8 DR. HARRISON: Private plan alternatives to the
9 fee-for-service Medicare program are now available to all
10 Medicare beneficiaries, a very slight change from last year
11 or this year actually when 99.6 percent of beneficiaries had
12 access to a private plan, and a significant increase from 84
13 percent in 2005.

14 There was not much growth in beneficiary access to
15 local coordinated care plans in the past year. For purposes
16 of categorization, we consider HMOs and PPOs to be
17 coordinated care plans. In 2007, 81 percent of Medicare
18 beneficiaries will have a local HMO or PPO plan operating in
19 their counties of residence, up from 80 percent in 2006 and
20 up from 67 percent in 2005.

21 I want to note also that the 81 percent figure is
22 a national average that doesn't show the large differences

1 between urban and rural areas. Less than half of rural
2 beneficiaries have access to a local coordinated care plan,
3 while more than 90 percent of urban beneficiaries have
4 access to such a plan. This large difference does not occur
5 for the other plan types.

6 Access to regional PPOs was unchanged with no
7 plans entering the five regions that didn't have plans in
8 2006, although those regions that have plans in 2006 will
9 tend to have more plans in 2007.

10 Private fee-for-service plan availability,
11 however, has increased substantially in 2007 to virtually
12 100 percent of beneficiaries. In 2006 private fee-for-
13 service plan service areas had included 80 percent of
14 Medicare beneficiaries and that was up from 45 percent in
15 2005.

16 Overall, most plan types are widely available and
17 beneficiaries will have many more plan options to choose
18 from in 2007 than in the past. An average of 20 plan
19 options are offered in each county in 2007, compared with 12
20 plan options offered in 2006 and five per county offered in
21 2005.

22 Now I will briefly touch on two plan variations

1 that are not detailed on this table but are experiencing
2 rapid growth for 2007, the MSA plans and special needs
3 plans.

4 High deductible plans linked to Medicare Savings
5 Accounts, or MSAs, will be available for the first time in
6 2007. MSA plans combine packages with high annual
7 deductibles and catastrophic level beneficiary out-of-pocket
8 caps with savings accounts that can be used to pay for
9 covered health care services below the deductible and for
10 qualified services that are not covered under the package.

11 MSA plans will be available in 38 states and the
12 District of Columbia through one insurer. The deductible
13 will range between \$2,500 and \$4,500 depending on the
14 county. The deductible level is equal to the catastrophic
15 cap, as required by law. Beneficiaries pay the full
16 Medicare allowable costs for care until they reach the
17 deductible and then the plan pays for all Medicare covered
18 care about the catastrophic cap.

19 The sole source of funds for the MSA accounts is
20 the Medicare deposit to the account consisting of the
21 difference between the plan bid and the benchmark. The
22 entire amount is deposited in the beneficiaries' account.

1 There is no retention of the 25 percent in the trust funds,
2 as Carlos indicated would be the case for other types of MA
3 plans with bids below the benchmark.

4 The plans cover Medicare A and B benefits only, as
5 MSA plans are not permitted to offer plans that include drug
6 coverage. Of course, the beneficiaries can choose to buy
7 their own Part D coverage.

8 In addition, beneficiaries in New York and
9 Pennsylvania can join a demonstration plan that is a
10 variation of the MSA model. In the demonstration there are
11 separate deductibles and catastrophic caps. The
12 demonstration plan can pay for some care such as preventive
13 care below the deductible and also, for the demonstration
14 plan, there is cost sharing for expenditures that occur in
15 the range between the deductible level and the catastrophic
16 cap.

17 Including both the MSA plan and the demonstration,
18 77 percent of beneficiaries will have access to an MSA plan
19 in 2007.

20 Special needs plans, or SNPs, are allowed under
21 the 2003 MMA. They are MA plans in all ways, except they
22 are able to restrict their enrollment to one of three groups

1 of beneficiaries, the Medicare/Medicaid dual eligibles, the
2 institutionalized, and beneficiaries with certain chronic or
3 disabling conditions. It is also expected that the plans
4 will offer special benefits tailored to these groups of
5 beneficiaries.

6 The number of SNPs have grown exponentially to 276
7 plans this year and will grow to well over 400 plans next
8 year. Over 80 percent of the SNPs this year are for dual
9 eligibles. There are only 13 chronic condition plans and
10 there are 37 institutional SNPs, but most of those are
11 offered by one insurer who had previous offered similar
12 plans under a demonstration.

13 The growth in SNPs will increase the percentage of
14 Medicare beneficiaries that have an opportunity to enroll.
15 In 2006, 59 percent of Medicare beneficiaries live in
16 counties where some type of SNP is offered. In 2007, 76
17 percent of Medicare beneficiaries will live in a county
18 where a SNP is operating.

19 The distribution of plans will change for 2007.
20 Most of the growth is in chronic and institutional plans
21 although again in the institutional market one insurer will
22 offer almost 60 percent of the plans.

1 Now looking quickly at enrollment, in July there
2 were about 440,000 beneficiaries enrolled in the dual
3 eligible SNPs, about 70,000 enrollees in the chronic
4 condition plans, and about 20,000 in institutional SNPs.
5 Combined there were more than half a million beneficiaries
6 in special needs plans.

7 I am now putting up our recommendations from our
8 June 2005 report, which is the last time we made formal
9 recommendations on the Medicare Advantage program. This
10 will serve as a reminder of our positions on Medicare
11 Advantage because they will be included in the private plans
12 chapter.

13 We recommended that the Congress should set the
14 benchmarks at 100 percent of fee-for-service costs and those
15 fee-for-service costs should be calculated without including
16 the indirect medical education payments that the Medicare
17 program makes directly to hospitals on behalf of all
18 Medicare payments, both fee-for-service and private plan
19 patients.

20 If the benchmarks are set at 100 percent of fee-
21 for-service, we further recommended that any savings from
22 plans bidding below those benchmark should be redirected to

1 a fund that would redistribute the payments back to the
2 plans based on their performance on quality measures.

3 We also recommended that the Congress make a
4 technical adjustment to the calculation of regional
5 benchmarks so that local plans and regional plans would be
6 on an equal footing, and similarly, if you go down to the
7 bottom bullet, we recommended that Congress eliminate the
8 stabilization fund that would allow higher payments for only
9 the regional PPO plans. And we recommended that the
10 Secretary collect enough quality data from the traditional
11 fee-for-service Medicare program to enable comparisons
12 between fee-for-service Medicare and the private plans.

13 Now Rachel will discuss our past recommendations
14 as they relate to Part D.

15 DR. SCHMIDT: Last month I told you about two
16 demonstrations that CMS initiated for Part D. Just to
17 review, current law says that for 2007 CMS should weight
18 Part D plan bids by their levels of enrollment in 2006, when
19 figuring out the national average bid, plan payments and
20 enrollee premiums for 2007. CMS is also supposed to use
21 enrollment weighting to figure out the thresholds that
22 determine which plans are premium free to beneficiaries who

1 receive Part D's low-income subsidies.

2 CMS made the decision to transition to enrollment
3 weighting for both of these purposes in two separate
4 demonstrations. Under the first demonstration, this means
5 that enrollees will pay lower premiums than they would
6 otherwise because there's a higher federal subsidy. Under
7 the second demonstration, this means that more plans
8 qualified to be premium-free to beneficiaries who receive
9 Part D's low-income subsidies. So fewer low-income
10 enrollees will need to switch plans for 2007 or beginning
11 paying part of the premium to stay in their current plan.

12 Now according to CMS's Office of the Actuary,
13 these two demonstrations will cost \$1 billion in 2007. They
14 will also have costs in future years but we don't know how
15 much yet because CMS has not determined over how many years
16 enrollment weighting will be phased in.

17 The Office of the Actuary estimates that the
18 second demonstration will reduce the number of low-income
19 enrollees who would otherwise need to change plans or pay
20 some of their premium to 500,000 people from what would have
21 been 3.3 million people under current law.

22 CMS took this action using its general

1 demonstration authority, which brings me to this
2 recommendation on the slide. The Commission supported this
3 recommendation last January in a report to Congress about
4 how changes in payment policy are affecting oncology
5 services, and you may want to consider whether you'd like to
6 repeat this recommendation for our upcoming March report
7 within the context of these Part D demonstrations.

8 The recommendation reads: The Secretary should use
9 his demonstration authority to test innovations in the
10 delivering of quality of health care. Demonstrations should
11 not be used as a mechanism to increase payments.

12 An ongoing concern of the Commission is that
13 Congressional support agencies and other organizations
14 obtain access to Part D claims data in a timely manner. The
15 Commission needs drug claims to help us carry out our
16 mandate of advising the Congress on Medicare policy. Until
17 recently, CMS has not been very clear about whether it had
18 authority to use Part D data for purposes other than
19 payment. In other words, it wasn't even clear that other
20 parts of CMS that are not involved in payment, such as those
21 that conduct evaluations of Part D and other types of
22 research, could have access to the claims.

1 Last month the Agency issued a proposed rule that
2 clarifies their authority to make claims data available to
3 other parts of CMS and to private researchers and other
4 Executive Branch and Congressional support agencies so long
5 as they sign daily use agreements. That proposal would rely
6 on CMS's authority to add additional terms to its contracts
7 with plans to make this happen. If this proposed rule goes
8 forward, it would address concerns that the Commission has
9 raised, but there's no guarantee that it will necessarily go
10 forward.

11 Unlike some of CMS's other proposed rules, there's
12 no obvious deadline that drives this process of moving this
13 proposed rule forward, other than the fact that CMS wants to
14 use claims data for evaluation of Part D and other
15 nonpayment reasons.

16 You maybe also interested to know that Senators
17 Grassley and Baucus introduced a bill in September that
18 would explicitly give authority to CMS to share Part D data
19 with other government agencies, Congressional support
20 agencies and private researchers.

21 The Commission supported a recommendation in our
22 June 2005 report about Part D data. The recommendation then

1 reads: The Secretary should have a process in place for
2 timely delivery of Part D data to Congressional support
3 agencies to enable them to report to the Congress on the
4 drug benefits impact on cost, quality, and access. You may
5 want to consider whether you would like to repeat this
6 recommendation in our March 2007 report.

7 Another option that you may or may not want to
8 consider would be to provide more certain guidance through a
9 change in law by, for example, adding a few words to this
10 recommendation, beginning by reading Congress should direct
11 the Secretary to put a process in place to again have a
12 timely delivery of Part D data, and so on.

13 That's the end of our presentation. Were happy to
14 take comments and questions.

15 MR. BERTKO: A couple of comments. First, a
16 compliment on the three of you, getting through this set of
17 slides as quickly as you did.

18 On the MA slides, one, I think directionally all
19 of your answers are certainly in the right direction. And I
20 will only quarrel on the magnitude very slightly. As I
21 mentioned to Scott and Carlos earlier, the infamous VA/DOD
22 ghost is still not present yet here. It's worth something

1 and there's urban legend that it might appear in the rate
2 book next year. But what it is is it's a small amount,
3 perhaps a percent or so, that is understated in the rate
4 book and so the comparison of the 112 is probably a little
5 bit less than that.

6 A second point on this is just to remind everybody
7 here for 2007 the BNRA, Budget Neutral Risk Adjuster phase-
8 out begins, dropping from 100 percent amount in '06, for
9 example, to 55 percent. I don't know what other companies
10 will do, but our modeling would show that's a significant
11 drop, perhaps as much as 2 or 3 percent, out of that. Scott
12 and I have had these discussions a couple of times already.
13 So I'd just throw that out there as a somewhat unknown,
14 because there are several other moving parts, including who
15 signs up where.

16 Lastly, just a comment that companies like ours
17 and people trailing us quickly behind are doing what we
18 think Congress intended us to do, which is to march into
19 rural areas and offer health plans. More important than
20 just offering the health plans, our enrollment now is of a
21 scale and experience that we're beginning to see things.
22 And private fee-for-service is not a formal coordinated care

1 plan, but we're doing a lot of stuff there. And we're
2 seeing some efficiencies again -- and I won't give you a
3 number -- but measurable. We think that with more
4 experience, we will be able to gain some more.

5 So I would suggest again that while I support our
6 recommendation overall, giving us time to achieve those in
7 order to continue offering these things in rural areas is a
8 good idea.

9 DR. REISCHAUER: I'll start with a quip to you.
10 You said you're gaining efficiencies in rural areas, which
11 probably helps Humana. But how does it help Medicare?

12 MR. BERTKO: Well, over the long run --

13 DR. REISCHAUER: Okay, that's enough.

14 [Laughter.]

15 DR. REISCHAUER: I want to ask Scott just to
16 educate me and others a little bit about the MSA plans. You
17 said the deductibles were going to be between \$1,500 and
18 \$4,500. What's the size of the deposit that's being made
19 into the medical savings account, sort of a rough idea?
20 Question one.

21 Question two. Will there be a Medigap policy that
22 is available not for the amount below the deductible? But

1 once you're in the catastrophic realm the text here said
2 that the catastrophic plan pays everything that Medicare is
3 supposed to pay. But I didn't know if that left cost-
4 sharing or didn't leave cost-sharing, that it sucked up the
5 whole thing.

6 Then what price does the beneficiary pay below the
7 deductible? Do they pay the 100 percent of what Medicare
8 would pay? And so it will vary widely across the country
9 for the same service because Medicare's payments to
10 providers vary across the country?

11 And then what happens at the end of year one when
12 I have \$2,000 in my account and I've been just healthy as a
13 horse, and I sense something happening and I sign up for
14 John's plan the next year? What freedom do I have to use
15 the \$2,000 that's still in my medical savings account?

16 DR. HARRISON: First, we got some numbers from CMS
17 on the deposit amounts. I don't know that they're public
18 yet. The website is still a little funny on the MSAs. And
19 so I'll just say that it's between \$1,000 and \$2,000 per
20 year, in that range.

21 They pay 100 percent above -- no cost-sharing
22 above the deductible and no help below the deductible. You

1 pay the full Medicare rates. I believe they are guaranteed
2 to be able to get Medicare rates?

3 MR. ZARABOZO: Right, guaranteed the Medicare
4 rates. it is at the option of a plan to allow balance
5 billing if they want to do that, that is above the allowable
6 charge. If they want to.

7 DR. REISCHAUER: There's no Medigap coverage for
8 when I travel abroad or something like that?

9 MR. ZARABOZO: The Medigap situation is the same
10 as any other MA plan, which is Medigap does not pick up any
11 costs related to MA.

12 For one thing, even if you had a Medigap plan, no
13 coverage is possible because these are "non-Medicare"
14 covered.

15 DR. REISCHAUER: There's those coverages like
16 foreign travel coverage.

17 MR. ZARABOZO: Foreign travel, you could --

18 DR. REISCHAUER: Which an MA plan can cover.

19 MR. ZARABOZO: These plans can also offer optional
20 supplemental benefits. They cannot have mandatory
21 supplemental, but they can have optional.

22 DR. HARRISON: But they did not choose to offer

1 any this year.

2 MR. HACKBARTH: Can I ask you about what you said?
3 The plan may permit balance billing. How is that accounted
4 for relative to the deductible? Is the amount over the
5 Medicare fee counted towards meeting the deductible?

6 MR. ZARABOZO: I think so. I think if the plan
7 says we recognize 115 percent of the amount, the allowed
8 balance billing, I think that would be counted towards it.
9 I'm not entirely sure about that. But I assume that most of
10 them would say we will just recognize the Medicare allowed
11 amount.

12 DR. REISCHAUER: I want to know what happened to
13 my money at the end.

14 DR. HARRISON: You get to keep it in the account
15 and you can use it for any IRS qualified medical service.

16 DR. CROSSON: This is speaking to the draft
17 chapter and the restating of the recommendation with respect
18 to setting the MA benchmark at 100 percent of fee-for-
19 service.

20 I think, as we discussed at an earlier time, I
21 think in the original chapter there was a discussion about
22 trying to mitigate the impact of this by phasing this

1 recommendation over a period of time. I'd like to suggest
2 that we at least reiterate that or perhaps expand that part
3 of the text for a couple of reasons, and these were
4 discussed last year.

5 One is the fact that this change will undoubtedly
6 have an impact on beneficiaries. There will be an
7 acceleration of benefit reduction, most likely, as a
8 consequence of this. And as we've seen before, there's a
9 higher proportion of low-income beneficiaries in MA plans.
10 And therefore I think these individuals will need time and
11 the plans will need time to adjust to that.

12 The second point may be peculiar only to our
13 organization. Not totally, but we are the largest organized
14 delivery system serving Medicare beneficiaries, and almost
15 all through MA. And that has to do with the impact on
16 capital planning, particularly for an organization like
17 ours. We have about a seven-year time frame from the time
18 we conceive of the need for a hospital until we open the
19 door. Some of that has to do with the peculiarities of
20 California, but nonetheless that's the reality.

21 Both of those things, I think, speak to the need,
22 particularly for organized systems, which is what I can

1 speak best to, for some sort of reasonable consistency and a
2 timeline that matches the need to plan for capital
3 improvements, and also more recently for complex and
4 expensive information technology systems, the use of which
5 is another goal of MedPAC.

6 So I would just like to see, as we bring forward
7 this chapter, that we at least restate this issue and
8 perhaps expand on it to some degree.

9 MR. HACKBARTH: We, as you know, did discuss it
10 the last time in the report where we initially made these
11 recommendations. And we'll pull for that language and you
12 can take a look at it and we'll deal with that.

13 MR. DURENBERGER: Thank you. I was going to ask
14 the question Bob asked but I have another one that relates
15 to the dual eligibles. I really like the special needs plan
16 approach and the way the plans are adapting to it.

17 There's 440,000 people in dual eligibles today.
18 What's the alternative that's in place in most other places
19 for the dual eligibles? And to what degree is it being --
20 are these plans replacing something else?

21 DR. HARRISON: I think most dual eligibles,
22 whether or not they're in managed care on the Medicaid side,

1 are in the fee-for-service Medicare program and the state
2 Medicare program would pick up the copayments, sometimes.
3 Sometimes they set their rates below Medicare rates and so
4 there really aren't a lot of copayments that they pay. But
5 that's generally what happens.

6 A lot of the 440,000 that are enrolled were
7 actually what was called passively enrolled. This was a
8 one-time thing for 2006 where if you were in a Medicaid
9 managed care plan as a dual, that plan had the option to
10 become a SNP and to have you rolled in. You could opt out
11 if you didn't want to stay in that plan, but a lot of the
12 involvement came that way.

13 MR. DURENBERGER: I'm just curious as to where the
14 440,000 are coming from, also, because I assumed it would
15 relate in some way to whether or not you lived in a state
16 that had a program in which the states were contributing.

17 DR. HARRISON: As I recall, it was sort of in the
18 states with big managed care in general. We have not been
19 able to get the passive enrollment data to see sort of where
20 the big groups came from. So we haven't been able to do
21 that. And in general it just looked like big states had big
22 enrollment in the duals.

1 There were also some rollover from duals who were
2 already in managed care plans.

3 DR. CASTELLANOS: Rachel, I almost hate to bring
4 the subject up but the oncology demonstration project, where
5 are we going with that? I'll leave it like that.

6 DR. SCHMIDT: Joan was the author of this report.
7 She's the most knowledgeable person about it. But the
8 Commission has made this recommendation about the
9 demonstration. And I think the status of things -- Joan, do
10 you have more to add?

11 DR. CASTELLANOS: I have some very big concerns
12 over that demonstration project and the worthiness of it and
13 the validity of it.

14 MR. HACKBARTH: Those were the concerns that we
15 expressed that lead us, in part, to this recommendation.

16 To make a long story short, it looked like
17 demonstration authority was being used to increase payments
18 to oncologists without a serious design that would yield
19 data to help improve the program. So we considered that an
20 inappropriate use of the demonstration authority, and hence,
21 the recommendation.

22 Is that a fair summary, Joan?

1 DR. SOKOLOVSKY: I think that sums it up. Also,
2 that was in 2005. There was a much smaller demonstration in
3 2006, for which we haven't seen any data yet. Going
4 forward, we don't know that there's going to be anything.

5 MR. HACKBARTH: So these new demonstrations are
6 actually much, much larger in terms of their fiscal impact
7 and raise the same concerns about is this the right way to
8 make policy. And hence, the new recommendations to that
9 effect.

10 Let me just quickly check. We've got how many
11 draft recommendations in total, in this package? I'm not
12 counting the restatement of the MA. So it's just the two
13 that relate to Part D?

14 DR. SCHMIDT: Yes.

15 MR. HACKBARTH: People feel okay with those? I
16 just wanted to make sure.

17 All right, we are done with this topic for today
18 and down to our very last one, which is the first draft of
19 the context chapter.

20 MS. BURKE: Glenn, I apologize. Do we have a new
21 recommendation?

22 MR. HACKBARTH: There are two of them. They are

1 on pages 15 and 16 in the packet.

2 MS. BURKE: That's old language for new? This was
3 in the June report.

4 MR. HACKBARTH: We're using, as I said, the old
5 language to make a new point with regard to these Part D
6 demonstrations.

7 MS. BURKE: We're restating our old
8 recommendation?

9 MR. HACKBARTH: Using the same language but saying
10 this time it's not the oncology demonstration that we're
11 objecting to. This time it's these Part D demonstrations
12 that we're objecting to. And then the other one has to do
13 with access to claims information.

14 MS. BURKE: So the language we're going to use is
15 the language on 15 and the language on 16, which mimics the
16 language which was --

17 MR. HACKBARTH: Exactly.

18 DR. SCHMIDT: Just to clarify with respect to the
19 Part D claims one, I kind of gave you two options. One was
20 to use the language as given. Or if you believe there needs
21 to be a stronger force of law, you could modify it slightly
22 to say that the Congress could require the Secretary to have

1 in place is process.

2 MR. HACKBARTH: Okay. Context.

3 DR. SCHMIDT: Each year in our March report, we
4 include a chapter that puts the Commission's recommendations
5 on payment updates within their broader context. To help us
6 think about that chapter, last September we brought to a
7 panel of experts who gave their perspectives about
8 Medicare's financial sustainability and what to do about it.

9 Several of those panelists spoke about how
10 Medicare's situation is really part of a bigger crisis, a
11 general problem that the entire country is facing due to
12 rapid growth in health care spending. Today, I'm going to
13 quickly remind you about Medicare's financial situation.
14 We've talked about it on several occasions. But in the
15 spirit of what our panel experts told us, we'll also talk
16 about some of the broad forces that have gotten Medicare and
17 other payers into our current situation.

18 Just to review what the Medicare trustees found
19 for 2006, the trustees project that the trust fund for Part
20 A will be exhausted by 2018. Medicare has no authority to
21 make payments once the trust fund is exhausted, so Part A
22 will require major new sources of funding.

1 The SMI program's trust fund is financed primarily
2 with general revenues and beneficiary premiums. And just to
3 remind you, general revenues are federal tax dollars that
4 are not dedicated to a particular use and they're made up of
5 individual and corporate income taxes.

6 The SMI trust fund technically cannot be exhausted
7 like Part A's trust fund. However, the trustees say that
8 SMI would need very large increases in revenue to cover
9 projected spending. This means that fewer resources will be
10 available for other federal priorities. And also, on
11 average, beneficiary premiums and cost-sharing will grow
12 more rapidly than incomes.

13 Under current law, the trustees are to warn the
14 Congress whenever 45 percent or more of Medicare outlays are
15 financed with general revenues. This is known as the 45
16 percent trigger. The trustees said that general revenue
17 funding would reach 45 percent in 2012. If they have the
18 same finding in next year's trustees' report, the Congress
19 must consider legislative changes to Medicare by the spring
20 of 2008.

21 This slide is just to remind you that Medicare is
22 not in this situation alone. All payers are confronting

1 health care spending that is growing considerably faster
2 than our national income, and that's shown on this slide by
3 the general upward trajectory of all of those lines.

4 The draft in your mailing materials talks about
5 some of the consequences of rapid growth in health spending.
6 Some consequences are good. Our health care system
7 generates a lot of medical innovations and some of those can
8 improve health outcomes. But other consequences are more
9 worrisome, such as the decision of some workers to forgo
10 taking up health insurance because the price of payments is
11 so high, or the decisions of some employers to quit offering
12 health coverage.

13 These are worrisome in the sense that the United
14 States has a relatively large uninsured population and
15 increases in the numbers of uninsured can raise demand for
16 public coverage and, in order to finance providers
17 uncompensated care, can raise health care costs for those
18 who are insured.

19 In most sectors of the economy, we rely on market
20 forces to set prices and determine how to allocate
21 resources, whether more of our societal resources should go
22 to produce iPods or televisions, for example. But

1 economists have long argued that health care is different
2 from other sectors in some important ways.

3 First, in other sectors, consumers are deciding
4 whether or not they want to buy an iPod and then they do so
5 if at its price the iPod has greater value to them than
6 other things they could purchase. In the case of health
7 care, patients often don't know what services they need.
8 Sometimes they don't know what condition they have. And
9 rarely do they do what the price of those services. They
10 rely on providers, usually physicians, to diagnose them and
11 help them decide what treatment they need. Providers have
12 to tailor these services for each individual patient. And
13 while the professionalism of providers usually leads them to
14 try to furnish appropriate care, providers often do not know
15 exactly what their patients would prefer among treatment
16 options.

17 There's also a huge amount of uncertainty
18 surrounding decisions about treatment. There are simply
19 limits on our society's medical know-how and certainly
20 limits on how much anyone provider can know. For these
21 reasons, there may not be much consensus on what type of
22 care is appropriate for certain patients. Similarly,

1 providers do not always know the relative value of newer
2 technologies compared with alternative therapies and may use
3 newer technologies more broadly than their relative value
4 merits.

5 Most patients pay for their care through
6 insurance. There is some substantial literature that
7 suggests that at the margins such coverage leads patients
8 and their providers to use more care or more expensive care
9 than they would otherwise.

10 Finally, some parts of the health care sector are
11 less competitive than others. For example, some providers
12 may have a local monopoly for their area or maybe there is
13 no comparable alternative treatments for a new medical
14 technology. This can lead to relatively high prices and
15 sometimes little incentive to improve efficiency over time.

16 So most of these are general characteristics of
17 providing health care that all types of payers face. These
18 characteristics, along with the incentives that are built
19 into particular payment arrangements, can affect how well
20 prices act as signals of value in this sector of the
21 economy. When prices are not very good signals, that can
22 lead to a misallocation of resources over time. For

1 example, if RVUs for certain physician services become
2 overvalued, over time that may affect the decisions of
3 medical students about whether and how they want to
4 specialize.

5 I don't want to spend much time on this slide but
6 it's here to remind us that as market oriented as our
7 economy is, federal and state governments are heavily
8 involved in health care. Governments get involved as a
9 regulator, as a major payer through incentives it creates
10 through tax policy, gets involved in promoting public
11 health, and to conduct and finance medical research.

12 People can and do certainly argue over whether
13 some of these roles for government are justified or whether
14 the governments can carry out these roles well. But again,
15 this is just to remind you that the role of the government
16 in health care is substantial today.

17 Federal and state governments get involved in
18 health partly because of the characteristics of health care
19 I just outlined in the previous slide. But they also get
20 involved in order to address other redistributive goals, as
21 we've talked about today.

22 Let's turn now to some of the forces driving

1 growth in spending for all payers in our health care system.
2 One of the most important forces is income. Many
3 international comparisons of health care spending point out
4 that there is a strong correlation between a country's GDP
5 and its health care spending.

6 One recent paper argues that we should expect to
7 continue to spend more on health care. As our standard of
8 living continues to grow, the U.S. could reasonably expect
9 to spend 30 percent of its GDP on health care by the middle
10 of the century, according to these estimates, compared with
11 about 16 percent today. The argument goes like this: as
12 individuals become better off and their consumption
13 increases over time, the incremental value to people of
14 buying another iPod or another television falls but, by
15 comparison, the value to them of extending their life
16 doesn't fall as quickly.

17 However, even if you support this point of view,
18 there's still the question of how much more we will spend in
19 the future, as well as how to finance it. Given evidence of
20 inefficiencies in health care spending, it's hard to argue
21 that all health care spending is appropriate.

22 Other factors driving growth are insurance and

1 technology, and the two are interrelated. I already touched
2 on the point that when an individual patient and provider
3 are deciding about treatment options, insurance can lead
4 them to use more care or higher price services, and often
5 those include newer technologies.

6 However, a recent paper suggests that insurance
7 may have bigger effects when you look more broadly than at
8 the individual level. Amy Finkelstein looked at what
9 happened to hospital spending around the country before and
10 after the start of Medicare. She found a bigger than
11 expected effect on hospital spending, and she believes that
12 the increase in demand for hospital care at the start of
13 Medicare lead more hospitals to enter the market and
14 encouraged them to expand and purchase new equipment and
15 that sort of thing.

16 Insurance coverage and our rising standard of
17 living have helped to finance innovations in medical
18 technology. David Cutler and his colleagues recently
19 published a study arguing that, on average, increases in
20 health spending, which he largely attributes to advances in
21 medical technology between the years of 1960 and 2000
22 provided reasonably good value in terms of gains in life

1 expectancy. The same study notes, however, that the average
2 cost per life year gain has been declining over time and
3 growth in costs for the elderly in particular have been
4 outpacing gains in life expectancy.

5 At the same time, the literature by Fisher and
6 Wennberg continued to point out that there is considerable
7 geographic variation in Medicare spending and that higher
8 spending is uncorrelated and sometimes negatively correlated
9 with indicators of quality. From this, the authors believe
10 that a sizable amount of spending is inefficient.

11 Another force driving health spending is our
12 country's underlying health status and related changes in
13 provider's patterns of care. A recent study by Thorpe and
14 Howard estimates that most of the growth in health care
15 spending for Medicare beneficiaries between the years 1987
16 and 2002 can be attributed to patients with five or more
17 conditions. The proportion of beneficiaries with that many
18 conditions grew from about 31 percent in 1987 to about 50
19 percent in 2002. At the same time people who have five or
20 more conditions now have a higher self-reported health
21 status. In 2002 about 60 percent of them said that they
22 were excellent or good health compared with about 33 percent

1 in 1987.

2 The authors conclude from this that providers are
3 treating healthier patients, maybe lowering their thresholds
4 for treatment, and that treatment is improving health
5 outcomes, or both are occurring.

6 The authors also believe that obesity plays a part
7 in this because many obese individuals have multiple
8 comorbidities and the prevalence of obesity has been growing
9 substantially.

10 The back end of the draft chapter discusses
11 approaches policymakers could use to address Medicare's
12 financial sustainability, and I've shown them on this slide.
13 I should note that one area we were looking at for the June
14 2007 report looks at potential changes to Medicare's premium
15 and cost-sharing, its benefit design, as well as the role
16 that supplemental coverage pays in that. That's just a
17 pitch for future work we have going.

18 The draft chapter for March that was in your
19 mailing materials also talks about how the effectiveness of
20 policy changes could vary across health care sectors and
21 depends on other broad trends in health care delivery. For
22 example, if policymakers wanted to constrain payment rates

1 in Medicare's fee-for-service payment rates over a long
2 period of time and other payers were not doing the same
3 thing, that could backfire and lead to access problems for
4 Medicare beneficiaries.

5 With that I'll close and be happy to take your
6 comments.

7 MR. DURENBERGER: Thank you, Mr. Chairman, and
8 thanks very much, Rachel.

9 I've already sent my suggestions but I'd like to
10 reinforcement it wit just a brief conversation I had with
11 Humphrey Taylor on the telephone the other day. He's the
12 Harris Interactive person. He says lately in all my
13 speeches I say how many of the people in the audience
14 believe that there's a lot of inappropriate and unnecessary
15 health care in this country? And all the arms go up. He
16 says now let's have a show of hands for all of you who have
17 sought inappropriate or unnecessary care. Of course, no
18 hands go up.

19 [Laughter.]

20 MR. DURENBERGER: But I think the point of what I
21 was trying to contribute to the context is to start out
22 right up front and say the program's financial outlook and

1 wide variations in quality and cost to individual
2 beneficiaries are driving change in the health care system.
3 Just put it right up there and then speak to both as we go
4 through the context chapter.

5 We certainly have a record in the quality, the
6 performance area. And it just helps the reader of this
7 context to know why we believe that the financing, if we
8 could ever align the financing system with the results we
9 want in this country, that would save the Medicare program.

10 And so the same suggestion goes when we get to the
11 end to the various options, to talk about safety, and to
12 talk about quality, and talk about performance, and those
13 sort of things as specific ways in which we might reduce the
14 costs of an entitlement program.

15 MS. BEHROOZI: Thanks very much, Rachel. I hope
16 you husband is doing the daycare pick up tonight?

17 DR. SCHMIDT: Mother-in-law this time.

18 MS. BEHROOZI: I just want to go to the point
19 about restructuring benefits and controlling costs.

20 There's a danger in assuming that when people use
21 less services or products because there is a cost associated
22 with it that that is, in fact, controlling costs by

1 eliminating wasteful use or inappropriate use of costs or
2 services. In fact, use of services may go down but it may
3 be appropriate care that people are not accessing because
4 too great a share of the cost is being put on them. In
5 other words, the cost doesn't go away. It still costs a lot
6 of money. But by putting too much of that cost onto the
7 individual people don't access to care. It comes up in so
8 many different contexts.

9 You made a reference earlier to working people not
10 being able to afford the premiums to pay for insurance that
11 is so-called offered by their employers. Similarly, if
12 Medicare moves to a system where people on fixed incomes --
13 they may be, as you say in the paper, doing slightly better
14 than -- the elderly may be doing slightly better than they
15 did before in the aggregate. But individuals who are facing
16 a burdensome share of costs may be, as you do note in the
17 paper, avoiding appropriate care and then in the end costing
18 Medicare more because they haven't received appropriate care
19 at the appropriate time.

20 So I think we really need to be sensitive to that
21 and not presume every time that we see a reduction in use
22 because of a cost share to the person that that's a good

1 thing, and that that's lowering overall costs.

2 MR. HACKBARTH: The RAND health insurance
3 experiment years ago looked at that specific question and
4 found that higher cost-sharing lead to reductions in both
5 appropriate and inappropriate care.

6 Then the next question is did the loss of that
7 appropriate care affect health status? And with the
8 exception of low income people, they found no effect on
9 health status. Now the RAND health insurance experiment did
10 not include Medicare beneficiaries, but there is research on
11 the issues you're raising.

12 MS. BEHROOZI: Right, but the paper also cites
13 more recent research. And I think there's even more recent
14 research going on as cost-sharing has really gotten out of
15 hand. It's qualitatively different now, I think, across
16 society, not just in Medicare, than it used to be.

17 MS. HANSEN: Three short ones. One I spoke to
18 Rachel about.

19 Just kind of putting Medicare, as you noted in
20 your presentation, relative to the whole health care system
21 issue so that Medicare by itself, even though we are looking
22 down the pike of 2018, a big issue. So I just didn't want

1 to have, frankly, the politicalness of the programs of
2 entitlement almost kind of singled out. It's an issue of
3 the health care system.

4 The second one is to corroborate, I think, Mitra's
5 point about especially people who tend to be a little bit
6 more vulnerable, who this cost-sharing is high.

7 And I wonder, and I know this is more informal,
8 John and I were talking about whether or not there is a
9 different way to look at cost-sharing. In other words,
10 certain things that preventively we want people to do, there
11 should be no cost-sharing, and to do that preventively
12 versus things that are a little bit more questioned in terms
13 of there evidence base, there would be some tiered cost-
14 sharing.

15 The third and last point is the whole area, your
16 point about many of the diseases now, people have five
17 chronic conditions, and whether or not the whole
18 directionality of care coordination that we're going into
19 maybe could be -- it's in the chapter but it could be lifted
20 as a highlighted area because the nature of the Medicare
21 program is so different now than it was 40 years ago.

22 So raising that in terms of the directionality

1 side.

2 MR. BERTKO: One quick add-on to this recent
3 discussion that Jenny referenced and Mitra said. On
4 benefits, I think we should at least think about looking at
5 some minimum cost-sharing level. Several people today
6 referenced that it's not only the physicians who do this
7 but, as I think Dave joked, it's how many people have had
8 inappropriate care.

9 Supplemental insurance, whether it's a Medigap-
10 type or whether it's an employer-sponsored type, can
11 generate induced demand and everything else. So perhaps
12 with the context that evidence-based preventive care
13 services ought to be considered, as well.

14 Congress took some action, adding two Medigap
15 benefits with the MMA, this could be something.

16 The last one I would suggest also that we might
17 want to approach as a major topic is a public health
18 approach to obesity, much in the same way that 40 years ago
19 we had one to smoking. This is only for the current group,
20 but for say most of the people at this table who are
21 approaching Medicare age.

22 I'd just maybe put some words in about that if you

1 feel it's appropriate.

2 MS. THOMAS: I think the IOM just recently
3 released a report on the state of the art in where we are
4 with changing the trend on obesity. And we could certainly
5 characterize what they found in the report as a way to get a
6 little bit more specific.

7 MR. HACKBARTH: Okay, thank you, Rachel.

8 We will now have a very brief public comment
9 period.

10 That's just the right length.

11 [Laughter.]

12 MR. HACKBARTH: Thank you and we can reconvene
13 tomorrow at 9:30 a.m.

14 [Whereupon, at 5:30 p.m., the meeting was recessed
15 to reconvene at 9:30 a.m., on Thursday, November 9, 2006.]

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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.

Thursday, November 9, 2006
9:41 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
MITRA BEHROOZI
KAREN R. BORMAN, M.D.
SHEILA P. BURKE
RONALD D. CASTELLANOS, M.D.
FRANCIS J. CROSSON, M.D.
NANCY-ANN DePARLE
DAVID F. DURENBERGER
JENNIE CHIN HANSEN
DOUGLAS HOLTZ-EAKIN, Ph.D.
NANCY KANE, D.B.A.
ARNOLD MILSTEIN, M.D.
RALPH W. MULLER
WILLIAM J. SCANLON, Ph.D.
NICHOLAS J. WOLTER, M.D.

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P R O C E E D I N G S

MR. HACKBARTH: Good morning everybody.

We begin this morning with two sessions related to the SGR-mandated report and a distinguished panel to begin.

Cristina, will you do the introductions?

MS. BOCCUTI: Gladly. Good morning. Today we are lucky to have Dr. Fisher and Dan Gottlieb with us today from the Center for Evaluative Clinical Sciences at Dartmouth.

Dr. Fisher is a Professor of Medicine and Dan Gottlieb is a statistician at the Center and their research focuses on exploring both the causes and the implications for health and health policy of regional variations in Medicare spending and practice. They really don't need that much introduction because I think most of the commissioners are aware of their excellent body of work. Thank you.

DR. FISHER: Thank you very much, Glenn, Cristina. It's really a pleasure to be here.

The slides that I'll be presenting on the screen may have one or two changes from the slides that you have in front of you, just a heads up. I'll try to steer you in the right direction. We won't be talking about all of the detail that's in the slides in order for us to have plenty

1 of time for conversation.

2 Here's a map that many of you have seen and are
3 familiar with. There are huge regional differences in
4 spending across the country. I had a great pleasure of
5 presenting this to the Senate Finance Committee staff a
6 year-and-a-half ago and they complained bitterly about what
7 were the high cost or sort of bad states in their
8 perspective or bad regions being labeled red. So when I
9 went to the White House, I have a similar map that shows
10 exactly the same data. But whichever your preference is,
11 there are now two colors that you can use to label the
12 states.

13 When you look at the differences in spending
14 across regions, it is hard not to respect Uwe for what he
15 asked, which is how can the best medical care in the world
16 cost twice as much as the best medical care in the world?
17 What I'll try to summarize in the next two minutes is what
18 Dan and I and a lot of others have learned over the last 10
19 years.

20 When we look across regions of different spending
21 levels, and we've also repeated most of these studies at the
22 academic medical center or hospital level as well, comparing

1 populations served by different hospitals, we see the
2 following: higher spending regions have more hospital beds
3 per capita, more medical specialists, and more internists.

4 In terms of the content and quality of care, we
5 see on average that technical quality in the higher spending
6 regions of the United States is slightly worse, on average.
7 They don't get any more major elective surgery -- what Jack
8 Wennberg would call preference-sensitive care. But they do
9 get lots more hospital stays, many were frequent physician
10 visits, they're much more likely to be referred to
11 subspecialists. And if you're lying down and spending time
12 in the hospital and seeing more specialists, you also get
13 more tests and minor procedures because that's what we do
14 when you're there.

15 We've looked at the outcomes of care and we find
16 that the higher spending regions actually, adjusting for
17 everything we can do -- and that's the Annals studies that
18 Dan and I were working on and published in 2003 -- see
19 higher mortality in the populations who are cared for in the
20 higher spending regions. There's no improvement in their
21 function. We've now interviewed physicians across the
22 country. And when physicians describe the quality of care,

1 they say the quality of care is worse in the higher spending
2 regions than in the lower spending regions.

3 We have some preliminary data about patient
4 reported quality, mostly from California, in terms of
5 satisfaction with hospital care. The higher cost system's
6 patients seem to have less satisfaction with care. When we
7 look across the country, they perceive worse access to care
8 in the higher spending regions compared to the lower
9 spending regions.

10 The more worrisome finding was the one with the
11 Jon Skinner, Doug Staiger and I published in Health Affairs
12 in the spring or just about a year ago, when we know there
13 have been tremendous gains in survival following myocardial
14 infarction over the last 20 years. But interestingly, the
15 gains have been smallest in the highest spending regions and
16 those regions with the highest growth rates. The gains in
17 survival have been greatest in the more conservative
18 regions. The higher spending regions also seem to have the
19 greatest growth in per capita resource use following a heart
20 attack.

21 As a clinician and now as a sociologist studying
22 what's going on, the key difference in both growth and in

1 spending, growth over time and differences in spending
2 across regions, are related to this category of care that
3 Jack Wennberg and I have been referring to now for years as
4 supply-sensitive services. We've now used clinician
5 vignettes to look at physicians practicing in different
6 regions. They are equally likely in a high and low spending
7 to do the right thing when we know what the right thing is.
8 When the guidelines say do this particular treatment,
9 they're equally likely to do it in high spending and low
10 spending regions. The difference in spending is largely due
11 to discretionary decisions in the gray areas of medicine
12 where there is uncertainty about the right thing to do.
13 Should I see this patient in a month? should I refer them
14 to a specialist?

15 As I've tried to sort out what the problem is
16 likely to be, and I think yes, the likely diagnosis for --
17 unwarranted variations in care, poor quality, and growth in
18 spending is the problem of local capacity and culture and
19 the fact that now no one is accountable for local capacity
20 and political culture. Clinical evidence is an important
21 but very limited determinant of physician practice.
22 Physicians practice within a local organizational context in

1 a policy environment that profoundly influences their
2 decision-making. The payment system that we currently have
3 ensure that we're all able to stay busy. And any new
4 capacity, recruiting new physicians, a new orthopedic
5 surgeon, a new interventional cardiologist, is able to stay
6 busy as well. And that creates the culture within which
7 these physicians are practicing. They all need to stay
8 busy, they see their patients more frequency.

9 The consequence is that what appear to the
10 individual or to the system in the current payment system to
11 be reasonable clinical or policy decisions, recruiting new
12 physicians, lead in aggregate to the higher utilization,
13 greater costs, and inadvertently to the lower quality care
14 and the worse outcomes that we see.

15 So accountability capacity is going to be
16 essential to control the growth in spending.

17 So a theory, would be to strengthen local
18 organizational accountability for the decisions that drive
19 higher costs and worse quality, decisions about capacity,
20 what services to invest in in the local hospital, the local
21 community, whether to recruit physicians, whether to allow
22 certain physicians to practice within that community or

1 within that organization, the issues of accountability for
2 longitudinal costs and quality, and accountability for care
3 coordination and communication.

4 I've read your minutes, you're all familiar with
5 what we know about how many different physicians are
6 involved in a given patient's care and how many care
7 transactions are experienced. I'll come back to that in a
8 few minutes because I think some of the approaches that
9 we'll be laying out offer us a path forward to dealing with
10 these kinds of organizational accountability issues.

11 There are a number of potential approaches that
12 have been nominated. Individual physicians, the notion of
13 an advanced medical home, which you've all discussed.
14 Established multi-specialty group practices. The problems
15 are that individual physicians only control their own
16 practice and it is very hard, given the five physicians
17 involved or the hospitals that are involved, to think about
18 how a primary care physician is going to influence the
19 practice of a cardiologist across town. Establish multi-
20 specialty group practices are few and far between in current
21 U.S. health care.

22 So building on work that Mark and Peter Welch did

1 in the 1990s thinking about inpatient hospital stays and how
2 to foster accountability among physicians for the services
3 provided during hospital stays, we've tried to build a model
4 that extends that to all beneficiaries and all physicians
5 within the American health care system.

6 The empirical work I'll present really addresses
7 four areas: the feasibility of making the assignments to
8 these medical groups? Characteristics, do they seem to have
9 some kind of face validity? How could we measure
10 performance of these levels and what might the kinds of
11 measures we would be implementing look like? And then how
12 might the extended hospital medical staff work as a
13 framework for assessing volume growth? And then we'll have
14 some discussion of some of the advantages and disadvantages.

15 Feasibility. Let me briefly describe the general
16 approach we've taken to assigning patients. If a physician
17 works in an inpatient setting, we assign them to the
18 hospital where they provided care to the greatest number of
19 Medicare beneficiaries say saw. If they get no inpatient
20 work, we assigned him to the hospital where the plurality,
21 or actually the majority in most cases, of their patients
22 they billed for were admitted. So if you touch a patient,

1 you identify all the Medicare beneficiaries they touch, and
2 you see which hospitals they go to.

3 It turns out, not surprisingly, that you can
4 assign virtually all physicians billing Medicare to a
5 hospital. So 95 percent of the ones that we cannot assign
6 are either excluded because they are caring for patients in
7 a non-U.S. hospital or were in a specialty in some of the
8 few categories that we could not assign because we wanted to
9 know the specialty of the physicians.

10 When we look at the populations they serve, to how
11 to identify the population served by an extended hospital
12 medical staff, for all Medicare beneficiaries we assign each
13 patient to their predominant care physician, usually a
14 primary care physician or medical subspecialist. If they
15 did not see a primary care physician or a medical
16 subspecialists, we then allow very small percentage of the
17 patients to be assigned to a general surgeon or some other
18 specialist. That's the only other specialty to which we
19 assign patients, the predominant one.

20 An important methodologic advance we think we've
21 made recently is we first assign patients to their primary
22 hospital based on their physicians assignment. But we also

1 identified a secondary hospital for each hospital in the
2 country. Which hospital is the next most frequently used
3 hospital by the patients who are cared for at that
4 particular hospital?

5 There are many hospitals that have well-
6 established referral networks with another hospital.
7 Smaller hospitals will refer to a specialty hospital. In
8 our region, it's all of the outlying rural hospitals refer
9 their patients to Dartmouth-Hitchcock Medical Center. You
10 can imagine that there are well-established referral
11 networks. And so we also identified the secondary hospital
12 used by each beneficiary, each hospital's patients. It's
13 usually a referral hospital.

14 We can again assign virtually all Medicare
15 beneficiaries. If you saw a physician during a two-year
16 period, we can assign you to that physician. If you only
17 saw one physician, only had one visit, you still get
18 assigned. And we've been using the 20 percent sample and we
19 find that about 93 percent can be assigned to a U.S. acute
20 care hospital based on the visits that they've had during
21 that period.

22 The next question we address and will walk you

1 through a little bit is do these extended hospital medical
2 staffs have some kind of face validity? For the purposes of
3 this presentation, I'll show you the averages of some
4 characteristics of the medical specialty groups. But we've
5 also grouped them according to whether they're urban or
6 large town hospitals and whether they're large, medium or
7 small hospitals, and then we looked at rural areas. The key
8 point here is that basically 90 percent of physicians and 90
9 percent of beneficiaries are in large hospitals and most of
10 them are in urban areas or large towns. We will come back
11 to that in a second.

12 So here, for instance, is a display that shows how
13 many physicians per hundred beds are there in each hospital?
14 Bigger hospitals will obviously have more physicians? So
15 the average hospital in the United States has about 30
16 primary care physicians per hundred beds and then 21 medical
17 specialists, 21 surgeons and a bunch of other physicians
18 associated with it, pathologists, radiologists, et cetera.

19 I've bolded on the slide a distinction to help you
20 understand that these actually do seem to make clinical
21 sense as multi-specialty group practices, if you will.
22 There are relatively similar number of primary care

1 physicians across the size of the hospitals, 30 and 30 in
2 this particular case. But in the urban large hospitals,
3 there many more medical specialists, any more surgeons, and
4 many more other kinds of physicians. So they look like
5 multi-specialty group practices when step back. And similar
6 patterns hold in the rural areas.

7 How many physicians to inpatient work? And if
8 you're trying to create a medical staff that has some
9 coherence, how tightly affiliated are physicians? And what
10 proportion of their work is provided at the hospital to
11 which we've assigned them? It turns out 62 percent of
12 physicians perform inpatient work. 62 percent of those, by
13 chance, happen to work at only one hospital. So 100 percent
14 of their work is at their primary hospital.

15 But we were about the physicians who rotate from
16 hospital from hospital, so we looked at those, as well. 38
17 percent of physicians work in multiple hospitals but 75
18 percent of their work is at the hospital to which we
19 assigned them. Most physicians have a predominant hospital
20 where they provide their practice.

21 So therefore, from inpatient physicians, 90
22 percent of their inpatient work is assigned to their primary

1 hospital. That looks pretty good. These are coherent
2 groups are really are practicing within a local environment.

3 Among the physicians who perform no inpatient
4 work, dermatologists, radiologists, community radiologists -
5 - those are some of the specialties that would be in a -- or
6 pathologists who were running labs -- 38 percent of them
7 performed no inpatient work but 56 percent of the admissions
8 for their patients are at their assigned primary hospital.
9 So again, they're pretty tightly affiliated.

10 The next less frequent hospital is much, much
11 lower than 56 percent. So the remainder of their admissions
12 tend to be spread across a number of other institutions, not
13 to their primary institution.

14 This is a complicated slide but it really is there
15 primarily to emphasize one major point: that is the key
16 question if you're trying to foster accountability for the
17 care of Medicare beneficiaries and improve the coordination
18 and use of services, you'd like to see that if we've created
19 these virtual groups that most of the care to those groups
20 is actually provided by the physicians who work within the
21 groups that we created. This is all the magic of computers
22 somewhere. And wed like to know that the beneficiaries who

1 are assigned to these groups actually get most of their care
2 from the organization, either the physician or the hospital,
3 to which we've assigned them.

4 The slide distinguishes primary and secondary
5 hospitals. But if you look over on the left-hand side, that
6 average for all U.S. hospitals, what you see is that about
7 70 percent of the evaluation and management services
8 provided to beneficiaries assigned to a hospital is provided
9 by the physicians within their primary hospital, the group
10 that we've created, and about another 10 percent is provided
11 at their referral hospital. So over 80 percent, on average,
12 of the evaluation and management services, the really
13 cognitive services that would be required for care
14 coordination, are provided at the hospital to which we've
15 assigned them. They look like coherent groups, slightly
16 lower for proportion of medical admissions but still pretty
17 good. And surgery is a little lower. Because surgery is
18 often referred to other specialties, there are many
19 categories of surgery which even your next referral hospital
20 won't perform so more of them will be referred outside the
21 system.

22 As you look across 90 percent of the Medicare

1 beneficiaries are in systems that have a very high degree of
2 coherence, if you will, those large urban, large medium, and
3 large rural hospitals, where there's a high degree of
4 coherence within the medical staff and the patients they are
5 caring for.

6 Can we measure performance at this level? I know
7 you've all been thinking about this when you think about
8 physician efficiency, and I think this slide has a couple of
9 key points. What we see is that however you are attributing
10 patients to physicians, if you're trying get a predominant
11 care group for chronic disease patients, like patients with
12 diabetes, there are about half of physicians who have no
13 patients assigned. So if we look at physicians with one or
14 more patients assigned, we have about 250,000 physicians to
15 whom we've assigned no patients. But among those to whom we
16 have assigned -- maybe that's 300,000. So we have 250,000
17 who got a patient. But their panel sizes are relatively
18 small.

19 It gets a little worse if you throw into the
20 denominator all the docs that never touched anybody. That's
21 that little column so we don't really need to pay much
22 attention to that. But it still underlines the point that

1 there are going to be lots of physicians for chronic disease
2 who are not included in any kind of accountability or
3 performance measurement if we focus on the individual
4 physician.

5 But if we step back and say let's assess
6 physicians as members of their extended hospital medical
7 staff. Suddenly everybody has lots of patients that we can
8 evaluate them on. 98 percent of physicians are now in
9 medical groups where they're estimated to have more than 500
10 Medicare beneficiaries who can be followed.

11 You have similarly high numbers if you restrict it
12 to patients with chronic disease. This is for all patients
13 but we can provide you the data on those with chronic
14 disease.

15 So what kinds of performance measurements can you
16 now do if you have created these larger medical groups? You
17 can do traditional measures of quality of care. The first
18 four measures there are traditional chronic disease
19 measures. so any of the AQA or other measures that are
20 being considered for performance measurement at any level
21 can be performed at the group level.

22 I've just grouped the hospitals according to the

1 average spending in their region in our original Annals
2 stratification, updated to 2003, because we think there's no
3 evidence that those in the higher spending regions have
4 achieved better performance based on all of our data. We
5 know that the high spending regions don't have better
6 outcomes, have slightly worse technical quality on other
7 measures that we've looked at. This is just updated to look
8 at 2003 Medicare data.

9 But what you see is you can look at preventive
10 services. They're less likely to get mammography screening
11 in the high spending regions but more likely to get
12 colorectal cancer screening, perhaps because many more
13 beneficiaries are getting a colonoscopy for all sorts of
14 other reasons and regardless of the indication it's counted
15 in the AQA measures as a screening colonoscopy. And I can
16 promise you that they are doing more procedures of other
17 kinds in the high spending regions. They are about equally
18 likely to get an eye exam and slightly less likely to get a
19 hemoglobin Alc if they're diabetics, which I found quite
20 surprising.

21 But I think the really important set of measures
22 are the ones in the next two categories because now we can

1 start to look at how frequently are the patients within this
2 group hospitalized? 30 percent more frequently in the high
3 spending systems compared to the lower spending regions.

4 We're not substituting hospital care for SNF
5 stays. They're getting more SNF stays.

6 We can start to look a care transitions. How many
7 Medicare reimbursed different care transitions did the
8 patients experience in one group of systems compared to the
9 other? You see it's almost 30 percent higher in the groups
10 who practice in the higher spending regions than in the
11 lower spending regions. And you can also look at physician
12 services and acute hospital services. These are age, sex,
13 race adjusted using standardized payments per beneficiary
14 services in the low spending region. In the groups located
15 in the low spending regions compared to the groups located
16 in the high spending regions it's 60 percent higher and
17 about 26 percent are for acute hospital care services, again
18 using standardized payments.

19 What about the EHMS or extended hospital medical
20 staff? I think I forgot to reverse those. I'm not sure
21 this is the right name for those things. Anyway, EHMS we'll
22 call it for the moment.

1 There are two approaches. You can look at all
2 services billed by the medical staff, including those for
3 patients who were not assigned to them. And the advantages
4 are that attribution and responsibility are absolutely clear
5 for the services billed. You touched them, you billed for
6 it, I know you did it, we're going to hold you accountable
7 for it.

8 The real problem is that it includes some patients
9 who they touched once and some patients who they are fully
10 responsible for. And so over time, if referral patterns
11 change quickly or groups merge, the changes in the
12 populations served can really fluctuate and I think are
13 going to make it very hard to interpret what a per
14 beneficiary cost means if you're using as a denominator
15 anyone they touched.

16 Also, the problem is every beneficiary gets
17 captured in every group, so that you end up double counting
18 in a way that doesn't let you disaggregate back to per
19 capita spending.

20 Secondly, you can't easily expand it beyond Part B
21 to include all services because of this overlap in which you
22 can't define the denominators appropriately.

1 The disadvantages of this extended hospital
2 medical staff, all services provided to their patients
3 regardless of where or by whom, the disadvantage is that out
4 of system care isn't directly controlled by the group that
5 you've created. In some cases about 20 to 30 percent of it
6 is at other places. Although that's a relatively small
7 proportion. And if I were a Medicare beneficiary or if I
8 were a physician, I would think it's a great idea to have me
9 or our group be responsible for what's happening to our
10 patients if they're somewhere else, especially if I know
11 exactly where it is. It's that secondary hospital to which
12 we refer all of our patients.

13 So the advantages are the population is well
14 defined, providing a stable denominator for rates,
15 measurement can easily expand to little services as I just
16 showed you, and now the incentives come to manage care both
17 of your own patients within your system and of the patients
18 if they're outside your system.

19 So what I'm going to show you now and what I
20 actually showed you on the prior slides is this analysis
21 that focuses on assigned patients.

22 What this slide does, we have use standardized

1 payments for physician services. We grouped all of U.S.
2 hospital referral regions according to the magnitude of the
3 growth in per beneficiary spending on physician services
4 over a four-year period. So we took those that had the
5 highest absolute increase in per beneficiaries at the
6 regional level, because I wanted to make sure we had stable
7 denominators, and said which regions had the highest per
8 beneficiary growth and which had the lowest?

9 So what you see is that -- and each of those red
10 to pale colored lines and dots represents a quintile, a
11 fifth of the Medicare population. These are stratified in
12 the number of the beneficiaries within the regions to create
13 these equal sized groups.

14 so what we see is that there are differences in
15 absolute growth and in relative growth rates. There are
16 regions where in this four year period, using just
17 standardized payments, so this is basically volume and
18 intensity growth, it's the numbers of services provided, and
19 perhaps some shifting from level two to level three codes
20 which would be included here, we see an \$800 per beneficiary
21 increase on average in the highest growth regions, 32
22 percent overall, and an absolute increase of about \$360 per

1 beneficiary in the lower spending regions.

2 The fun starts to be when you get to look at the
3 regions that fall within these. I can never resist a
4 regional analysis. So if we look at some of the higher
5 growth areas, those include Miami, Los Angeles and East Long
6 Island, areas that have long been red in our maps -- I guess
7 now blue. And then if you look at the regions with the
8 lowest growth in spending, they are regions including Des
9 Moines, Portland and Albuquerque.

10 Interestingly, there is one region in the highest
11 growth regions that began in the lowest spending quintile in
12 terms of absolute rates. We haven't figured out why that
13 is. Maybe staff and you all will want to know. But it
14 almost certainly is that something happened within that
15 region to recruit more physicians and generate more
16 physician services.

17 It's a relatively small region so you wouldn't
18 have to recruit many new physicians to have a substantial
19 increase in per beneficiary costs, if it were one group
20 recruiting four new cardiologists or six new orthopedic
21 surgeons, because I believe fundamentally that that's the
22 driver of growth in spending that you have the opportunity,

1 through the policies you're thinking about, to control. If
2 we try to control volume at the individual physician level
3 it means cutting fees, whereas if you look to the future and
4 encourage people to make wise decisions about the capacity
5 they're putting in place, that's their professional approach
6 to maintaining their incomes in the future.

7 What are the advantages? I think performance
8 measurement is more tractable. It can include all
9 physicians who contribute to care within the frame of
10 measurement immediately. We can do it tomorrow -- well, six
11 months -- with adequate sample sizes. It allows much
12 broader measures: quality, outcomes, coordination, costs.
13 It may, in fact, face lower resistance from physicians than
14 individual reporting. I think many physicians will be much
15 more comfortable to have their aggregate performance of
16 their group publicly reported and rewarded than to be on the
17 Internet as the high cost outlier, especially using systems
18 much I'm uncertain about whether the outlier status is well
19 deserved if you include regional analysis.

20 The last issue, and this really comes from my
21 experience on the IOM Committee thinking about performance
22 measurement, and if we are to make performance measurement

1 robust and effective it's going to have to include auditing.
2 It's going to have to include accountability for the
3 accuracy of the measures that we're using. If we decide
4 that we're going to look at 5,000 hospitals and their
5 medical staffs and we sample patients within them to audit,
6 to measure performance on, to survey patients, to look at
7 how they're doing, we now have 5,000 units that we have to
8 worry about instead of 500,000. I think it will be much
9 more administratively feasible to get what I believe are
10 really good measures of patient outcome, patient-centered
11 care, the degree of coordination, risk-adjusted outcomes.
12 You could review enough charts in any these systems to
13 identify the baseline risk characteristics and look at
14 outcomes of care. I think it's a much more tractable
15 approach than trying to think of it at the individual
16 physician level.

17 It does establish a locus of accountability for
18 capacity, and I don't see any other local candidate that's
19 going to do that.

20 If you do it at the regional level, I don't know
21 how you are going to prevent a new MRI center from opening,
22 whereas if the physicians themselves decide that they don't

1 want to open one I think you have a shot at it.

2 And an SGR-like formula at the medical group level
3 would create incentives for the physicians to say, hey, the
4 way to preserve our incomes is not to recruit six more
5 cardiologists next year. We've already got 20. If you're
6 in Leary, Ohio they probably have 30.

7 I think the third reason is that hospitals have
8 the organizational capacity in the current environment.
9 Large medical groups do, too, but there are just not very
10 many of them to intervene to improve quality. They can
11 finance the electronic health records for associated
12 physicians, and there are examples around the country of
13 where that is now happening. It seems to change the
14 conversation even among physicians who are in solo practices
15 if the hospital has bought the electronic health record for
16 them. This is the experience anecdotally from some of
17 hospitals in Boston, where they have purchased electronic
18 health systems for the private practice physicians who are
19 associated with that hospital. I think hospitals also have
20 the capacity to intervene to improve quality, much more so
21 than individual physician offices, who will be hard-pressed
22 to build the capacity to do this.

1 The barriers, there are plenty and we shouldn't
2 dismiss them. Current market has been and clearly is going
3 in the opposite direction of physicians, the association
4 between physicians, medical staffs and hospitals is tortured
5 at best in many regions. But that is, I think, largely a
6 consequence of the payment system that we've established
7 that rewards physicians for moving out of the hospital.

8 We have lack of organizational structures and
9 physician groups in medical staffs that may be hard. There
10 are legal obstacles that will have to be overcome. And
11 there's variation across hospitals and markets in the
12 relative coherence of these staffs. It won't surprise you
13 to hear that the least coherent places in the country are
14 places like Miami and Los Angeles where still the average
15 concentration of care for beneficiaries is well over 50
16 percent, but it's not the 70 percent that's average for the
17 country. So we have to think about how to address that
18 variations in market coherence.

19 So how might we move forward? I think there's
20 some options that you could consider about ways to enhance
21 the coherence of the hospital medical staff. Provide
22 incentives for physicians to choose the hospital with which

1 they wish to be affiliated for performance measurement or
2 for accountability for the SGR. Perhaps provide incentives
3 for beneficiaries to identify their responsible physician,
4 although that wouldn't be essential in this system because
5 most patients turn out to be highly loyal to the hospitals
6 and doctors where they receive their care. You could also
7 provide positive financial incentives for a shared
8 electronic medical record at that level that would link the
9 hospitals and the physicians who are associated with it and
10 start to achieve the integration that we know we need to
11 achieve.

12 I think even starting to report performance
13 measures at the hospital medical staff level is important.
14 It can be done now. In fact, we've been doing it in the
15 Dartmouth Atlas since last January. The hospital-specific
16 measures of the care of patients with severe chronic illness
17 that Jack Wennberg and others developed are available on the
18 Web to tell you the relative costs of care for seriously
19 ill, chronically ill Medicare beneficiaries across
20 hospitals. There are dramatic differences. Those
21 differences are due, we believe, to the hospital with which
22 these patients are associated and the medical staff who is

1 practicing within those systems, and the relative capacity
2 of those systems relative to the size of the populations
3 they serve. But we could do much better. We need to report
4 quality measures at that level so that we know that the
5 lower cost places are actually providing care.

6 And then we need to think about payment reform.
7 Are there shared savings demonstrations that could be
8 pursued? You're all thinking seriously about whether we
9 should establish growth pools at the extended hospital
10 medical staff level.

11 Let me end with a slide that I really owe to Chris
12 Castle and Garrett Harden and Howard Hyatt. The physicians
13 in this country are sharing a medical commons that Medicare
14 beneficiaries and taxpayers are funding us to provide. The
15 challenge is that we are all rewarded for putting more sheep
16 on the commons in the current system. The challenge you
17 face, we face, is to try to think of a level of
18 organizational structure that will allow physicians to have
19 the conversation about how many sheep they should have on
20 the medical commons.

21 I don't see how that can happen at the national
22 level. I don't see how it can happen easily at the regional

1 level. I think it can happen at a medical staff or
2 physician group level. And so I would encourage us at least
3 to consider it as one element and a tool that we bring to
4 bear to address the growth in spending.

5 Thank you very much. I think there's enough time
6 for conversation and I look forward to it.

7 MR. HACKBARTH: Thank you Elliott, as always a
8 great job.

9 To kick off the discussion, I'd like to throw out
10 a few additional ideas that I think are complementary to
11 this and get your reaction to them.

12 As you well know, we have the assignment from
13 Congress of producing this report on alternatives to the
14 current SGR, and we are a long ways from having the answer
15 to that question. Personally, I have a few touchstones that
16 I've been developing and I'd like your reaction to how they
17 fit with what you just presented.

18 Three ideas intrigue me at this point. One is
19 introducing geography into any system of targets. And so
20 the basic idea being that if we're going to have targets and
21 constraints established by policymakers, that we ought to
22 design a system that applies more pressure in the areas that

1 have the highest costs and relatively less pressure in other
2 places. Leaves lots of very difficult questions to be
3 answered about how exactly to set those targets and apply
4 that pressure, but directionally that makes sense to me.

5 A second point is that if we're going to have such
6 a system of constraint that it makes sense to apply it at
7 higher levels of aggregation of services within the Medicare
8 framework, Part A and B services, as opposed to just on Part
9 B, as is done currently with the SGR. There the basic
10 notion is, and I think this is quite consistent with what
11 you just said, what we need to do is get providers engaged
12 with one another and thinking about how to reduce total
13 system costs as opposed to just their silo.

14 The third notion that interests me is within such
15 a framework of total cost and geography creating
16 opportunities for what I'll call accountable organizations
17 to get their own performance assessment. So if you have a
18 geographic system the target would still be the target for
19 the geographic region. But as opposed to their payment
20 consequences being based on the whole region's performance,
21 it could be for a smaller subset like an extended hospital
22 medical staff and they would have their own cost and quality

1 assessment and be rewarded or penalized accordingly.

2 At first blush, it seems like what you've
3 presented fits well within that framework, but let me ask
4 your reactions to it. Let me just ask you reactions to
5 those ideas.

6 DR. FISHER: As a geographer for the last 25 years
7 trying to study the implications of geography, I'm strongly
8 supportive of the notion of trying to redress the imbalances
9 in spending I see in resource use that are unrelated to
10 quality that we see across geographic regions. I support
11 each of those three ideas, and I think they're very
12 important ones.

13 The question that I have about incorporating
14 geography into targets, and I will need to think more about
15 this and I'm happy to correct my testimony by sending you
16 some notes or talking to you if I have further reflections.

17 I don't know where the conversation about capacity
18 growth happens at the regional level right now. If we are
19 to try to -- in my still evolving understanding of the
20 health care system here, if you did it at the hospital
21 referral region level, many of these places have 50, 100,
22 200 hospitals and medical staffs within the region. And if

1 setting a growth target at a regional level that penalized
2 them all for untoward growth, but I think would penalize
3 within that region those who are doing better, if everybody
4 else still decided to be selfish and thought that the way
5 they would make money would be to grow their own system.

6 But maybe having a regional cap and internal
7 targets at the same time and penalties for untoward growth
8 at the internal level as well would foster the conversation
9 of let's merge, where is the FTC, we need their advice about
10 how you could pull that off, but let's create larger
11 organizations that are cover more patients, that are more
12 integrated. Maybe you would create that conversation.

13 But that seems to me to be the challenge. We know
14 already that the regional levels reflect the average of the
15 groups within it. So that a group level reward that was
16 appropriate, that was well designed, should, if it were
17 based on some absolute growth rather than percentage growth,
18 would make the higher spending places grow more slowly by
19 relatively rewarding the groups that kept their prices. You
20 could achieve the same goal, I think, at the accountable
21 staff level.

22 I love your notion of accountable organizations.

1 It's exactly the right thing we want to create. And I agree
2 completely with applying it to all services. It should
3 include the whole gamut of care so we get rid of the silos,
4 because you look at the numbers of care transitions and you
5 just see that these places are churning patients from
6 hospital to acute care to nursing home back to the hospital.
7 So I agree that those two principles -- and what I wonder is
8 whether the third goal could be achieved through the first
9 one.

10 MR. MULLER: Elliott, thank you, as usual, for
11 good data and a stimulating conversation.

12 This idea is very attractive to me, not so much in
13 my current role in a hospital but my once upon early life as
14 a political scientist. And I think if I can draw an analogy
15 from that, when you think about all these kind of efforts 30
16 or 40 years ago to create metropolitan governments and how
17 they all came awash and never -- these are theories being
18 offered in terms of how to get some kind of collective good.
19 But they also came up against the reality of existing
20 organizations called cities and suburbs and so forth that
21 fought against it.

22 I think one of the real advantages of the extended

1 medical staff is we have over 200 years of histories of
2 volunteer hospitals in America. They are legal entities
3 that are licensed by all states and sometimes cities. They
4 are regulated by CMS and the Joint Commission and many other
5 entities. They have governing boards. They have all the
6 faults of governing boards, some are good, some are not so
7 good.

8 The important point is they really have
9 constitutional authority and they can, in Glenn's words, be
10 accountable units. I think what's very attractive about the
11 data you pointed out today, which I was not familiar with
12 before, is that you can, as you say, assign 98 percent of
13 physicians to one of them.

14 None of this is to gainsay all of the kind of
15 political problems of do doctors want to be part of medical
16 staffs? And how do you control the governance of a
17 hospital? And all those kinds of things.

18 But I think the fact -- I worry about trying to
19 create new geographic units that don't exist in American
20 medical care right now, such as regional units and having
21 SGR at kind of super regional levels. The fact that we have
22 hospitals and they're there for 200 years and we know their

1 service areas, I think it is an incredibly attractive to --
2 I say my one time mind as a political scientist. And it
3 allows you to then think about this in terms of how do we
4 organize and manage medical care.

5 Now obviously as a payment advisory commission, we
6 tend to focus very much on financial incentives and
7 behavior. My feeling has been for many years the real
8 problems in the system. And it's not to gainsay, as you
9 said too, the financial incentives right now get in the way
10 of doing want to do. And we have to keep thinking about how
11 one overcomes some of them.

12 I think the really heavy thinking on this has to
13 go into how you get accountable units, how you get
14 responsibility in governance of medicine in this country.
15 If I can use my analogy to political units, you have states
16 and you have cities, and you have a national government.
17 Almost everything in between doesn't work that well. On
18 some levels -- you know, counties do work.

19 So I think taking organized structures that have
20 been there for a long time is the right way to go and we
21 should be spending more time, perhaps not in our role as a
22 payment commission, but we should be spending more time

1 thinking about how one implements something like this
2 because getting accountability in the system, I think in
3 many ways, is the biggest failing we have right now, not
4 again to gainsay some of the real difficulties we have with
5 payment incentives.

6 So I find your suggestion very attractive and to
7 supplement your data that you offered today, I think at
8 least shows us there is an end in sight where one has units
9 that exist to which one can assign physicians and start
10 thinking about how one has an organized process of governing
11 these entities that deal with the issues that are so
12 powerfully demonstrated once more by your work today.

13 MS. BURKE: Elliott, I too think you've made a
14 number of suggestions that make an enormous amount of sense.
15 I think the opportunity to begin to look at essentially the
16 full episode truly of services and the incorporation of both
17 A and B into that view because you essentially match the
18 physician side with the hospital side is very much the
19 direction we all want to go. So I agree, I think this is
20 terrific in that respect.

21 I had two questions, both of them I suspect
22 relatively narrow.

1 One is just a question in terms of the likely
2 diagnosis. I was interested that in the list of the things
3 that you think had an impact in terms of spending you did
4 not mention legal. Yet in the barriers at the latter part
5 of the presentation you did mention legal issues.

6 I wondered if, as part of the diagnosis, the
7 suggestion that one hears not infrequently is that there are
8 a series of things that occur, largely around testing, on
9 interventions that are a result of a fear of reprisal if one
10 doesn't do everything one is supposed to do. That's really
11 tossed out. Not something you noted, and I wondered why
12 that was the case.

13 My second question again is a fairly narrow one.
14 And that is I wondered how one dealt with the relationships
15 that exist in places like the Cleveland Clinic, the Mayo,
16 Hopkins, places that are essentially utilized by folks that
17 come from a much broader catchment area because of the
18 nature of the services they provide where, in fact, you do
19 have this sort of break in relationship. People come,
20 they're treated, they go. And trying to link those
21 relationships in the pre-admission, admission, post-
22 admission management of the patient, how you might imagine

1 that we would track folks of that nature, as well.

2 Again, a small universe arguably, but nonetheless
3 if you look at utilization, certainly high-cost patients are
4 a relatively narrow percentage of the Medicare population
5 but they are the folks that use obviously the most services,
6 some of whom would fall into that category.

7 DR. FISHER: Good questions. The malpractice I
8 didn't mention for want of time. But it is a factor that
9 does not explain much of geographical variation in practice.
10 Every doc in the country is terrified of malpractice.

11 Now there are differences in the relative
12 malpractice pressure that physicians experience, and from
13 the best data that I've been able to find, it's about 10
14 percent of the twofold variation in spending across regions
15 is due to differences in malpractice pressure.

16 There have been some ideas that I've heard of and
17 haven't studied well around group liability which might
18 actually be enhanced if you created organizational units and
19 allowed the liability to be more corporate rather than
20 individual. I think Bob Berenson wrote some stuff about
21 that about 10 years ago, if I recall.

22 the malpractice is important. We ought to do

1 something about tort reform.

2 The Cleveland Clinic, Mayo, Dartmouth-Hitchcock,
3 we get half, 40 or 60 percent of our patients from outside
4 the hospital -- I mean patients who reside outside and are
5 referred for specialty services. I think that almost all of
6 those places actually do care for relatively large defined
7 populations already. So Mayo does care for, we've
8 identified nice populations, well circumscribed, who get all
9 of their care from within Mayo. So they should be rewarded
10 for doing a good job with them.

11 I think that the issue of referrals, transitions,
12 I conceptually don't mind the idea of putting the
13 responsibility back on the primary care delivery systems or
14 extended hospital medical staff for choosing which places to
15 send their patients to.

16 If the Cleveland Clinic, for example, can do
17 aortic resections and repairs better and more cheaply than
18 anybody else in the country, I'd want my hospital to send me
19 there. So I think it actually starts to put in place -- it
20 starts the conversation between the local hospital and the
21 local referral center around what's good care for these
22 patients? What do they really need? I don't want my

1 patients trapped at the tertiary medical center getting too
2 much care. I have a strong incentive to pay attention to
3 getting patients back to me when it's at the ideal time to
4 do it.

5 There's obviously more complexity to how one --
6 the problem of accountability without control, in a sense.
7 That is, the hospital makes the referral to the specialty
8 hospital and they get you in trouble because they are doing
9 much too much. So there may need to be some what you can
10 imagine ways of sharing financial rewards across the primary
11 and secondary unit, for example, I think. Although I'll
12 have to think more about that. It's a very good question.

13 MS. BURKE: One quick follow-up to that if I
14 might. Glenn. The reference you made to Dartmouth and the
15 fact that 60 percent --

16 DR. FISHER: Some percentage. It could be 20 to
17 80.

18 MS. BURKE: -- or some percentage comes from
19 outside, somewhere between 20 and 100.

20 To what extent do you believe that the decision to
21 go outside of the traditional catchment area is a decision
22 made by the hospital, the referring hospital, by the

1 physician, or by the patient's choice? Because the
2 penalty/reward system, in part, also reflects -- I mean, I
3 had a recent experience where my husband chose to be treated
4 at Stanford. We chose it for a lot of reasons, having
5 nothing to do with what anybody else told us to do, having
6 to do with our own research. So it wasn't a local physician
7 here, it wasn't a hospital here, it was just a right
8 decision we made based on information.

9 So to what extent do you assume in that structure
10 that, in fact, the relationship is such that the
11 reward/penalty system, in fact, is appropriately placed on -
12 - just because I live near NOVA or whatever hospital I live
13 near, Sibley or whatever it is, has absolutely nothing to do
14 with the decision that I make?

15 DR. FISHER: A couple of comments. On one side, I
16 would like my local system to have strong incentives to want
17 me to check with them about where I'm going and then give me
18 the information support that helps me choose wisely. So
19 that if you have an incentive system such as we're
20 imagining, the hospital and its staff would have a very
21 strong interest in making sure you know how to stay in touch
22 with them, that you're supported in the decisions that you

1 make, that you're making wise choices. Because if they're
2 responsible for your choices, they should be helping --
3 they'll be contracting with some good managed care plan who
4 can help them get great information to patients, perhaps.

5 But I think it puts incentives in the right place.

6 There are tweaks that you could do, adjust
7 copayments the way point of service plans are doing it, the
8 various tweaks to help give the hospitals some shot at
9 having the patient's pay attention.

10 But I think it starts to put the accountability
11 right where I want it because so many of these decisions are
12 based on advertising on the Net. There's a lot of bad
13 information out there as well as good information and I'd
14 like people not choosing on the basis of U.S. News and World
15 Report's Best Hospitals but based on good clinical
16 information.

17 DR. SCANLON: I share Sheila's and Ralph's
18 admiration for this because there's a lot of interesting
19 aspects of this and recognizing that particularly
20 complicated care is not delivered by a single physician and
21 that the idea of finding some kind of workable accountable
22 group is truly challenging. At least with the hospital

1 staffs we can presume there's some communication that goes
2 on among them. It's probably variable but we can assume
3 that there is some.

4 You've already anticipated the idea of pushback
5 and I'd like to follow up a little bit on that, and it's
6 actually in the context of what you and Sheila were just
7 talking about.

8 Because if you go to your chart on concentration
9 of care, you see different patterns in terms of who is using
10 the primary hospital versus the secondary hospital. It
11 raised for me the issue of risk adjustment, and thinking of
12 risk adjustment potentially in a different context than we
13 normally do, which is normally in risk adjustment we're
14 thinking about adjusting for health status. Here there's a
15 question of do we also need to adjust for scope of services?

16 And what you just raised in the conversation with
17 Sheila, in some respects, you could think of it as services
18 that I have direct control over and services that I may be
19 able to influence. There's a question of how acceptable it
20 will be to be accountable for things that I only might be
21 able to influence, and that may depend upon who are the
22 neighbors. Because certainly distance matters, in terms of

1 a lot of this.

2 My question is have you thought about this aspect
3 of things, how to risk adjust?

4 I think it could go also in the direction of when
5 you presented the two alternatives of dealing with all of
6 the services that a hospital provided verses dealing with
7 the patients that are assigned to the hospital, which of
8 those two models, whether if we had some kind of adjuster we
9 could bridge that gap and reduce some of the disadvantages
10 of the two different models in some process.

11 DR. FISHER: Bill, I think that's a great question
12 and I've spent a fair bit of time trying to think about how
13 you could do it and I haven't yet come up with an easy way
14 or a way that I can get my hands around. The place that I
15 stumble is around the appropriate denominator or population
16 for each of those judgments, because the referral hospitals,
17 if they touch them once they've inflated their denominator
18 dramatically and they look efficient.

19 But I think the notion of trying to think about
20 scope of -- the second barrier that I stumbled against was
21 the incentives. Because the incentives, as soon as you can
22 do better by getting somebody out of your system and

1 shifting those services that you could provide yourself to
2 somebody else who now becomes responsible for that cost,
3 even though they might not have wanted it. That is you say
4 why don't you just go down the street to that place, they do
5 much more open heart surgery than we do. As soon as you
6 have the financial incentive on the primary staff to shift
7 more services away, I think the thing unbundles and people
8 are competing to make more money by moving patients around
9 to other systems. That was the second barrier that I came
10 up against.

11 I'm a relatively simple epidemiologist. I like to
12 know the denominator for the rates that I'm calculating and
13 not be unsure about whether a piece of someone has shown up
14 somewhere else. And I really worry about the incentives for
15 pushing people to different systems. Maybe it's possible.
16 It's certainly worthy of further thought.

17 On the risk adjustment, I do want to comment on
18 the risk adjustment. And it's that we'll all have to think
19 really carefully about risk adjustment because everything
20 I've seen in the last two years, as I've now struggled to
21 try to do this, and we've tried to do these geographic
22 comparisons, is that almost all of the risk adjusters that

1 are available to us are based on how many diagnoses you've
2 accumulated in the claims data. And the best way to make
3 people look sick is to send them to see more specialists.
4 And so we see much higher "risk" in populations that have
5 the same mortality rate in high-cost regions where they're
6 fragmenting the care across multiple specialists. So far I
7 haven't figured out a way in the Medicare data -- and it's
8 even going to be problematic when you ask patients about
9 what conditions you have, because they're going to have
10 learned that from their doctors. So the person who has
11 arthritis in Miami is someone who has aches and pains in
12 Minneapolis.

13 DR. CROSSON: Elliott, I'd also like to compliment
14 you for what I've now come to understand is a character
15 characteristically, clear, logical and thoughtful
16 presentation.

17 I don't know how much I like the acronym EHMS.

18 DR. FISHER: Me neither.

19 DR. CROSSON: I probably would choose another one,
20 MGIF, which I would say is medical groups in formation.

21 DR. FISHER: It sounds a lot like some tumor
22 markers we've --

1 [Laughter.]

2 DR. CROSSON: That would probably give away more
3 of my thought that I'd like. So we'll go with EHMS.

4 DR. FISHER: No, I like Glenn's accountable
5 organizations, ACOs, accountable care organizations.

6 DR. CROSSON: But obviously this does point the
7 way to try to get this general movement we've been
8 interested in, which is to get physicians to work with each
9 other, to get physicians in groups to work with hospitals,
10 and then to create more accountable organizations because we
11 have some, as you say, but they're not present in every
12 single part of the country.

13 But the question I have specifically is within the
14 universe of extended hospital medical staffs that you've
15 been looking at, as I think you indicated, there's probably
16 a range of extended medical staffs entities, some of which
17 are probably completely disaggregated and chaotic, and
18 others of which are not because, in fact, there has been
19 some work over the last 10 or 15 years.

20 The PHO movement, the integrated delivery system
21 construct that I think fell apart in most places, didn't
22 everywhere, and there are some places in the country where

1 as a consequence of that medical staffs have been working
2 cooperatively with hospitals.

3 There are, in the academic community, faculty
4 practices that are more organized and more medical group
5 like than in other places. I think of places like
6 Vanderbilt for one, the University of California at Davis,
7 and others.

8 So the question is have you or can you look into
9 your database and look at if you could characterize them
10 somehow, look at issues of already of coherence, as you call
11 it, in the relationship between the patients and the doctors
12 and hospitals, issues of quality and efficiency?

13 And the reason to think about it would be that
14 were this change to come about the first question would be
15 in all of these places that now have incentives to come
16 together and create accountable organizations, how did they
17 do that? How did they avoid the failures that we saw 10
18 years ago or so?

19 And so if we were to look at the success stories
20 over the last 10 or 15 years and try to look at issues like
21 what actually have the doctors and hospitals done in terms
22 of things like payment systems and governance, how to share

1 governance and control? How to use information technology
2 already? If we were to look at the ones that have succeeded
3 or are succeeding or are building this irrespective of the
4 current incentive situation, what lessons might there be for
5 how to assist the newer version of these on a path to
6 success?

7 DR. FISHER: Jay, thank you. There is remarkable
8 variation in the data and we can certainly provide staff, we
9 have measures at the regional level of the degree of
10 coherence both at hospital and for physician services and
11 medical services and surgical services. And there is a
12 modestly strong correlation between fragmentation and
13 spending. That is, the more fragmented places are in the
14 higher spending regions. So that the Miamis of the world
15 tend to have slightly lower degrees of coherence.

16 There are a quarter or 30 percent of Medicare
17 beneficiaries are in what already appear to be highly
18 integrated systems where 80 to 90 percent of the care is
19 provided to what looks like a hospital and its closely
20 affiliated medical staff.

21 I think it would be well worth pursuing the
22 political science and sociology of the successfully

1 integrated organizations in a variety of settings, that is
2 those that were academic, those that were private practice
3 but non-academic, successful groups.

4 I understand that in the Physician Group Practice
5 demonstration there is at least one hospital that has
6 physicians who were already in a PHO, in Connecticut I
7 believe.

8 If we are to move this idea forward it will
9 require careful thought and enough research to help guide
10 those who need to learn how to do it. And so the idea is
11 nominated and the responsibility falls to me and others who
12 think it might be worth pursuing further to try to get the
13 support there to allow it to happen.

14 But certainly I think that the anecdotal or
15 qualitative research that I've done through talking to
16 people now as I get to go more fragmented and less
17 fragmented higher cost and lower cost markets would lead me
18 to think that it will be challenging in the most fragmented
19 places because many docs are actually excluded from the
20 medical staffs of hospitals. They might have wanted to have
21 admitting privileges but are not granted them. There's
22 variation in that.

1 And there are many hospitals that want every
2 physician in the community on their medical staff because
3 they want to get all of their admissions and they're
4 competing for their admissions. So there will be some
5 challenges moving forward.

6 But it's pretty remarkable, and we can provide the
7 data to staff, on the range of variation in degree of
8 affiliation and degree of coherence across these 5,000
9 extended hospital medical staffs. And even the lowest
10 numbers are relatively high. That is, it's close to 50
11 percent of the care being provided by the docs. And the
12 next lower one really drops down to 10 percent, so that the
13 second hospital is really pretty low.

14 So at least on average it looks pretty good. And
15 in bigger hospitals it looks very good. That's where most
16 beneficiaries are getting their care. The fragmentation
17 really seems to be in the -- the greater degree of
18 fragmentation is in the smaller places. Is that helpful?

19 DR. CROSSON: Yes.

20 DR. FISHER: It will be work, though.

21 MS. HANSEN: Dr. Fisher, this is really extremely
22 interesting and really informative. I come from probably a

1 history of a bit of an anomaly, the PACE program. So that
2 we integrate Part A, Part B, Part D and Medicaid. So
3 ironically these small organizations are the accountable
4 entity, per se.

5 My question has to do with something I raised with
6 Glenn before in a conversation we had about what you
7 mentioned to be the churn that tends to occur with the
8 fragmentation.

9 I also hear your comment about being careful about
10 risk adjusters because one of the concerns I brought up
11 yesterday is when sometimes an older, more complex person
12 goes into the hospital what happens is there's iatrogenesis
13 that occurs. And there's a lot more conditions and they get
14 sicker. But then should we be rewarding for induced
15 frailties or complexity?

16 So how do we address that issue of getting a --
17 what's going to help mitigate that churn to be able to do
18 the right care? It's almost like the five rights in
19 medication administration: the right patient, the right
20 treatment, the right time, and so forth. So that we don't
21 create, frankly, more diagnostic conditions for billable
22 purposes but are not good for the beneficiary?

1 DR. FISHER: It's the most -- I think it's
2 actually the most important question we're facing a we think
3 about performance measurement and pay for performance. And
4 I don't think it's particularly easy.

5 I'm increasingly nervous about performance
6 measurement, the current performance measures we have,
7 because they focus on a narrow scope of practice that is
8 easily defined as correct and is not very broad. It doesn't
9 identify any of the issues that you -- giving the right
10 medication for a pneumonia is kind of trivial. Getting the
11 patient out alive and without complications is actually
12 really important.

13 As I think about one of the advantages here and
14 what I hope we can start to pilot, perhaps, is the notion
15 that we really ought to identify either the populations that
16 we serve and measure their quality of life -- and this goes
17 back to Bob Brook, 25 years ago or 15 years ago, let's
18 measure everybody's functional status and health status at
19 time one. Let's measure it again at time two and let's see
20 if they're better. Bob was pushing that 20 years ago.

21 I think we really ought to revisit that. One of
22 the advantages of having 5,000 accountable units is that you

1 can sample 1,000 patients there. Or if we care about
2 Medicare patients a lot, we'd actually have them all fill
3 out an online health status survey that wouldn't ask them
4 about do you have rheumatoid arthritis? It would ask how
5 well are you functioning? And we'd know enough respect
6 factors that we could look at your predicted risk of death.
7 And then the system would be measured on how those patients
8 were doing on average a year later or two years later.

9 We've been in some conversations recently at
10 Dartmouth as we try to figure out how to encourage our
11 clinical groups to be inspired or incented to do better.
12 And the notion of setting the goal not around providing 30-
13 minute time to reperfusion but around a goal that says will
14 have all of our heart disease patients at national norms for
15 functional status a year after they first see us, or we'll
16 get as close as we can do it and we'll be the best place in
17 the country for that.

18 The clinicians all start to say now that's
19 something I could work for. I think it does some of what
20 you're asking for, which is align the work with a goal that
21 we really care about. That is, improving function,
22 preventing time in the hospital. You'd ask not just

1 function. You'd ask did your doctor listen to you? Did you
2 have informed patient choice? I come from Dartmouth. We
3 care about patients not being told by their docs what to do,
4 but about making informed choices about the risks and
5 benefits.

6 I think we really need to think more carefully
7 about what are the performance measures that we really want
8 that will give us in five years the delivery system that we
9 need. A large enough accountable organization, and then
10 performance measures that are really important that capture
11 the important dimensions of care. It's the only path
12 forward I see that's not going to make things a whole lot
13 worse and reward physicians for doing things that I think
14 are really stupid, to use the technical term, and harmful.

15 DR. REISCHAUER: Elliott, as always, a great
16 presentation. Every time I hear you I'm convinced you're
17 right and then get terribly nervous because you made it
18 sound so doable. Here we are out in search of an
19 accountable organization in what is basically a free range
20 environment and you had a great ending slide, but it really
21 wasn't the right one. It was a whole bunch of well behaved
22 sheep eating on a prepared lawn. And really it should have

1 been the Serengeti. It should have been one with some lions
2 and some hyenas and elephants, and them not only eating the
3 grass but also each other.

4 [Laughter.]

5 DR. REISCHAUER: We're looking for some kind of
6 accountable organization wherein we can measure growth in
7 spending, measure quality, set updates possibly, reward
8 performance and so on. I think your work has convinced many
9 of us skeptics that if you really went to a unit like the
10 extended hospital staff, you encompass a lot of the care
11 that's provided and there doesn't seem to be a whole lot of
12 questionable accountability. Should it be here or there?
13 It really is much more concentrated than any of us believed
14 before we saw your work.

15 That doesn't create an organization. What it
16 basically does is say if you drew your line around this
17 group it could work. But then there has to be an
18 organization. And I want to hear whether my skepticism
19 about the existing organization off of which one might build
20 is warranted or just too pessimistic.

21 You have, as you say, a group of docs who are
22 associated with this hospital who do have a relationship

1 with one another and with the institution. But then you
2 have a whole bunch of other ones. And right now their
3 relationship often with hospital administration is not,
4 shall we say, a peaceful collaborative wonderful
5 organization. It has some conflict in it. And if one puts
6 in all of these other consequences the relationship might be
7 even more problematic.

8 You're going to get a lot of other people who say
9 well, if this is going to affect updates or performance
10 measures, I want a voice at the table. I want to be part of
11 this organization, as well. And I wasn't quite sure where
12 the nursing home, the ASC, the lab, the home health agency
13 that are sort of out there and are part of this, fit into --
14 I can see us defining something and then having to create
15 decision rules for this organization. And maybe these exist
16 somewhere and can serve as a model for us, but I'm a little
17 still skeptical on that front.

18 And then I asked myself well, Medicare isn't
19 everything. We're acting -- in a way if this were just
20 Medicare, maybe we could work this out. But over half of
21 what's going on has nothing to do with Medicare, and how
22 would we account for that? Or would accountable groups or

1 whatever just say I don't want to be part of Medicare if
2 it's going to involve all of this? And we develop, in a
3 sense, two systems out there.

4 DR. FISHER: I've got a bridge I'd like to sell
5 you.

6 There's no question that there is variation across
7 markets and across organizations. So there are plenty like
8 Rochester, New York or Northern California where they really
9 look remarkably coherent and I think all the docs are pretty
10 tightly associated. When I presented these ideas to
11 hospital associations, one in particular, there was pretty
12 strong support for the notion that we've been driven apart
13 by current policy and this would get us all on the same
14 table because we know we've got a bunch of nursing homes
15 popping up and we need to coordinate care with them.

16 I think the specialty hospitals, the surgeons, the
17 ASCs, the nursing homes, independent labs, those are going
18 to be challenging.

19 But I guess the question is really whether we want
20 to think about the long-term goal and try to make steps that
21 we take in the meantime more likely than not to need us to
22 that long-term goal. I think that's really important.

1 Because I worry that if we say all right. the feasible
2 things to do in the short term, the easiest thing to do, is
3 we'll do the silo-based updates, we'll drive these people
4 further apart, I think we're going to further commercialize
5 an upend the clinical delivery system.

6 So if, starting with performance measurement, and
7 maybe tiny pieces of the update that encourages people to
8 start having a conversation -- and if we took as given the
9 current system, the real gains for efficiency and quality
10 are changing the trajectory of where we're going so that not
11 having another ambulatory surgery center open in your
12 community and not having six more for-profit not necessarily
13 very good new institutions spring up because they can make
14 money doing it, if they understand that the long-term
15 incentives are aligned, that they will be penalized for that
16 kind of behavior, I think you start to create the
17 opportunity to move the system in a different direction.

18 But you know, Ralph is a political scientist and I
19 am a naive epidemiologist.

20 DR. BORMAN: A couple of technical questions and a
21 couple of more philosophic ones, maybe.

22 On your slide 17 that's got the coherence

1 histogram, this would not then capture the independent
2 testing facility or the independent imaging center in this,
3 what you've got currently. So patients who had lots of work
4 up done either through an independent clinical lab or
5 independent imaging center only their actual hospital-based
6 part would capture them in this. Is that true?

7 The reason for my concern on this point is that
8 pretty cleanly the highest growth or the most rapid growth
9 spending areas are testing and imaging. And to get a handle
10 on that, while this is a very powerful organizational
11 argument, to not be able to capture that piece of that seems
12 to be a problem.

13 DR. FISHER: If you go to the -- I think it's the
14 next slide. But the key question is, the first question is
15 to define the group of physicians who we think are
16 responsible for the care of these patients. That was our
17 first challenge. That slide shows us what proportion of
18 evaluation and management services and hospital-based
19 services are provided by the physicians and hospitals to
20 which we've designed these patients.

21 For performance measurement purposes, you can
22 capture all of the services provided to those patients. So

1 I can tell you for each of those places what was spending on
2 imaging. We can look at growth in imaging across these
3 systems, across these extended hospital medical staffs, from
4 1999 to 2003. We've offered to provide staff, when I met
5 with Cristina before this, with growth at the hospital staff
6 and regional level stratified by type of services, which
7 would include testing and labs.

8 And what I believe we'll see when we look at that
9 is that you will see there are places that have remarkably
10 grown their imaging and testing. And there are other places
11 that haven't. There's one place in the country that seems
12 to have had a decline in physician services in terms of
13 standardize prices. One out of all the markets in the
14 country. And it's not a very big decline and it's a small
15 market. So we will see heterogeneity.

16 And it is captured, when you look at total
17 services. When you look at total services provided to the
18 beneficiaries that you're responsible for, we do capture
19 testing and we do capture imaging. And so much of the
20 decision-making there is by the physicians who are
21 responsible for the care of those patients, the ordering of
22 MRI scans, the ordering of CT scans.

1 Some of it will be the radiologist ordering more,
2 I need to take more cuts because I want to see the pelvis in
3 addition and I can bill for extending the service there.
4 But the total cost of that care will be attributed back to
5 the medical staffs that we've defined. And those docs are
6 the ones I'd like to hold accountable. I'd say don't send
7 them to a radiologist who's going to provide unnecessary
8 services to the beneficiaries for which you are responsible.

9 Does that answer your question? Because they are
10 grouped in terms of you have a population and now we can
11 look at all the services that are provided, too.

12 DR. BORMAN: I guess the practical encounter that
13 I have on a relatively regular basis goes as follows, and
14 this is in part what I'm trying to get at. I ultimately get
15 this stack of reports that come with the patient because I'm
16 in an academic medical center, also. And you know how the
17 folks arrive.

18 And as I start looking through to see what was
19 done prior to that patient encountering me, I find that they
20 got sent for test X, ordered in very good faith maybe on a
21 very good clinical rationale by doctor number one. The test
22 comes back with X result, could characterize further by next

1 test. That test gets done, comes back, could learn more
2 from Z test, Y test or whatever. So by the time I see the
3 individual, probably five tests have been done and maybe two
4 of those needed to be done.

5 On the other hand, I'm real sympathetic to the
6 doctor who got that report that now is certainly freely
7 available to all manner of folks that has implied that the
8 next appropriate care is to do more.

9 And I worry a little bit about yes, we say that
10 that doctor did order the test but they did face some
11 relatively potent pressures to do that, and certainly
12 practice guidelines and so forth somewhat address some of
13 that. A piece of it that I think may not get addressed and
14 that I would have to respectfully disagree and with some
15 trepidation disagree with your enormous knowledge base about
16 the professional liability piece and the geography of that.

17 Because I think the geography, I think there is
18 important geography but I think the geography distribution
19 is not as obvious because it is hugely specialty driven.
20 And that if you did it on a specialty specific, by geography
21 there would be huge variation and there is an underlying
22 piece of this. And that's not the only answer to wasteful

1 care but I would make that conclusion, at least from my
2 viewpoint, that I would worry about that, is a little more
3 geography.

4 But what I'm trying to get at is how do you get
5 back to properly attributing that test? And yes, in the
6 ideal world, this would come back to where I would say to
7 the radiologist you know, I really wish you would quit
8 writing that kind of report or whatever. But I think my
9 power to influence the imaging and lab pieces is maybe
10 overrated.

11 DR. FISHER: The radiologists and the pathologists
12 are all assigned to hospitals under this model. So if the
13 radiologists buy that new MRI scanner, stick it in and start
14 -- or buy the new ultrasound machine and stick it in and
15 start recommending oh, the MRI didn't give us the answer, I
16 want the CT, or I saw something at the top of the kidney so
17 I want to go all the way down, they're going to be in the
18 same pool of penalty for having recommended that additional
19 service.

20 DR. BORMAN: And if's at an imaging center that
21 the own, how is it captured?

22 DR. FISHER: It's captured in the professional

1 services and you can certainly include the outpatient -- we
2 haven't yet built in standardized prices for outpatient
3 services because we're struggling to figure out how to do
4 that exactly correctly. But it's all completely built in
5 here. Testing would be built in here.

6 It would not immediately change the conversation
7 among the physicians but it would promote an environment
8 where those physicians would have an interest too in the
9 conversation about how do we test wisely?

10 And on the malpractice, we actually have looked
11 specialty by specialty. To some extent there is variation
12 in the malpractice pressure. People do seem to respond to
13 it for certain things. It just doesn't explain much of the
14 difference in regional variations in per capita spending in
15 the empirical work we've done.

16 There's lots of -- when you interview physicians
17 in our physician surveys, half of the physicians pretty much
18 everywhere are saying they do things because of their fear
19 of malpractice. It's somewhat higher in the high spending
20 regions than the low spending regions, but it's not a big
21 driver of the differences across regions in the overall
22 costs. And that's largely because the overall costs are in

1 these what we call supply sensitive services. Do you see
2 your patient in three weeks or do you see them in six weeks?
3 That's perhaps the most expensive decision physician make,
4 do I see them in a month or two months?

5 DR. BORMAN: And I think it also might relate to
6 specific conditions that may be higher risk litigation
7 areas.

8 DR. FISHER: Neonatal care, high risk OB.

9 DR. BORMAN: There's a lot of ways to slice and
10 dice this.

11 DR. FISHER: Absolutely. We need to change the
12 payment.

13 DR. BORMAN: It wouldn't be measured in the --

14 DR. FISHER: We need to fix it.

15 DR. BORMAN: In the interest of time, just a quick
16 philosophic thing. You've given this very nicely in a way
17 that the physician responds to likely diagnosis. My
18 challenge to you is what's the differential diagnosis?

19 DR. FISHER: Good question. Do you want me to
20 talk about the differential diagnosis?

21 DR. BORMAN: I asked the question.

22 DR. FISHER: The differential diagnosis include,

1 it's all patient preferences. And we've got pretty data
2 that suggests it's not. There are some differences in
3 patient preferences across regions but it's very hard to
4 figure out how they could explain the magnitude of what we
5 see, given the small differences in patient preferences in
6 our interviews.

7 The second one is malpractice, and I've already
8 told you that doesn't really expect a lot of the difference.

9 So malpractice, patient preferences, physician
10 training. But that sort of falls into the clinical judgment
11 and clinical culture, and we've actually looked at that.
12 Physician training does seem to have some impact on how
13 physicians are making decisions.

14 That's why I come back with my likely diagnosis,
15 and it's a hypothesis. But I think it's the only hypothesis
16 I've been able to come up that really explains at the level
17 of the clinical practice why one group of physicians would
18 see a patient with hypertension every month, well-controlled
19 hypertension, and another group of physicians would see
20 those same patients after six months or every 12 months.
21 And that comes down to how many docs there are in that local
22 delivery system and the need to stay busy.

1 It's invisible, it looks like it's a reasonable
2 decision to see them in a month. It feels good. There's
3 good clinical reasons when you talk to the clinicians, and
4 we ran focus groups. They said well, you know, my patients
5 are going to forget to fill their meds. So I need to see
6 them once a month. And some of the other docs are saying
7 every six months.

8 MR. HACKBARTH: We're going to need to do some
9 time management here. We're running over. This is an
10 important discussion so I want to get to the four people I
11 have who have been waiting: Arnie, Nick, Nancy and Ron.

12 We're sort of taking time from our next session,
13 which fortunately is also on SGR. So I think we're sort of
14 company the two, to some degree.

15 DR. FISHER: And I'll try to be concise.

16 MR. HACKBARTH: Arnie, you're next up.

17 DR. MILSTEIN: Elliott, non-salaried physician
18 medical groups have generally struggled to moderate
19 individual physician grazing habits. And I think it's fair
20 to say that hospital-affiliated IPAs, even in California's
21 capitated HMO market, which is a very substantial fraction
22 of payment in California, have equally struggled.

1 I've had a chance to personally sit with the
2 medical directors of both these hospital-affiliated and non-
3 hospital-affiliated IPAs and hear them talk about how
4 difficult it is for them to take symbolically a physician
5 symbolized by the sheep in the foreground and get them to
6 look like the sheep upward and to the right. It's very
7 tough for them.

8 And while I certainly agree with the point that
9 several aspects of performance measurement, especially for
10 chronic illness, are hugely easier at larger units of
11 aggregation, there are certainly some aspects of performance
12 measurement that are reasonably attributable to individual
13 physicians.

14 And so if we want to anticipate the struggle that
15 the medical directors of tomorrow's -- I hope I have this
16 right -- EHMS.

17 DR. FISHER: Accountable care organizations.
18 We're going to take Glenn's name.

19 DR. MILSTEIN: If we move forward, some day
20 there's going to be a medical director of such an
21 organization and a beleaguered board chair who are going to
22 be facing the same kind of struggles that today their

1 counterparts in IPAs in capitated California face.

2 And my intuition is that we could help them a lot
3 if for at least those aspects of measurement and
4 accountability that are reasonably attributable to the
5 individual physician level we also had some Medicare
6 incentives operating that pushed individual physicians to
7 reach for excellence in resource use and in quality.

8 For example, I guess the cleanest example would be
9 an orthopedic surgeon that does hip fracture repairs.
10 That's clean.

11 DR. FISHER: Absolutely.

12 DR. MILSTEIN: So I guess I'm asking for your
13 endorsement of a two-engine solution or three or whatever
14 because I worry that --

15 DR. FISHER: This is going to come back to bite
16 me, I can see. Let me quickly answer.

17 I think there is tremendous value to helping
18 physicians understand how they're practicing and to the
19 feedback that's done. If you look at what's happened in
20 Rochester and others in terms of the feedback or at Partners
21 in Boston, about they use feedback to help physicians make
22 wiser choices, I think it's very powerful.

1 A couple of things. First, I think some of the
2 difficulty around changing individual behavior will be
3 incredibly difficult. But if I look 10 years down the line,
4 what I want to influences is whether that group recruits
5 four more physicians because that's going to change what
6 spending is 10 years from now.

7 So this system, even if you can't change the
8 behavior of that group of physicians, the big thing that's
9 going to change their behavior is giving them fewer beds to
10 work with, converting some of those beds to nursing home
11 beds and having a really good local right in the hospital
12 nursing home, and not recruiting another 10 cardiologists
13 because that's how we make a lot of money in the short term,
14 by doing more cardiac procedures.

15 So the decisions about future capacity growth are
16 the ones that I think this really influences. Since there's
17 so much discretionary decision-making around how to see a
18 patient and when to refer, that's what I wanted to target
19 with this policy.

20 I'm perfectly open to individual physician
21 performance measurement, certainly on as many dimensions as
22 we can reliably do it. We don't want to have the discussion

1 about ETGs or other groupers here. I read the lively debate
2 that was carried on and I hope I can contribute in
3 constructive ways.

4 I believe it should be done within these groups
5 because that's the level at which capacity is having its
6 influence. And so relative to the performance of an
7 individual group within which you're working, I think that's
8 where you would actually see ETGs actually start to be
9 useful as a tool and much less likely to lead to the false
10 conclusion of he's an efficient doc but that's because he's
11 in Miami and they chop people up into lots of episodes.

12 DR. WOLTER: Like everybody, my mind is racing
13 with how might you translate this into something practical,
14 because I think it is absolutely the right direction. And I
15 think the power of placing the accountability at some
16 organizational unit level clearly is really important.
17 Arnie and I have had this conversation about individual
18 versus group many times, but I guess I would boil it down to
19 this: I think the best way to hold individual physicians
20 accountable is through the group process of other physicians
21 using data to work with individuals. We don't have that now
22 in American health care. We have an incredibly fragmented

1 cottage industry around which nobody is holding anybody
2 accountable.

3 I think maybe the insurance companies can do it
4 but that's been basically a miserable failure, I think, over
5 these many years. So what we're talking about now can be
6 incredibly powerful in terms of how physicians come together
7 to hold one another accountable, but at the same time put
8 system approaches in place that can really tackle, in the
9 initial years, the high-cost highly complex diseases that
10 really is where all the money is.

11 So this is the right direction. There are 10
12 million barriers, and it does seem hopelessly impossible to
13 go from point A to point B. And I couldn't agree with you
14 more, the way to think about this is that this is charting
15 about a 10 or 15 year course, rather than something that is
16 going to respond to the immediacy of the SGR-mandated report
17 or the change in control in the Congress that just occurred,
18 or whatever is on the hot button plate.

19 So how might one get there? That's what I've been
20 kind of racing about since this presentation began.

21 I was thinking, yesterday we had a great
22 presentation on multi-specialty groups. I was thinking

1 about all the enthusiasm in the '90s around integrated
2 systems. And at that time Jeff Goldsmith, who has presented
3 to this body in the past, wrote an article I just thought
4 was fabulous. It was called Driving the Nitroglycerin
5 Truck. It was about the absolute cultural differences
6 between physicians and hospitals that basically meant that
7 this approach to integrated health care was going to blow
8 up.

9 He really called that one, I think, very, very
10 well.

11 How could it be different this time, I think is
12 really the question. And I think the reason possibly it
13 could be different is if we chart a course that makes it
14 clear we do have a long-term view. But along the way we're
15 going to take this in some sort of steps. One way we might
16 do that would be to identify some of those high-cost, high-
17 volume areas, and make it very clear that we're now going to
18 pay for them in a way that puts A and B together, which
19 would cause certain physician groups in the way that you've
20 analyzed it to have to come together with hospitals to take
21 care of diabetes or congestive heart failure or asthma, et
22 cetera.

1 And over time we could migrate more of what goes
2 on in the care of these patients into that sort of organized
3 approach to care. That would allow for a lot of the
4 boutique-ey thanks to run their course that are going on,
5 and not everything necessarily needs to come into these
6 systems of care anyway.

7 I would say, Ralph, that there are many physicians
8 who would definitely not want the hospital to be the unit of
9 organizational accountability because there's just so much
10 mistrust of hospital control behaviors. But I think new
11 organizational entities can form, as they did with Middlesex
12 that we saw the presentation on.

13 So I think there would be a way to chart a course
14 that would allow migration into these models over time. And
15 if it was clear that was the direction and we did start to
16 put some payment incentives in place I think we could create
17 a trend in the right direction as opposed to -- I couldn't
18 agree with you more, so much of what's in the incentive
19 system right now is taking us in the other direction. And
20 that's the real danger over the next 10 or 15 years if we
21 don't rechart the course.

22 Lastly, I would say we know a lot about sheep in

1 Montana.

2 [Laughter.]

3 MR. MULLER: I think the evidence of the '90s in
4 trying to create physician groups around payment and around
5 capitation and the miserable failure of the Phycorps
6 [phonetic], MedPARs, and so forth shows you it takes 100
7 years to create Mayo, 50 years to create Kaiser, et cetera.
8 I think we should learn from that. It takes forever to
9 create these groups. And that's why I argued for taking
10 existing constitutional structures, rather than thinking --
11 and what we saw yesterday -- and I'm all in favor of multi-
12 specialty organized groups. But I think the notion you can
13 slap them together was incredibly disproved in the '90s.
14 And I think if it takes 100 years to create them, we should
15 plan on taking 100 years to create them.

16 That's why I was arguing for taking existing
17 constitutional structures.

18 DR. KANE: I'm a little bit with Nick on the
19 payment side of now do you get groups who have historically
20 warred over who gets which piece of the pie, and I think
21 that's where a lot of the PHOs fall apart in the past.

22 The other piece is is it really realistic to take

1 a fee-for-service and a DRG-based system and basically a
2 per-unit of service system and expect them to start to
3 improve quality if that means their payments are going to
4 get reduced by the reduction in the volume of emergency room
5 visits or inpatient care?

6 Do we really have to just think of a completely
7 different way of payment unit besides fee-for-service and
8 even DRG to get to the kind of incentives? That's the first
9 question? And I'll give you my second one because I found
10 that once people get started, you don't get a second shot.

11 My second question is you said several times that
12 constraining supply is really the main goal of what we
13 should be after that. And I've got little bells ringing off
14 here. I hear Mike Porter talking to me, or somebody who
15 thinks that competition and consumer choice and all of that
16 should be fostered. And somehow constraining supply doesn't
17 go with this notion that we should be encouraging more
18 choice and more opportunity and that this accountable --
19 whatever we're calling it -- would actually probably seek to
20 constrain supply and constrain the number of new
21 cardiologists that come in, and constrain the specialty
22 hospitals, and constrain the availability. And so where do

1 you see this? Where does competition and consumer choice
2 fit into your motto?

3 So how should the payment system changed to foster
4 these kind of collaborations that we need? And then what do
5 we do about competition? Or where does competition fit in?

6 DR. FISHER: Competition actually fits pretty well
7 in that 90 percent of Medicare beneficiaries live in markets
8 where there would be multiple accountable care
9 organizations. Now it depends on where the FTC is and it
10 depends on how you define them. But they're hospitals,
11 there are lots of hospitals and their medical staffs.

12 The way to constrain supply effectively would be
13 to have great performance measures that let us know which
14 systems were really providing better care. The flaw in Mike
15 Porter's assumptions is that people in the current system
16 can actually evaluate the value of the services we're
17 providing and that you can chop people up into disease
18 entities that will have competing disease entities when most
19 people have multiple chronic conditions. The last thing you
20 want is to be sent across town for your cancer when you're
21 being cared for for heart disease at someplace else, I
22 believe.

1 But the payment system, how could you do this in a
2 payment system? I think we're learning a lot from the
3 Physician Group Practice demonstration and the notion of a
4 shared savings model, which is fundamentally what a SGR-like
5 formula if you put the A and B together would essentially
6 be, that is you would be rewarded next year if you reduced
7 total spending within your group for the beneficiaries you
8 serve while providing high enough quality care.

9 Again, when I look at, from by epidemiologist
10 perspective, about the difference in spending across
11 systems, it's not about the services that are clearly
12 defined to be beneficial or that patients would really want
13 if given adequately informed choice. It's about unnecessary
14 visits to the physician's office, which most patients would
15 rather forego. I'd really rather do it by going than being
16 told to come back. And it's about imaging procedures, trips
17 to the lab, other services, time in the hospital that could
18 otherwise be spent at home.

19 And so if we look at the categories of services
20 that are overused in our current delivery system, I think
21 that's the tool whereby supply would have -- supply would
22 have it's impact on the discretionary services, not on the

1 necessary or even plausibly beneficial services, I believe.
2 And that's just 20 years of epidemiology and Jack and I
3 crying in the wilderness while everybody else believes more
4 medical care is better. With good performance measures, we
5 might actually see that more medical care is actually bad
6 for you in many of these circumstances, especially the kinds
7 of unnecessary services that patients are now receiving,
8 time in nursing home when they don't need to be there, time
9 in the hospital when they really shouldn't be there.

10 So I'm not going to give up my worries about the
11 overuse and the harms which the first slide really outlined
12 pretty clearly from more medical care, and the need to
13 design a system that gets us better performance.

14 DR. KANE: On the payment side though, doing less
15 means less inflow unless we get away from fee-for-service
16 and per unit payment.

17 DR. FISHER: But you could still use a fee-for-
18 service unit payment system with a shared savings model. I
19 think we ought to get away from fee-for-service in the long
20 run. We've argued that pay-for-performance is a way of
21 learning how to change the payment system. I'm certainly
22 happy to get rid of fee-for-service, don't worry.

1 MR. HACKBARTH: I think a practical concern is
2 whether the shared savings are powerful enough relative to
3 the underlying fee-for-service.

4 One way to think about that is that there's an
5 alternative where people can go that is decapitated. The
6 fee-for-service system is the base system for better or
7 worse. We're not going to be able to change that. But you
8 can create alternatives.

9 Ron, the last word.

10 DR. CASTELLANOS: First of all, I really
11 appreciate this conversation. I learned a lot.

12 I looked at the slide and I didn't see the
13 Serengeti. I saw a bunch of doctors out there ready to get
14 sheared.

15 [Laughter.]

16 DR. CASTELLANOS: I have to tell you, I am a
17 practicing neurologist in South Florida.

18 But the more I listened to you, I like the idea of
19 the accountability and the organization, be it the hospital
20 or a group practice.

21 Like Sheila, I had a little different concern than
22 she has. I lived in South Florida. My population goes from

1 500,000 in the summer up to 1.5. We have very poor
2 coordination of care along regions. We've thought about
3 episodic coordination of care but we really never thought
4 about it -- or at least I never thought about it --
5 regionally.

6 I think with accountability of organizations we
7 will have some coordination of care. And I think that's
8 really important. I think we could have tremendous cost
9 savings on that part. We could have better quality of care.
10 We could have efficiency. As we said, we can have more
11 appropriate care at a less price.

12 I guess my concerns are this, that a lot of these
13 patients come down and are not in the hospital setting but I
14 see them for chronic diseases or cancer, et cetera. This is
15 under Part B. How is that accounted without a hospital
16 involved?

17 DR. FISHER: The way we've assigned -- I mean
18 technically, in this data, we have probably assigned you to
19 a hospital, even though you never admit a patient, you may
20 not be doing inpatient care. And we've assigned a group of
21 patients who the ambulatory physicians are providing care.

22 For many of these Medicare beneficiaries in the

1 data that we've looked at, they're never hospitalized during
2 the year. But they're part of the group and their care --
3 if I understood your question, their resource use, care
4 coordination, would be managed at the level of the
5 physicians who are affiliated with this group.

6 DR. CASTELLANOS: I understand when that's in the
7 same region. But what it's two entirely different regions,
8 thousands of miles apart.

9 DR. FISHER: Snowbirds are going to be a
10 challenge. We have the same problem in Vermont, where they
11 all go south for a month and our geriatricians take a month
12 off.

13 But I do think the notion that's in one of the
14 slides there at the end, if patients assigned to -- chose
15 the physician or the group with which they were going to be
16 affiliated, and then that group had some responsibility to
17 communicate, if it were my patients in Vermont, had some
18 responsibility, I would have some responsibility to
19 communicate with you. When I was practicing at the VA and
20 my patients went south, it was always very hard to get the
21 conversation going with the physicians in the other
22 communities.

1 But that's, I think, what we need to do. And this
2 would give someone the incentive to pay attention to that
3 communication.

4 DR. CASTELLANOS: There's no question, it gets
5 doctors talking to each other, it gets doctors and hospitals
6 together. I really think there's a lot of attention here.
7 Thank you for your report.

8 DR. FISHER: Thank you.

9 MR. HACKBARTH: Thank you again, Elliott, terrific
10 job.

11 It is 11:25 and we are going to finish at 12:30,
12 the scheduled time, for those worried about getting to the
13 airport.

14 Our next session is on SGR again, and it has two
15 components. One is about combining SGR alternatives and the
16 second is setting targets for physician specialties.

17 So Kevin, what I would ask you to focus on is the
18 setting targets for physician specialties. I think we've
19 touched on the other topic a bit in the discussion we just
20 had. But I want to make sure we get to the specialty-based
21 target discussion.

22 What I'll do is allot about a half hour for that

1 and we'll pare down the hospital-based SNF discussion to 15
2 or 20 minutes and then have a very brief comment period and
3 be done at 12:30. That's the plan.

4 DR. HAYES: Just to revisit where we are here,
5 recall that the mandate for the SGR report identifies a
6 number of different alternatives to the current policy that
7 we should consider, geographic area, type of service,
8 hospital medical staffs, group practices and physician
9 outliers.

10 The law is not so prescriptive, though, as to
11 preclude the Commission from considering other ideas, and
12 this session is intended to be an opportunity to do so.

13 The two ideas that we would like to offer this
14 morning are combining SGR alternatives, at least some of
15 them that are listed in the mandate, and then the other idea
16 would be to set targets for physician specialties. I've got
17 three slides on the specialties idea. We'll go over those.
18 And then the rest of the slides concern the idea of
19 combining SGR alternatives.

20 Looking at the physician specialties, we see that
21 they vary in terms of how fast the volume of their services
22 is growing. Looking just the top 10 specialties in terms of

1 volume of services furnished to Medicare beneficiaries, we
2 see that their volume growth varies relative to the growth
3 in real GDP per capita which you know is the allowance for
4 volume growth in the current SGR policy.

5 Some specialties are at or below real GDP growth,
6 general surgery 0.6 percent, this is '04 to '05. Two other
7 specialties are within a percentage point of real GDP
8 growth. Internal medicine is at 2.9, ophthalmology at 2.4.
9 Other specialties differ from real GDP growth a bit more.
10 At the far right we see two specialties, emergency medicine
11 and neurology, differing from it the most.

12 So the idea with setting targets for specialties
13 would be to just try and rely, take advantage of peer
14 influence to work through physician specialty organizations.
15 This would be specialty societies, certifying boards and
16 residency review committees, and see if they couldn't come
17 up with some ways to use peer influence to bring about more
18 efficiency in the delivery of health care.

19 We have some examples of this kind of thing
20 already, not an all-inclusive list but there are some
21 appropriateness criteria that have been developed for
22 imaging services. We have the American Board of Internal

1 Medicine has changed the way it certifies physicians, moving
2 away from once-in-a-lifetime certification toward a
3 maintenance of certification program. And they're finding
4 in preliminary research is that more knowledgeable
5 physicians provide more appropriate care but also a more
6 conservative type of care.

7 More in the way of quality improvement, we have
8 efforts on the part of the American College of Surgeons,
9 Society of Thoracic Surgeons, to engage in some data
10 collection, provide some feedback to physicians, or to
11 physicians and hospitals together.

12 Doing this kind of thing comes potentially with
13 that advantage of taking advantage of what specialty
14 organizations can do. There are some questions, though,
15 about this kind of SGR policy would work. And that we've
16 listed them here. I won't go into any detail here, but if
17 you have questions about this I'd be happy to try and answer
18 them.

19 The basic questions here center around things like
20 whether this kind of setup would work against physician
21 collaboration of the type that the Commission has been
22 advocating, say in the area of care coordination, some

1 concern about how physician specialty is designated by
2 physicians. This is this something that they do for
3 themselves? Would does lead to perhaps some changes in
4 behavior there? And then there are a set of questions about
5 how to set targets for physician specialties.

6 MR. HACKBARTH: Is that the end of the specialty
7 piece? Could we just pause there? I want to make sure that
8 we have an opportunity to discuss that.

9 Any questions or comments about that?

10 MR. DURENBERGER: I don't so much have a question
11 as first, a compliment to Kevin for the work, and for the
12 inclusion of examples that already exists in the profession.
13 You haven't here mentioned them all, but I think in the
14 report you did. And I think that's really quite valuable.

15 As I'm listening to Elliott and I'm listening to
16 the Chairman's question and so forth, to articulate the goal
17 that's up through here, I'm reminded of old Walter McClure,
18 who was Paul Ellwood's partner in Minneapolis 30 years ago.
19 One of the things I will never forget that he said is that
20 American medicine is remarkably inventive. If you just
21 point it in the right direction and with the right
22 incentives, it will continually improve the quality, the

1 value, the satisfaction of the system better than any other
2 industry. We haven't had that experience with American
3 medicine in a long time.

4 My personal judgment is we've never had the
5 incentives lined up in the appropriate way, and we now seem
6 to be in a situation where for a variety of reasons, some of
7 them professional and some of them to get the incentives
8 changed, a lot of these specialty associations are doing the
9 hard work of data gathering so that they themselves can
10 improve a clinical performance.

11 It strikes me that whatever we do as we articulate
12 this chapter and build it into these alternatives, whatever
13 we do to encourage them to continue to do that, to take that
14 next step which is through maintenance certification or
15 whatever it is, to do that periodically as a way in which a
16 profession helps to police performance of its own members.

17 We eventually get to the point where hopefully we
18 begin to combine clinical outcomes information with price or
19 cost related information and within the specialties we see a
20 lot of that performance enhancement that we're looking at.
21 It's not an exclusive remedy for the problem, but it strikes
22 me as being a critically important one, particularly at a

1 time when the associations themselves are asking.

2 The last question will probably be around
3 financing and so forth, because at some level it would be
4 helpful to fund this. And what occurs to me, as one who is
5 neither a doctor nor anything else, is we're spending an
6 awful lot of money on Medicare Advantage organizations
7 trying to get them to do this same sort of thing with data.
8 It might be worth spending a relatively small comparatively
9 amount of money in helping the specialties themselves fund
10 some specific goals that we might set out for them.

11 With regard to the disadvantages you set out,
12 would a specialty SGR work against physician collaboration?
13 Again, it's just an impression that the collaboration
14 problem is not so much one specialty versus another
15 specialty, as it simply is one doc and one specialty and
16 another doc and another specialty in a community or
17 something like that.

18 Is there an issue with physician specialty because
19 it's self-designated? If I understand that, in reality the
20 Supreme Court a long time ago, I think it was Brandeis, gave
21 a legal definition to a profession. And there is an
22 obligation to self-regulate built into the profession. And

1 so I'm less bothered, if they take it seriously, by the
2 self-designated part of it.

3 And I think on the last one, how would the
4 Congress or the Secretary set the targets? Once we began to
5 establish a base or a benchmark for performance, it would
6 seem to me that the specialty organizations themselves will
7 provide, through the performance that comes through the
8 system, will provide the benchmark or the base that you need
9 to continue to enhance that performance.

10 DR. CROSSON: I had a somewhat similar comment, so
11 I'll make it short.

12 I think my initial reaction was thinking about
13 disadvantage number one, and that is that it doesn't appear
14 to have the characteristic that we've talked about, which is
15 encouraging physicians to work together. I'm not sure,
16 though, that I actually believe that it would work against
17 it. I think it's probably neutral to that goal.

18 But the one I thought bothered me the most is the
19 last one, and it's not so much how Congress or the Secretary
20 would set the targets as much as the fact that setting the
21 targets really would require a judgment about the clinical
22 issues relevant to that specialty in that particular year.

1 Because as science advances, even though some of this may
2 result in unnecessary spending, nevertheless a lot of it
3 results in appropriate spending. But science advances non-
4 linearly. And in each specialty from time to time there are
5 break-throughs which result in appropriate increases of
6 volume.

7 So my thought here is that the problem would be
8 that Congress or the Secretary would really have to make
9 some difficult clinical judgments about what was an
10 appropriate volume increase at any given time and what
11 wasn't. And that's generally not what they like to do.

12 DR. REISCHAUER: But they could rest on the advice
13 of MedPAC.

14 [Laughter.]

15 DR. REISCHAUER: I was wondering, Kevin, if you
16 had broken down the volume growth on page three into that
17 which was associated with doing more of the same things
18 versus an increase in the intensity. I think the way these
19 things are done is it's number of things weighted by the DRG
20 associated with them.

21 If you think about it, these numbers are
22 remarkable if it's sort of doing more of the same thing per

1 Medicare beneficiary, 4 or 5 or 6 percent increase in the
2 number of artificial knees you put in the average person.
3 At some point you can't do anymore. This would be getting
4 to Jay's point, if a very high fraction of it was an
5 increase in intensity, then there's a question of is it
6 because new and more complex and expensive stuff is
7 available? Or is it because the number of E&M visits per
8 hip transplant has gone up 11 percent a year? You might get
9 some insight.

10 I think I'm with Jay. The bottom line is that
11 this is probably something we shouldn't pursue because it
12 gets us or the Congress into areas well beyond our
13 competence.

14 DR. WOLTER: My instincts aren't taking me to this
15 either. I just think that it's not going to be easy to
16 decide how to set the targets. I think another one of the
17 disadvantages is when you do have regional variation of such
18 significance, how do you deal with the fact that one area
19 may be driving volume more than another? And what's the
20 equity in that? It's very difficult to think of how this
21 might be administered.

22 I'll say it again, I think we went on record as

1 saying we don't think the SGR has been effective in a
2 previous statement. I wish we could really dig in and start
3 focusing on the tactics that are more likely to get us to
4 appropriate resource utilization. I think these global
5 formulas have not worked very well for us.

6 MR. MULLER: I feel somewhat the same as the last
7 few comments. I think while I admire what the specialty
8 organizations do in terms of development of practice
9 guidelines, certifications of new physicians entering into
10 the field, and basically the kind of science of what they
11 do, I'd like to go back to the previous discussion with
12 Elliot. These are not accountable organizations. Nick and
13 others have just said it. so I think using them for this
14 purpose is fraught with too many difficulties without an
15 awful lot of gain.

16 DR. CASTELLANOS: I'm going to take a little
17 different approach. I think the SGR issue is no question, I
18 don't think it should be used there as a target.

19 But as we talked about yesterday, when you educate
20 physicians and show them that maybe they are an outlier, you
21 need to look at that. And you need to let the physician
22 community know that.

1 I happen to be a urologist and one of the things I
2 mentioned to Kevin yesterday, I said Kevin, what's the story
3 here? He was unable to give me the breakdown. And what we
4 had discussed afterwards is that I would love to look at
5 that, and so would my specialty, like to look at that to see
6 if we can identify appropriate volume growth versus
7 inappropriate volume growth or, as Mark had used an
8 expression once, looking at the root causes of this volume
9 growth.

10 So in this little section, I think that's
11 important. I don't think we should use it as an SGR target.
12 But I think to identify volume growth, I think, is very
13 important for the physician community to be acknowledging
14 that and to look at it.

15 MS. DePARLE: I like what you've proposed here,
16 Kevin, or what you've come up with. I think that it is
17 true, as Ralph says, that there is a merit to trying to use
18 currently existing organizations as accountable
19 organizations. Hospitals certainly are those. And we had a
20 long discussion before this about why they make more sense
21 ultimately.

22 But I view this in a step in the right direction

1 away from something that we know isn't working and the
2 combination of these alternatives seems to be moving in the
3 right direction, I think.

4 DR. BORMAN: Just quickly, I think that the other
5 thing that is advantaged by this information is the nature
6 of the services, at least in some groups here, are fairly
7 different. Volume here is a function, I think, of frequency
8 and intensity of the services. And I think that's pretty
9 hard to tease apart unless you break out some things that
10 are already packaged, for example the 90-day major surgical
11 package versus an individual one time encounter.

12 And so I think this does help inform the
13 discussion, and I would agree exactly with Nancy-Ann that
14 it's a means to an end that is kind of here and now and
15 could be helpful.

16 MS. BEHROOZI: Just quickly, I would want to add
17 my voice to supporting the notion, and I think this is
18 somewhat -- unless I'm misinterpreting you, Karen --
19 implicit in what you're saying. The type of service is an
20 important thing to look at. I wouldn't want to lose that as
21 one of the factors that we were supposed to be considering.

22 I think in terms of looking at the SGR, I don't

1 know how complete the correlation is been looking at
2 specialties and types of service. I know it's all fraught
3 with making those value judgments that are very difficult to
4 make, but I think it's hard to get away from that when
5 you're talking about controlling inappropriate volume
6 growth, to use a word that we've used before.

7 MR. HACKBARTH: I think that the work that
8 specialty societies are doing is critically important work,
9 and I'd love to see it not just continue but grow rapidly.
10 I, for one, would hesitate though to organize the payment
11 system around specialties, for some of the same reasons that
12 others have mentioned.

13 Like Jay, I'm not sure that it would make
14 collaboration worse. But I don't think it would help make
15 it better. If there's one point that we keep coming back to
16 over and over and over as a fundamental shortcoming of our
17 care delivery system and is that there's not enough
18 collaboration, integration, coordination of care.

19 So if you're going to make a new major payment
20 change and go through the administrative challenges and the
21 political challenges of doing so, to do something that isn't
22 going to address one of the fundamental problems in the

1 system, seems like an enormous lost opportunity if nothing
2 else.

3 I, for one, also agree with Jay about having
4 policymakers struggle with decisions about the level and
5 rate of growth by specialty or type of service. That's not
6 what policymakers do well. That's not their role in
7 society, as I see it at least. It's their role to say here
8 are the constraints. Here's how much we can afford to
9 spend. They have legitimacy in doing that. That's what
10 they're elected to do.

11 But it's clinicians and other providers who are
12 trained to make the decisions about how to best use the
13 available resources to improve care for patients.

14 And so let's have policymakers do what they are
15 responsible for doing, establish the broad limits. And then
16 have clinicians do what they're trained to do, which is to
17 allocate the available resources as best they can.

18 I don't see any of that has being inconsistent
19 with your point, Ron, that you made several times about
20 outliers and providing information back to clinicians about
21 where they stand relative to their peers. I see that as a
22 complementary strategy with some of the other ones. And I

1 agree with you, I think that's very important. That's a big
2 opportunity.

3 And then last, Nick, a couple times over the last
4 two days, has made his point about formulaic systems in
5 general and how in the past we've opposed such systems.
6 This is something that personally I'm really wrestling with.
7 I've got the litany of why formulaic systems are bad down
8 pat, I've done it so many times over the last five years.
9 And so that is a message near and dear to my heart.

10 I think ultimately, not today but ultimately, we
11 need to decide how to best to respond to Congress and the
12 question it has asked. Some think that they want us to tell
13 them what the best of formulaic option would be, even if it
14 wouldn't be our first choice which of the formulaic options
15 would we elect?

16 I'm not sure we can get a consensus around that.
17 We may come back to Nick's fundamental point that we can't
18 embrace any formulaic system. The best we could do in
19 response to the mandate is say here are the pros and cons of
20 different alternatives, without a formal embrace of any of
21 them. And I think that's very much an open possibility.

22 The fact that we're looking at all these in

1 detail, I don't want you, Nick, or anybody in the audience
2 to infer from that that the end product of these
3 deliberations will be a MedPAC boldfaced endorsement of any
4 formulaic system.

5 DR. WOLTER: The practical question I'm wrestling
6 with is at what level does a formulaic approach change
7 behavior? And if we were to do a cardiology SGR, would the
8 annual meeting of 8,000 cardiologists take a vote on
9 something that would change behavior? Or are we doing this
10 more just because we might get a financial result if we cut
11 reimbursement? I think that's maybe what we're doing, is we
12 may not be able to control behavior but at least we can cut
13 payment.

14 I don't know if, in the long run, that's going to
15 be the best way to control the resource utilization. And so
16 that's what I'm wrestling with. I'd like to get to the
17 aggressive list that might really work better than the SGR
18 has to control resource utilization, of course.

19 MS. BURKE: I absolutely agree.

20 Glenn, I don't disagree at all with what you've
21 said and the challenge that we face. And I guess the thing
22 that I continue to struggle with is we've spent this

1 morning, and we have in prior discussions, informing
2 ourselves as to what the drivers seem to be. There is clear
3 evidence that there are drivers that relate to geographic
4 location, all the things Elliott went through this morning
5 in terms of how one behaves in the area in which one lives
6 and what the incentives are, the resources that encourage
7 you to either utilize or not utilize services.

8 There are also specialty related activities, I
9 mean things that are -- the chart here very specifically
10 looks at volume as it relates to specific types of practices
11 and specific kinds of services. Arguably, there's also a
12 geographic impact on that and how people behave and resource
13 allocation.

14 So I don't disagree with you that formulaic
15 options are ones that we are fundamentally not comfortable
16 with. This morning's conversation suggested a system that
17 addresses the issue you raise, which is the communication
18 issue. How do you suggest that people begin to organize
19 themselves or talk with one another?

20 And so the problem, at least that I have, as you
21 look at each of these, there is argument to be made for a
22 geographic solution or some kind of intervention at a

1 geographic level. The suggestion has been made by Ron and
2 others that the availability of information that encourages
3 the physician to understand how she functions in the course
4 of her colleagues and how she might use that information to
5 better inform herself is something I think we would all
6 agree to.

7 So I think there are pieces of this that reflect
8 on the geographic issues, reflect on the specialty issues,
9 that are part of a solution. And the information sharing,
10 it would seem to me, is one that we are all moving towards.

11 So I wonder, as we all look towards next
12 discussion, trying to understand pieces of this that may not
13 be the whole solution or may not simply repeat a new formula
14 that's equally as challenging to apply, but what are the
15 pieces that we can piece together that while we can't give
16 you an absolute solution to the current SGR, which we can't
17 stand, we know there are certain kinds of things that we
18 ought to do that reflect on the realities that there is a
19 geographic issue, there is a resource issue, there is a
20 specialty issue, that we ought not simply, I think -- and
21 I'm not suggesting you're going this direction -- simply
22 give up and simply say we can't or simply say here are the

1 pros and cons of each of these.

2 There ought to, I think, also be an attempt to
3 try, if we can, find those things where there is consensus
4 and there is the opportunity to move the ball ahead, even
5 though it's not a total solution.

6 MR. HACKBARTH: I agree with that.

7 DR. KANE: I guess part of the problem with
8 geographic -- I was having this discussion with
9 Congressional staff people this morning -- is that if you
10 try to put something out in the political domain that looks
11 like you're going to move resources from one part of the
12 country to the other, it's kind of dead in the water before
13 you start.

14 So one variation on geographic area SGR-types of
15 tailored limits would be that you pick a national best
16 practice in the top 25 percent target and instead of saying
17 let's move resources away from Miami to Minnesota, you say
18 here's the best practice target and then try to reach that.

19 But I think specialty bothers me a lot because I
20 don't think you know what you're getting. But that there
21 might be some sort of a per capita age and sex adjusted for
22 best practice target that's nationally based that everybody

1 tries to strive toward.

2 Then I guess, yes, it will end up being
3 geographically implemented. But you're not going through
4 Congress trying to say Minnesota should get a lower target
5 than Miami. You're just saying there's a national -- I
6 didn't mean to pick on Minnesota. But if you look at all
7 the maps, it looks like the lowest rates of growth are in
8 places like Minnesota.

9 MR. DURENBERGER: I don't want to drag the topic
10 on but I just have to respond to that.

11 How do we think performance improves? Some
12 cardiologist, some drastic surgeon, some urologist from some
13 part of the country is setting a standard and then it
14 spreads. This is naturally what happens.

15 Sheila has got the right idea here. At the end, I
16 hope we mix this. But we should not put all urologists in
17 the same category and all whatever it is in the same
18 category. Because the only way to improve the performance
19 within those professions is to allow people in their
20 professions, who are already setting the standard -- whether
21 it's Miami or Minnesota -- to help the others improve their
22 performance.

1 DR. CROSSON: I just think we should not shy away
2 from the original intent out of fear of the word formulaic.
3 I think everybody recognize how complex the SGR is and it
4 failed. But I think the fundamental idea here, if I
5 understand it, is how can we take within the fee-for-service
6 payment system for physicians and potentially for hospitals,
7 and create incentives over time for the appropriate
8 management of resources, one important element of which is
9 inappropriate volume? And that there ought to be some
10 reward, and it probably based on all that we've heard, could
11 reasonably be directed at something called accountable
12 organizations which can be formed over time. How can we
13 then direct incentives?

14 The attractiveness of the update payment system,
15 as opposed to payment within a year, the kind of withhold or
16 reward system, the attractiveness to me of using the update
17 system is that it allows relatively small changes to
18 accumulate over time and turn into an important incentive.

19 In other words, if you end up, to fast forward
20 this, if you end up with a 2 percent differential between
21 one SGR pool and the payments delivered to a successful
22 accountable organization, that may not in itself be enough

1 to change behavior. But if that 2 percent is replicated
2 year after year after year everyone understands that you
3 can't allow that to happen without changing behavior.

4 MR. HACKBARTH: I'm actually feeling like this is
5 starting to come together. There are certain themes where I
6 think there is very broad consensus. I think what we come
7 up with will have multiple parts that will play on those
8 multiple themes. And I think realistically what we come up
9 with as a direction is something that would unfold over a
10 period of years. This would be sort of a long-term
11 direction. This isn't an overnight snap solution for a new
12 SGR system.

13 But I'm feeling like we're making good progress.
14 There are some really difficult decisions to come, but I
15 felt good about the progress we've made to this point.

16 Kevin, I'm sorry for having to cut short your
17 presentation, but we are going to have to move ahead and
18 have a brief presentation on the last item on hospital-based
19 SNFs.

20 DR. KAPLAN: The purpose of this presentation is
21 to report what we heard about hospital-based SNFs on site
22 visits.

1 Before the SNF PPS, the number of hospital-based
2 SNFs increased rapidly. Following the PPS, a number of them
3 closed. At the same time, however, a large number of
4 hospital-based SNFs remained open.

5 To find out how hospitals make decisions about
6 closings SNFs or keeping them open we, Kathryn, Craig and I,
7 with Urban Institute folks, went into the field to talk to
8 hospitals.

9 The chart on the screen shows the rapid increase
10 in the number of hospital-based SNFs prior to the
11 implementation of the PPS in 1998 when SNFs had a cost-based
12 payment system.

13 In 1997, the Congress required CMS to design and
14 implement a prospective payment system to control Medicare
15 spending on SNFs.

16 As you can see, the number of hospital-based SNFs
17 peaked in 1998 when the PPS began. The PPS pays a daily
18 rate for routine, ancillary and capital costs.

19 Since the SNF PPS was implemented, the number of
20 hospital-based SNFs declined. From 1998 to 2004 about one-
21 third of hospital-based SNFs closed. Nevertheless, two-
22 thirds of these SNFs remained open.

1 We worked with Urban Institute to identify and
2 arrange interviews in five market areas. Corbin Liu and
3 Emily Jones are in the audience.

4 We interviewed administrators, referring
5 physicians, and discharge planners at 15 urban and rural
6 hospitals in or near the cities listed on the screen. Eight
7 have closed their SNFs and seven still have their SNFs open.

8 We also talked with administrators at three
9 freestanding SNFs.

10 Hospitals made clear to us that their mission is
11 providing acute care. To the extent that a SNF is seen as
12 furthering that mission, it will probably remain open. To
13 the extent that the SNF is seen as detracting from the
14 mission, it will probably close. For example, if the
15 hospital needed the space for another purpose, the hospital
16 closed the SNF. I'll get into this more in a moment.

17 All hospitals weighed the same set of factors in
18 making their decisions. For hospitals that closed their
19 SNF, the losses from the SNF could not be offset by the SNF
20 facilitating a shorter hospital length of stay. Physicians
21 frequently failed to recognize that the SNF was different
22 than the hospital. they would order tests and labs for SNF

1 patients as if they were in the hospital. These practice
2 patterns made it difficult to control cost for SNF patients.

3 In addition, most of the hospitals that closed
4 their SNFs had found a more profitable use of the space the
5 SNF used. That might include adding to hospital beds,
6 opening cardiac catheter labs, or adding imaging. At least
7 one opened a long-term care hospital in the former SNF
8 space.

9 Another issue was the difficulty of staffing
10 hospital-based SNFs with RNs. These difficulties frequently
11 added to costs. For example, RNS in hospital-based SNFs are
12 paid the same rates as other hospital nurses. Turnover was
13 sometimes a problem and the cost of agency nurses were even
14 higher than staff RNs. RNs often preferred to work in the
15 acute care area rather than in the SNF unit.

16 Hospitals that kept their SNF open usually do it
17 because they can shorten the hospital length of stay by
18 quicker transfers than they could make to freestanding SNFs.

19 Another issue is other post-acute care providers'
20 unwillingness or inability to treat patients who need a high
21 level of nursing care or need specific costly services.
22 Hospitals that kept SNFs open also told us that the SNF

1 allowed them to improve continuity of care and frequently
2 physicians were negative about closing the SNF.

3 We heard about three different models of hospital-
4 based SNFs. The first model focuses on providing
5 rehabilitation services to patients who are likely to be
6 discharged home. We were told that the SNFs do this because
7 rehab patients are financially attractive under the SNF PPS.

8 The second model focuses on medically complex
9 patients. These SNFs had more nursing staff. In addition,
10 physicians visited frequently and often did not distinguish
11 between the hospital and the SNF in their practice patterns.
12 The reasons for these SNFs' focus on medical complex patient
13 is to shorten the hospital length of stay.

14 The third model has few Medicare patients and many
15 nursing residents. This model is similar to a freestanding
16 SNF and we found this model in New York City. Hospital-
17 based SNFs may use this model because of either historical
18 reasons or because Medicaid payments are relatively generous
19 in these areas.

20 We've done some preliminary data analysis for the
21 hospital-based SNFs we visited and the results show or the
22 results suggest that these models do indeed exist.

1 We also heard that certain patients are more
2 difficult to place at discharge from the hospital. We were
3 told that these include patients who require high levels of
4 nursing care and/or services not adequately reimbursed by
5 the SNF PPS. We were consistently told that these services
6 included ventilators, IV therapy, and equipment and staff to
7 handle bariatric patients.

8 The next steps for this are more work on hospital-
9 based SNFs and continuing work on refining the SNF PPS.

10 That concludes our presentation.

11 MS. BURKE: Sally, thank you for following up on
12 this.

13 One question that I had, and I'm sure we've
14 discussed it before but I just can't bring it to mind, and
15 that is the geographic distribution in terms of the closure.
16 As you look across the array of hospital-based facilities,
17 did they tend to be located in certain areas -- I mean
18 certain areas of the country, have they seen a
19 disproportionate reduction in the availability of services
20 as a result of the closures because they were more dependent
21 on hospital-based as compared to freestanding? Is there any
22 -- I mean because then you begin to get into real access

1 issues, as well, and distant issues if you're only available
2 SNF is 100 miles away from your home.

3 But as you looked at the hospital-based, did they
4 tend to be focused in certain parts of the country? Or is
5 it pretty widely distributed? So that as you saw closures,
6 you don't see any shift in availability?

7 DR. KAPLAN: I don't know that I can directly
8 answer your question about the distribution.

9 MS. LINEHAN: If you go back to that side, the
10 second slide that shows the growth and decline in supply of
11 hospital-based SNFs, I looked at this sort of by state just
12 to see if there were any differences. And in fact, there
13 are distinct patterns. There are some states where the
14 supply was basically flat and there are other states where
15 the supply looks like you see here nationally. I could look
16 more closely at the relationship between that and
17 certificate of need laws but I think that probably has
18 something to do with it. So this explosion in growth and
19 the decline was not distributed evenly across the nation.

20 There was a study that I think MedPAC actually
21 paid for that looked at what happened when hospital-based
22 SNFs closed. It did find that the ones that closed tended

1 to be in urban areas that had other alternative post-acute
2 sites of care and that they also tended to be SNFs that had
3 opened recently. So they got in during this period of
4 growth and then went out.

5 MS. BURKE: I think going forward, as we continue
6 to look at this issue, as you continue to gather data, I
7 think it will be help to understand that. It will be
8 helpful to look at whether or not you've seen patterns that
9 -- I mean, if they are largely urban, if there are
10 essentially -- if this is also a competition issue.

11 But also, I think, the attention. There's no
12 question, at least anecdotally, you hear that the acuity of
13 the patients treated in hospital-based facilities is higher.

14 Query whether that, in fact, has proven to be
15 actually correct and whether or not the absence of these
16 facilities that do have a higher preponderance of RNs and
17 tend to have patients that are ventilator dependent, that
18 are in need of a higher level of services, whether there is
19 over time an access issue. Because there may be a
20 freestanding SNF available. They may not be a SNF that
21 essentially wants to deal with a ventilator-dependent
22 patient.

1 So are we seeing a change in the nature of
2 availability? Even though the bed may be there, is it the
3 same kind of bed? And what are we seeing in terms of
4 behavior? So just as we go forward, it would be helpful to
5 understand that as well.

6 then query whether they're staying in the hospital
7 or where they go? And are we seeing changes in lengths of
8 stay as a result of that? Or what's occurring?

9 MR. LISK: Just to answer that, in some of the
10 places that we had visited, for instance, the ventilator
11 patients may just have stayed in the hospital or the SNF may
12 never have done ventilator patients. So that may not have
13 changed things. But in many cases, the cases that end up
14 staying in the hospital may end up becoming outlier cases.
15 And from a reimbursement standpoint, financially it was more
16 advantageous for them to change.

17 In other markets, you had markets where there are
18 availability of those things outside. And so it was kind of
19 a no-brainer decision then for those places to close those
20 places. Again, a lot of the decision was there's better use
21 of the space in many, many cases.

22 DR. SCANLON: I just wanted to add to this point,

1 and Craig brought it up to a degree. I think as we look
2 forward in this and looking at data that we need to look at
3 both the hospital-based SNFs, the freestanding SNFs, as well
4 as the swing beds, all as alternatives for basically the
5 same service to be able to assess access appropriately.

6 MS. HANSEN: One other question I had was the
7 readmission rates at all, whether or not we look at whether
8 people are getting discharged potentially a little more
9 quickly, and as a result another episode starts over and
10 they come back into the hospital. I don't know if that was
11 looked at.

12 And then the question about New York is a bit of
13 an outlier state there, is that affected by the rate of the
14 reimbursement from the Medicaid side, just because it is so
15 significantly higher than anyplace in the country?

16 MS. LINEHAN: I'll answer your last question
17 first. We think so but we need to look more at this. New
18 York does have a differential payment for hospital-based and
19 freestanding SNFs, so they pay more.

20 As part of the work that Andy Kramer did, that he
21 talked about in September, he looked at national rates of
22 readmission. But one of the things that we're looking at

1 going forward with that work is to look at whether there are
2 differences across freestanding and hospital-based SNFs. So
3 we're going to have the results of that work in the spring.

4 MS. DePARLE: Maybe you said this, Sally, but in
5 the discussion we were just having about ventilator
6 patients, I wondered if you looked at availability of LTAC
7 or long-term acute care hospital beds in a market, these
8 five markets, and whether that would tell you anything about
9 the likelihood of a hospital-based SNF bed to still be there
10 or not?

11 MR. LISK: To give you an example, I think it was
12 Tampa I don't think had any long-term care hospitals. I
13 can't remember. But in many of those places, the patient
14 just remained in the hospital or they found other places
15 where reimbursement was better and in some places
16 transferred those type of patients like Ohio and other
17 states. Because the state had poor reimbursement they found
18 other places where the reimbursements were better because
19 most of these patients were going to not be Medicare
20 patients after they reached their limits. And that's one of
21 the things that they're looking at for some of these really
22 long stay type of patients that may be requiring more acute

1 care.

2 I don't know if that answers your question.

3 MS. DePARLE: It starts to, but you must have
4 thought of this. Do you know anything more?

5 DR. KAPLAN: When we chose the areas that we went
6 to, we actually chose them based on the fact that there was
7 some variation in whether they had long-term care hospitals
8 and also IRFs.

9 New York does not have long-term care hospitals
10 but all the other areas do. Tampa did. Actually, in Omaha,
11 we heard about how one hospital chain had close three
12 hospital base SNFs and opened up three long-term care
13 hospitals within hospitals in the place where the SNFs were.
14 They still had one hospital-based SNF left open.

15 But we really didn't find a pattern of where the
16 hospital-based SNF closed, immediately a long-term care
17 hospital moved in there. We did not find that pattern.

18 MS. DePARLE: Not to prolong this, that's
19 interesting that it was that direct. But if there were,
20 let's say in an area, some LTACs that were established,
21 would that add to the decision-making of a hospital to
22 decide maybe these beds aren't needed? It sounds like you

1 don't know but it's interesting thing to think about.

2 MR. LISK: It's a question whether those places
3 were originally taking those type of ventilator patients to
4 begin with, because many of the hospital-based units
5 weren't. In New York, for instance, the place we visited
6 had a 20-bed ventilator unit in their SNF.

7 MS. DePARLE: There was a ventilator demo that
8 Medicare did -- I'm dating myself but Sally, you remember
9 it.

10 DR. KAPLAN: I do remember because I was involved
11 with the evaluation.

12 MS. DePARLE: I think some of those hospitals were
13 in that area. Philadelphia there was one. It seems like
14 there might have been one in New York.

15 DR. KAPLAN: Temple, Mayo, and I can't remember.
16 Yes.

17 DR. REISCHAUER: Sally, I don't remember if we did
18 this in your previous work but did we look at the occupancy
19 rates of hospitals which closed their --

20 DR. KAPLAN: Frankly, I don't remember ever
21 looking at occupancy.

22 DR. REISCHAUER: Versus those who kept them open.

1 That might get to the point of the beds could be used more
2 profitably in other activity. And then we could also look
3 at those that were still open and see what the threat was
4 going forward.

5 DR. KAPLAN: Occupancy really was more often
6 raised as an issue of why one opened a hospital-based SNF
7 before the PPS. If you had access demand and you needed to
8 free up beds or you weren't using all your beds so you'd
9 open up a -- we did hear it in a couple of places where they
10 really felt pressure to close a SNF and open additional
11 MedSurg beds.

12 DR. REISCHAUER: But it's a little unseemly to
13 talk about it as a reason you closed your SNF, as opposed to
14 opened it.

15 DR. KAPLAN: We can certainly look at occupancy.

16 MR. MULLER: I thought the chapter captured the
17 choice process quite well. Obviously, the PPS dramatically
18 reduced the payment. I was trying to remember yesterday
19 what it was, but was it minus 30 percent or minus 40
20 percent? What's the margin on hospital-based SNFs? Minus
21 86, big number.

22 It gets people's attention and they close units.

1 We should be surprised that this happens.

2 So patients get backed up in the hospital. As
3 Craig says, every once in a while some of them fall into
4 outlier status. Most of them don't. So it becomes a loss
5 inside the hospital and bad care. At minus 86 percent,
6 people notice and close units.

7 I'm not saying we should get rid of an 86 point
8 gap and save the money for SGR, but none of this should
9 surprise us when the payment policy changes that
10 dramatically. Unfortunately, I think the patients get
11 backed up in the hospital.

12 DR. MILLER: Ralph, some of the point was why did
13 so many stay open and what are the strategies that they're
14 using? I think that was really -- because we all have
15 discussions about how much accounting is going on inside the
16 minus 86. So the question was at minus 86 you would think
17 anybody would close anything that moved that was minus 86.

18 And so the point of this was to get a better sense
19 of inside why were people staying in the game? And I think
20 that's what --

21 MR. MULLER: I get that quite well, because it's
22 the only way to get the continuity of care and also to free

1 up the hospital beds. Because oftentimes there are not
2 other nursing home placements available in the area that
3 your medical staff feels comfortable with. So as a way of
4 getting to the care for your population you do it, even
5 though it's a big loss.

6 Obviously, you don't run 500-bed SNFs at minus 86.
7 A lot of them are fairly modest.

8 MR. HACKBARTH: Thank you. Sorry for the
9 shortened session.

10 Okay, we'll have a brief public comment period.

11 Kathryn, do you want to go to the microphone and
12 make a public comment? I cut you off when you started to
13 make one.

14 DR. MILLER: Just indicate what organization
15 you're with.

16 [Laughter.]

17 MR. HACKBARTH: Okay. We finished ahead of
18 schedule.

19 [Whereupon, at 12:20 p.m., the meeting was
20 concluded.]

21

22