MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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COMMISSIONERS PRESENT:

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BRUCE STUART, PH.D.
NICHOLAS J. WOLTER, M.D.

AGENDA PAGE

P R O C E E D I N G S

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

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

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

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

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

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

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

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

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

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

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

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

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

Research shows that there is wide variation in the

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

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

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

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

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

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

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

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

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

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

use incentives to perform well on quality measures.

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

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

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

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

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

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

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

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

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

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

hospitals in the bottom quartile.

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

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

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

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

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

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

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

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

are adjusted today.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Alternatively, we could let hospital B, our

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

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

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

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

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

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

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

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

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

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

Bob, do you want to ask a clarifying question?

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

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

MR. LISK: This is national.

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

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

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

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

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

P4P, with respect to readmissions --

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

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

What this approach does is say it's a

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

we're all above average.

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

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

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

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

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

just makes the analysis too complex?

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

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

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

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

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

Nancy-Ann?

MS. DePARLE: Everything I've heard, including

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

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

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

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

beyond the hospitalization.

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

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

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

insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So that really is something to go for.

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

using outside.

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

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

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

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

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

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

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

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

Bob, you had a comment?

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

system, an incentive to go into it.

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

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

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

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

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

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

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

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

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

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

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

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

and then they have more to share with one another.

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

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

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

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

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

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

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

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

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

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

the number of admissions to begin with?

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

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

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

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

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

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

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

coming back the next time.

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

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

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

DR. REISCHAUER: Maximizing complexity.

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

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

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

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

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

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

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

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

mandatory versus voluntary versus virtual. Thoughts on that?

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

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

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

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

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

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

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

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

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

The point about giving people warning is what you

really want to do. You want to get the behavior aligned. If you give people enough data and time to do it, than you're likely to have a better result as a consequence.

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

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

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

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

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

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

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

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

MR. WINTER: Good morning, almost good afternoon.

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

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

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

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

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

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

Physician owners also provide capital to expand health care capacity.

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

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

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

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

situations where there are not evidence-based guidelines.

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

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

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

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

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

explored.

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

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

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

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

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

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

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

whether the additional services were appropriate.

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

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

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

Now we'll move on to Jeff.

DR. STENSLAND: Why are we doing a new imaging

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

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

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

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

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

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

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

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

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

Thank you.

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

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

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

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

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

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

too many. Why would you need four?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

grow.

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

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

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

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

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

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

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

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

DR. STENSLAND: I was thinking that was more just

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

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

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

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

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

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

MR. EBELER: Thank you.

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

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

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

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

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

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

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

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

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

Those are just a few questions that occurred to me.

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

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

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

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

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

That's a good point.

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

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

appropriateness.

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

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

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

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

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

readmissions from physician-owned hospitals.

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

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

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

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

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

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

DR. REISCHAUER: Yes.

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

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

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

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

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

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

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

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

MR. HACKBARTH: Thank you. Good work.

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

Okay, we will reconvene at 1:30.

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

AFTERNOON SESSION [1:36 p.m.]

MR. HACKBARTH: First up this afternoon is valuing physician services.

DR. HAYES: Good afternoon.

Our work on this topic fits in with the Commission's work in general on ensuring and improving the accuracy of prices for physician services. Issues here are important, of course. Inaccurate prices can distort the market for physician services. They can make some specialties less financially attractive, reduce the value of taxpayer and beneficiary spending.

The work that we have in mind here is in three areas. The first one is more process oriented. It would be a follow up to work that the Commission did in the March 2006 report.

The other two projects are more specific to how the fee schedule itself is constructed, the data and methods used to develop the relative values in the physician fee schedule, how terms are defined for the fee schedule, things of that sort. We'll get to the details of the matters in the minute but I just wanted to give you kind of an overview of where we're headed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The question here is whether this definition of

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

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

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

If we go back to that question about the office

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

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

major surgical procedures.

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

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

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

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

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

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

Thank you.

MR. HACKBARTH: Karen.

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

We can take the RUC that whole valuation process

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

sure I understand what you were saying.

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

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

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

Am I seeing this differently than you are?

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

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

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

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

existing things.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

in a lot of instances.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

piece of the answer.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So just that last technical piece.

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

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

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

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

that has to be done.

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

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

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

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

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

phrase in there, the tyranny of the urgent.

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

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

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

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

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

So let us think a little bit about how we might

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

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

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

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

MR. HACKBARTH: Thanks a lot, Kevin.

Next is hospital construction spending.

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

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

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

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

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

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

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

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

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

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

trend to even higher spending?

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

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

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

DR. STENSLAND: Where is this construction taking

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And then the other question would be --

DR. STENSLAND: No.

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

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

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

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

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

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

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

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

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

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

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

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

in a medical offices --

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

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

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

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

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

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

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

third of what we typically had before.

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

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

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

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

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

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

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

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

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

DR. WOLTER: I understand that the accountants and

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

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

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

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

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

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

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

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

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

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

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

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

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

There are a number of examples around the country.

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

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

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

We've been doing this medical arms race syndrome

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

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

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

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

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

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

But beyond that there are the factors that are

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

explain something that we see between 2002 and 2007.

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

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

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

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

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

Next is hospital outlier payment reform.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This slide illustrates a --

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In 1989, the marginal cost for cost outlier cases

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

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

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

There was no analysis at that time to say whether

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Julian will now talk about the impact of these

changes on payment accuracy and the distribution on total payments.

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

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

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

figure rises to 58 percent.

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

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

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

greater.

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

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

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

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

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

Whatever you take away, you're giving back.

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

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

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

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

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

The next three slides show the distributions of

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

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

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

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

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

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

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

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

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

A second complication is that the prevalence of

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

that.

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

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

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

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

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

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

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

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

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

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

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

[Laughter.]

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

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

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

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

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

change. Although from this change they wouldn't.

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

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

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

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

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

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

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

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

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

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

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

DR. REISCHAUER: But they're eating the

deductible. So we're overcharging them.

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

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

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

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

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

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

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

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

MR. PETTENGILL: It is.

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

[Laughter.]

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

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

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

MR. PETTENGILL: No, that's true.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. PETTENGILL: They do.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. HACKBARTH: That's true too.

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

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

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

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

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

One place we will have a running tab is when we come back and do the payment adequacy analysis. Implicitly

that's a running tab of all the policies and what the effects are, and we can disaggregate as much as you need. But you can see this conversation come again when you see those distributional differences that Jay spoke to and the issue of accuracy at that point, you may see this issue again, well, does this look more attractive in light of what you see at that point in time? Or is the leap too far, given who it's going to go to, that it doesn't look attractive? That's where I could see this coming up again say in December. Is that fair?

DR. REISCHAUER: If we go down below the 4.6 and save money, which is what Jack wants to do, then the average negative margin of Medicare hospitals is going to go up. It's going to be more negative because you're taking money out of the system.

DR. MILLER: If you money out of the system, no question. But we were talking in this conversation about moving things to the base. But you're right, Jack did raise that point.

MR. HACKBARTH: Just for the record, I do think that the best thing to do is to put it back in the base and we can argue about what the update factor out to be

separately from this.

Thank you.

Next is expanding the unit of payment in the outpatient PPS.

DR. ZABINSKI: Medicare spending has been growing rapidly in the outpatient PPS, increasing by an average of about 11 percent per year from 2001 through 2006. This trend in spending in the outpatient PPS is also expected to continue, as its greater spending also adversely affects taxpayers through higher taxes and beneficiaries through higher Part B premiums.

Analysis by CMS and MedPAC staff indicate that this rapid increase in spending is due to hospitals furnishing more complex services and providing more services per outpatient visit and is not due to increasing beneficiary enrollment or to higher prices.

An important feature of the outpatient PPS is that it's largely a fee schedule and that hospitals typically receive separate payments for individual services rather than a single payment for entire packages of services. This feature likely contributes to the rapid growth in spending because hospitals have little incentive to think about the

efficiency of their methods because each service they furnish is reimbursed by Medicare.

A possible way to slow the growth in volume and spending is to expand the unit of payment. Today, we will discuss two possibilities. One is packaging, which involves combining an independent service and the associated ancillaries into a single unit of payment. Under packaging, payment for an independent service is the same no matter the number or type of ancillaries furnished. For informational purposes, we define an independent service as a procedure or medical visit that is the main reason for a patient's visit to an OPD. It includes such things as surgical procedures, advanced imaging and clinic and ER visits.

In contrast, an ancillary service is something that adds time and cost to a visit but it is secondary to the independent service. An example are plain film x-rays and anthology services. Also, the term ancillary is a bit of a catch all in that it includes drugs as well as actual ancillary services.

A second possibility for expanding the unit of payment is bundling, where hospitals receive a single payment for all clinically related independent services in

the associated ancillaries furnished during an outpatient visit or over an entire episode of care, which can include multiple visits. A simple example of bundling is low dose rate brachytherapy treatment for prostate cancer, which typically involves two independent services, the preparation of the site and the actual implementation of the brachytherapy seed.

Because these two independent services are typically provided in the same visit, CMS has proposed to bundle them into a single unit of payment rather than to continue to pay for them separately beginning in 2008.

CMS has also gone ahead and proposed expanded packaging and bundling in the outpatient PPS as ways to help slow volume and spending growth in that sector. CMS used their proposals as a first step, as they are somewhat limited in how far they can actually expand the unit of payment. So CMS has also expressed interest in going beyond the amount of packaging and bundling it has proposed. We are also in the process of exploring ways to further expand packaging and bundling and today we'll discuss the work we plan to do on packaging and our work on bundling will come later.

A key feature of packaging is it works off the concept of averaging. That is, hospitals receive a single payment for a package of services comprised of a single independent service and the associated ancillaries. The actual package of services furnished varies from patient to patient so that sometimes the payment exceeds the cost of the package actually furnished and sometimes the payment is less. In particular, the greater packaging increases the likelihood that payments for a package of services will differ from the hospital's costs more so than what you would see under a fee schedule.

But despite this greater variation in packaging, on average payments reflect the costs of the packages of services that hospitals provide.

So under greater packaging, hospitals face more risk because, as I said, payments are more likely to differ from costs than under a fee schedule. This increased risk faced by hospitals increases their incentive to furnish care in the most efficient way in order to avoid losses. They can accomplish this efficiency by considering whether patients can be effectively treated using fewer ancillaries or lower-cost ancillaries or establishing protocols and

working with physicians to make sure hospital resources are efficiently used. This increase in efficiency, in turn, can help slow growth in volume and spending.

I note that hospitals have some experience facing a single payment for a package of services under the DRG system that is currently used in the inpatient PPS.

Our research on packaging indicates that there are two keys to an effective system of packaging. First, packaging should increase hospitals' exposure to financial risk beyond what they face under a fee schedule in order to increase incentives for efficiency but that additional risk should not be excessive.

Secondly, a packaging system should be easy to understand and use, especially among hospitals and their staff to implement it. Over the next few slides I'll discuss these two points in more detail, beginning with the issue of avoiding excessive risk.

On the one hand, more risk is needed through greater packaging to increase hospitals' incentive for efficiency but the risk should not be excessive and should be avoided because first, it would give hospitals an incentive to avoid complex patients or to limit necessary

care; and secondly, it would disadvantage hospitals that attract a relatively complex mix of patients.

To avoid putting hospitals under excessive financial risk, we should package ancillaries that meet one or both of these two thresholds, in particular package ancillaries that either lower in cost in relation to the associated independent service or there are always or usually used with the associated independent service. The problem, though, with these two threshold is that they are somewhat arbitrary and that there is, for example, no definition for what relatively low cost might mean or what usually used with an independent service might mean.

So what we plan to do is to explore appropriate thresholds which might include consultations with researchers who have developed packaging methods for other hospital outpatient systems.

Before moving on, one final thought on risk is that some may still be concerned that even if a packaging system does not expose hospitals to excessive risk, that hospitals might still have an incentive to limit necessary care or to avoid complex patients. But I'd like you to keep in mind that mechanisms are in place that can offset these

incentives to hospitals to limit care. In particular, the Commission has recommended pay for performance in order to improve quality of care in Medicare and also CMS has established a set of quality measures for use in the P4P program and it will begin collecting them this coming year.

In addition, the outpatient PPS has an outlier policy to offset losses from costly patients.

Now I'd like to turn to the issue of making a packaging system that is both easy to use and understand. Two methods of packaging have been developed, both by researchers at 3M Health Information Systems. One is a clinical option, which relies largely on experts judgment to determine which ancillaries to package. For a particular independent service, only ancillaries that are originally provided with it are packaged with it.

The other alternative is the more broadly defined uniform option. This method relies generally on empirical information to determine which ancillaries to package. Examples of information that could be used are the cost of the ancillary in relation to the associated independent service or how frequently the ancillary is used with that independent service. Then once you determine which

ancillaries could be packaged, you create a master list of the packaged ancillaries. Then any time an ancillary on that list is used with an independent service, it is packaged with it.

Although 3M's method that relies on expert's judgment, as it has the attractive feature that payments are based on a collection of services that are clinically meaningful, experience with it indicates that this approach is confusing for hospitals and their staff because an ancillary can be packaged when coded with some independent services and paid separately when coded with others. This confusion among hospital staff can make it difficult for hospitals to plan their resource use, which is important if you want to improve their efficiency. In contrast, using an approach based on empirical information has been shown to be easier for hospitals and staff to understand and use because there is simply a single list of ancillaries that are always packaged whenever used with an independent service.

And finally, something that's true no matter what method of packaging is used, is that the more an ancillary is used with an independent service, the more its costs will be reflected in the payment rate for that independent

service. For example, an ancillary that is used 20 percent of the time with an independent service, 20 percent of the cost of that ancillary would be reflected in the payment rate for the independent service that's associated with it. But if an ancillary is used 80 percent of the time with an independent service, about 80 percent of the cost of that ancillary would be reflected in the payment rate.

The next step we plan to take in our analysis of packaging is to evaluate alternatives for expanding the amount of packaging in the outpatient PPS. One option we'd like to explore is to package ancillary clinical lab tests and drugs that are currently separately paid or are low cost or frequently used in relation to the associated independent services.

A second option we would like to look at is implementing the packaging in the ambulatory patient group, or APG system. This is a system that for classifying outpatient services on the basis of clinical and cost similarity, and it has served as a basis for the classification currently used in the outpatient PPS, the ambulatory patient classification system, or APC. The big difference between these two systems is that the APG system

has more packaging though than the currently used APC system.

To show how we might identify ancillaries or drugs that could be packaged in the outpatient PPS, we developed a simplified example. We started by comparing the cost of all separately paid ancillaries and lab tests to the cost of their associated independent service or services. We calculated relative cost for each ancillary and lab test as the cost of the ancillary or lab test as a percentage of the associated services. For example, if an ancillary is used with more than one independent service, we calculated the relative cost of the answer is averaged across all independent services with which it is used. Then if an ancillary or lab test has a low relative cost, we can consider packaging it.

In this diagram we show the results from our example. We started by dividing the separately paid ancillaries and lab tests into groups based on their costs relative to the associated services. In the first column we illustrate this, where in the first row you have the ancillaries with a relative cost below 10 percent on down to the fifth and bottom row where you have ancillaries and lab

tests with a relative cost below 50 percent.

In the second column, we show the percent of total ancillary volume that is attributable to each relative cost category in the first column. For example, if you're looking at the first row, the ancillaries and lab tests that have a relative cost below 10 percent, encompass about 25 percent of total ancillary volume.

In the third column, we illustrate the estimates of actual spending for each category in column one. For example, ancillaries and lab tests that have a relative cost below 10 percent encompass about $300 million dollars in total spending.

I think one point you can take away from this diagram is that opportunities do exist for greater packaging and that packaging could have an effect on slowing spending and volume growth in the outpatient PPS. For example, 76 percent of ancillary volume is attributable to ancillaries and lab tests that have a relative cost below 30 percent and packaging those ancillaries and lab tests would redistribute about $1.2 billion in spending.

Moreover, I want to emphasize that this is actually a pretty restrictive example in terms of

identifying ancillaries that could be packaged. Because if we added to our analysis drugs and ancillaries that are high cost but frequently used with their associated service, the amount of spending redistributed would be higher than what we see in the final column.

To summarize, volume and spending have increased sharply in the outpatient PPS and expanded packaging could help slow that growth. An effective system of packaging would increase hospital's exposure to financial risk in order to increase incentives for efficiency but this additional risk must not be excessive and packaging should be easy for hospitals and staff to understand and use.

In the future we plan to consider alternatives for expanding the amount of packaging in the outpatient PPS. We also plan to explore greater bundling, which creates a single payment for all clinically related services furnished over a visit or an entire episode of care.

As I turn things over to the Commission for their discussion, particular issues we'd like to get into in particular are, first of all, alternatives that we might explore for expanded packaging, whether empirical information or clinical judgment is the better option for

identifying which ancillaries to package, and whether you have a good idea on where thresholds could be set for identifying ancillaries that are relatively low cost or frequently used with their independent service.

MR. HACKBARTH: Thanks, Dan. Could I ask a question about the table on page 15? I'm trying to get a sense of the opportunity here.

So even if you go to 50 percent, the cost of ancillary relative to services up to 50 percent, so you've got $1.8 billion in spending on ancillaries that meet that test. But that's the total spending. It's not going to all go away.

So even if you were successful in avoiding, because of the new packaging policy, 20 percent of that you're talking $300 million or $350 million. Am I thinking about this correctly? The $1.8 billion is the total spending on ancillaries, not the savings opportunity.

DR. ZABINSKI: Right. At the same time, though, I said I tried to be conservative here. I only worked with the answer that have relatively low costs. I didn't consider drugs that might be relatively low cost. I didn't consider ancillaries that are pretty expensive but almost

always used with their independent service. So I'm not going to even venture a guess at how high that number could go.

But in terms of your takeaway specifically from this slide, that's pretty accurate.

DR. REISCHAUER: Are the ancillaries growing at a hugely faster rate than the underlying service?

DR. ZABINSKI: Their overall growth rate is higher than the rate for your average service, yes. In a sense, yes.

MR. HACKBARTH: That's a sort of a hedged response. Could you just be a little bit more specific?

DR. ZABINSKI: Let's see, since 2002 to your average ancillary growth is somewhere around 7 percent. Your average service is somewhere around 5 percent in volume, so it's a couple of percentage points higher.

DR. SCANLON: A couple points. I know we want to try and move away from fragmentation, but I think in doing that we still have to remember are we getting what we paid for? I think the issue of risk, we've got to go much more beyond the issue of the risk to the hospital, but it's the risk to the patient.

The criteria where an ancillary is provided most of the time is, in some respects, a good one because that suggests that what we're talking about is a more homogeneous package. But we have to know they we're getting the homogeneous package, that we're getting everything that's in it. And I think we're premature if we're putting our faith in pay for performance kind of reporting. I think we need, as we design this, to consider what are the other mechanisms that we're going to know that there isn't stinting, that we talk about in other contexts.

The second comment is with the issue of what should our design be? The question comes to the objection that were made about the earlier designs from 3M in the sense that they were going to be confusing to hospital staffs. There's a question of who needs to know what. If I'm the clinician sort of providing the service, what do I need to know about the payment system in terms of making my decision as to what ancillaries I should use? In some respects, you'd like them to not take the payment system into account when they're deciding what ancillaries to use.

If I'm the head of the department and I'm ordering the ancillary supplies, what do I need to know about the

payment system in order to make those kinds of decisions?

It didn't totally ring true that this should be sort of a showstopper in terms of one design versus another. It seems to me that we need to think about what's the best design from our perspective, think about then what would be the real problems that a hospital would have and decide whether or not they're manageable. Because as you move up the chain then the payment system and its features become much more relevant. But those folks are the best and the brightest; right? So they're going to be able to figure this out and they should be able to work with the system that we have, that's working from our perspective.

MR. EBELER: I know you had a bullet point that talked about slowing growth in spending so I don't have to make it here.

Say a little more about this clinical versus uniform method. In the paper you described it as sort of a clinical method and a uniform method and sort of instinctively it struck me that you want something that's clinically coherent for the future. But in your presentation this afternoon, there was a clinical judgment and an empirical method.

Could you say a little more about the problems with the clinical approach?

DR. ZABINSKI: I'm going to switch shoes here. Mark, correct me if I'm wrong on this. Usually Mark is asking staff to correct him if he's wrong.

In any event, the clinical, my understanding is it uses experts judgment on what ancillaries should be with what primary service. And that's got a nice feature to it. You get this clinically coherent sensible unit that you're paying for.

But I guess this idea was sort of thought about in practice, that it was real difficult for the staff to understand at hospitals and they sort of scratched their heads, this ancillary here is packaged in this case and it's not packaged here. It really caused a lot of confusion. And that confusion sort of made it real hard to work with and for hospitals to plan their resource use, which of course then makes it hard to increase your efficiency.

MR. EBELER: Thank you.

DR. MILLER: I was involved in some of these conversations 10 or 15 years ago. And when the APGs -- that's the one that does all of the packaging, Dan? Correct

me if I'm wrong, please?

DR. ZABINSKI: Right.

DR. MILLER: When that was done there were two things that sort of came up in that discussion. There was a set of clinical judgments that stood behind the packaging, which not all clinicians agreed with. So the confusion came in two varieties. There's the charge master billing, that side of the hospital, kind of what? But then there was also I'm not sure I agree with this.

I won't take issue with you, Bill, but there were some who also made the argument that you don't necessarily want the clinician -- I mean, one of our concerns right now with the current system is clinicians are completely unaware of what the potential -- and you do want some sense of I use this resource, there's some impact here. And people couldn't look out on the landscape in the outpatient setting and know at each time they were making a decision when something was packaged, what was in and what was out. So the confusion kind of ran in a couple of directions.

And what you picked up on precisely, Jack, between the writing of the paper and putting the presentation together, is there is this label. When you say clinical,

everybody goes right, better. But it was more of a judgment thing, and the ancillary wasn't consistently in with -- in some cases, it was together with the independent services. In some cases not. And that's sort of the distinction we're trying to imply. There's a judgment and it's not always present. And is that harder or easier to work with?

I don't think we're litigating the point, but we are telling you that the history was that there was a bad reaction to this when it was put in the field.

DR. SCANLON: The whole issue of being efficient -- and I'm not trying to be counter to that. But there's this issue of management. Medicare is one payer. So if you think about the clinician supposedly being prepped in terms of here's how Medicare pays, think about it in these terms, versus this is how somebody else pays and think about it in those terms.

I think that management one of these types of settings would be to make the clinicians aware of resource use and be monitoring it at a much more aggregate level and be giving them feedback at a more aggregate level so that there's efficiency across the board. But to keep track of all of the payment flows and try and say okay, now that

Medicare is spending this way, do this differently. I think that's what's inappropriate and that's what doesn't ring true from their perspective because that's not how they're going to implement it either.

DR. BORMAN: One of the categories that we've seen data about growing enormously over a relatively recent time frame is so-called minor procedures, many of which now are in this basket of things, in terms of outpatient prospective system procedures. A number of things around those episodes, in terms of lab and radiologic diagnostic stuff, is somewhat regulation driven in terms of JCAHO, or in terms of other things that have to be reported to various entities -- payers, other regulators, whatever.

But that does generate a number of relatively fixed packages. And I recognize that a system, in order to be useful, has to be able to be implemented by the people that have to enter the data or regulate the charges or whatever. But certainly hospitals that are doing these things, by and large, have this parsed out finer than on a DRG basis.

I could understand that if this somehow was all the things grouped up into one DRG and yet within that

there's 10 different procedures or kinds of care and in each one of those the ancillaries are different, then doing it on a DRG basis is confusing and not helpful for the hospital.

But if it's parsed out on a finer basis, just for an example, by a CPT procedure code which outpatient hospital now uses, whereas there was a time when it didn't and it was using ICD-9 III procedures, you can get this to a more granular level where the bundles are indeed constant.

If somebody's coming in for an angioplasty, just for an example, there's going to be some lab that every single one of those people is going to get, or those patients is going to get. And that patient is going to be attached to a pretty specific code in the system.

I don't know if there's been enough change in the reporting system or in the IT systems in institutions that are doing a lot of things that are covered under this. But I do think that there should be a pretty good ability to do this at that level.

And I remain puzzled by the inability to do it, unless it's just a factor of what's changed over time in terms of IT and the reporting system.

DR. MILLER: I was with you all the way up until

the last sentence. I didn't quite get the landing.

DR. BORMAN: If I hear what has been said about hospital push back before, was that this was too confusing, that if --

DR. MILLER: [off microphone] And you're saying now the system should have evolved to the point where it shouldn't be --

DR. BORMAN: Right. What I'm trying to say is I think there may be changes in the way that this is reported by the hospital, because it's using a more granular system. And I also think the sophisticatedness of the systems that hospitals have to track it at that more granular level has increased. And maybe that now does allow it. Maybe there's been enough passage of time.

If that's not the answer between then and now, then I am still puzzled as to what the answer is.

DR. MILLER: Now I see.

DR. CASTELLANOS: I don't think it surprises anybody that we have an increase in volume. I mean, site of service, everything is coming out of the hospital, which is much higher cost, and going into the outpatient arena, whether it's the physicians' office, an ASC, or the

hospital. I think the site of service tells us why we have an increased volume.

I'm just making a point. You hear the word clinical and you say gosh, the doctor doesn't have the equipment to do the operation. That certainly is not the case. This is a charge issue to the hospital. The equipment is available and he or she has the opportunity to be able to take care of that patient under any circumstances. So you're not holding the doctor up or tying his hands.

Again, the point here was that you need to get the physicians involved. You need to get the physicians understanding costs. You need to get the physicians, in my estimate, financially involved. And again, we're not talking about bundling yet. But you can talk all you want about what the hospital needs to do, but it's the physician that has to understand these ramifications. And I think the best way to put that is to put both the hospital and the physician at risk for both cost and quality.

MR. HACKBARTH: Okay. Thank you, Dan.

And last, but not least, is Jennifer and Medicare Advantage.

MS. PODULKA: As Glenn mentioned, I'm here to talk about special needs plans or SNPs. You may recall some presentations on this last year, so this is a bit of an update with some new information.

Special needs plans were added as a type of Medicare Advantage plan by the 2003 MMA. SNPs are paid the same as any other MA plan type and are subject to the same requirements. There are only two differences. First, they must provide the Part D drug benefit. And also, they are allowed to limit their enrollment to their targeted population. This authority to limit their enrollment will lapse at the end of 2008 unless the Congress acts to extend it.

And SNPs targeted populations include three types of beneficiaries: those who are dually eligible for Medicare and Medicaid, those who reside in institution or in the community but are nursing home certifiable; and third, those who are chronically ill or disabled.

There are several aspects of SNPs that raise concerns. First, we are concerned about the lack of Medicare requirements designed to ensure that SNPs provide specialized care to their target populations and SNPs'

resulting lack of accountability. This raises questions about the value of these plans to the Medicare program. For example, dual eligible SNPs are not required to coordinate benefits with Medicaid programs and many dual eligible SNPs operate without any state contracts.

Third, since they were introduced, SNPs have grown rapidly, both in number and enrollment. I'm sorry, that was second.

Third, organizations entering the SNP market include those with experience with Medicaid and special needs populations but also include MA organizations that chose to add SNPs to their menu of plans. This raises questions about whether this represents plans' marketing strategies or a real investment in providing specialized care to their targeted populations. I'm going to talk more about each of these concerns but first about that growth.

SNPs have grown rapidly in number since they were introduced. Currently, there are more than 400 SNPs. Just last week we learned that if all applications are approved, next year we're going to see more than 700 SNPs. SNP enrollment has also grown quickly, nearly doubling from last July. We are currently at over one million beneficiaries

enrolled in special needs plans. The enrollment in SNPs is roughly proportional -- by type, is roughly proportional to the plans availability.

In light of concerns about SNPs being offered by organizations both with and without specialized experience, we examined SNPs available in 2006 and found that only 13 percent of them were offered by a parent organization that focused exclusively on operating special needs plans. The rest offered some other type of MA plan. This is an issue because the Congress created SNPs, in part to allow certain demonstrations in specialized types of plans to continue on a more permanent basis. I think it's been a surprise to many just how many other SNPs are being offered by other types of organizations. As I mentioned earlier, this raises the question of whether this represents plans' marketing strategies or a real investment in specialized care.

A couple other things I want to make sure you know before we continue with some of the policy options. First is that special needs plans are required to be coordinated care plans under Medicare Advantage. And SNPs, along with employer-sponsored plans, were the only source of enrollment growth in local HMO plans between 2006 and 2007. I'll leave

this to your interpretation, but it may be encouraging news given the Commission's concerns about growth in less managed forms of MA plans. Of course, it also means that special needs plans also receive the same additional payments that we're concerned about for all MA plans receiving.

Second is that SNPs 2006 benchmark and payments relative to fee-for-service are similar to regular HMOs moreso than some other plan types, which you can see on this table.

Now you have somewhat of a picture of special needs plans and one question that frequently comes up as a possible explanation for all this SNP growth is that the risk adjustment system is not working like it should. We recognize that risk adjustment has improved a lot over the past several years, but there are at least two ways that it could be fueling SNP growth.

First, the risk adjustment system is based on a list of diagnoses that plans submit. But there are degrees of severity in each of these diagnoses that are not captured by design. For example, a plan could potentially enroll people only with stage I cancer while receiving a risk-adjusted payment that is based on expected costs for the

full range of cancer patients.

An alternative explanation could be the risk adjustment systems intended goal. It is designed to predict spending for patients in fee-for-service Medicare and a plan, simply by managing care, could spend significantly less than this amount. We very well may need to revisit the risk adjustment system but addressing the first issue will require additional data collection and analysis and addressing the second would require a philosophical shift in what we expect of our risk adjustment.

Rather than going into more detail on these now, I'd like to discuss some other aspects of SNPs that I'd like you to keep in mind. This is in preparation for a whole slate of questions.

As I mentioned, SNPs, or at least their authority to limit their enrollment, expires at the end of 2008. The question of whether to allow them to continue comes down to whether SNPs need to limit their enrollment to do something special. In other words, can whatever SNPs do be accomplished just as well by regular MA plans?

A key motivation for creating SNPs still applies to allowing them to continue and that is providing a big

umbrella to cover all special plans and demonstrations. If the SNP authority ceases, then some existing SNPs could change into regular MA plans while other SNPs could revert to or become demonstrations. This would mean that CMS would need to continually reapprove these types of demonstrations and any new projects that hope to build off lessons learned would also need to enter the program as demonstrations.

However, if SNP authority is extended, then SNPs should be expected to provide specialized care for their enrollees that regular MA plans cannot provide as well or as efficiently. SNPs may be able to tailor unique benefit packages that allow them to provide efficient high quality care through economies of scale. However, there are SNPs that clearly do not meet this standard right now. Given that the MMA language which created SNPs was broad and vague and CMS has done little to further focus SNP requirements, I'm going to suggest a whole list of policy options for your consideration.

The first ones have to do with quality, information and accountability. On the first bullet, currently SNPs must measure and report the same quality measures as other MA plan types. If SNPs need to limit

their enrollment to a target population to provide specialized care, then the quality of that specialized care may need to be measured by appropriate measurement sets. CMS has contracted with NCQA to develop new SNP-specific measures, but it could be a year or more before they even began collecting data on those.

On the second bullet, based on discussions that we've have with SNPs, states and CMS, we have learned that a lack of clear information is an impediment to beneficiaries learning about and making an informed decision about joining a SNP. Because the CMS website is structured to compare all MA plans in a consistent manner, and CMS has yet to provide sufficient flexibility for SNPs, these plans are not always described accurately.

For example, the Medicare Compare website shows cost-sharing requirements for some dual eligible SNPs that charge their enrollees no cost-sharing because it's covered through contracts with state Medicaid agencies.

An option for dealing with this would be to require CMS to include comparative SNP information on their website, and even as written information for eligible beneficiaries.

The third bullet there, if SNPs are allowed to limit their enrollment, then they should better manage the care of their enrollees than a regular MA plan. Linking enrollees with an individual responsible for coordinating their care would be a minimum step towards managing that care. This would also allow plans and CMS to survey enrollees about their awareness of and satisfaction with this service.

Next, there's something I need to bring up before I can proceed to the next policy option, and that's the disproportionate share provision. Under this, SNPs may limit their enrollment to the targeted special needs population. That's a given. Or they may apply to CMS for permission to enroll any other beneficiaries as long as their membership includes a disproportionate share of their targeted population. This means that the percentage of the target population in the plan must be greater than the percentage that occurs nationally in the Medicare population.

Until this year most SNPs had chosen to limit their enrollment to their target population, in other words not taking advantage of this provision. However, we are

concerned about some notable exceptions.

For example, the SCAN social health maintenance organization became an institutional SNP in 2007 under this rule because 26 percent of their enrollees are nursing home certifiable living in community, and that's not even necessarily in institutions. So if you are unsatisfied with this existing provision, a simple option to deal with it would be to require that SNPs predominately enroll beneficiaries from their targeted population.

One more thing that I need to set up before we talk about the policy option, and that's dual eligible SNPs. There are two types of dual eligible beneficiaries. Most are full duals in that they qualify to receive full Medicaid benefits. Beneficiaries with somewhat more income and assets are eligible for more limited Medicaid coverage under multiple categories collectively known as the Medicare Savings Program. CMS currently does not allow plans to limit their enrollment to the Medicare Savings Program duals alone because the Agency said it was concerned about selection issues, as these tend to be healthier individuals than their full dual counterparts and the current risk adjustment system does not distinguish between full dual and

the MSP duals.

Instead, CMS decided that an MA organization can offer two dual eligible SNPs in the same county, one for full duals and one for all duals. This has the benefit that it may facilitate state contracting with the plans because the states might not be willing to contract with plans where they had exposure for more cost-sharing than they currently are required to cover. However, in practice it runs the risk that organizations that choose to do the two dual eligible SNP options may attract the MSP duals into the all dual plan, thus getting around CMS's original prohibition.

If you tracked on that, we have a couple of options for dual eligible SNPs. First, all dual eligible SNPs could have a contract with states to cover Medicaid benefits because without one it is unclear that a dual eligible SNP would behave any differently than a regular MA plan. We feel that it might be reasonable to give plans a few years to get ready for this because based on our discussions with SNPs that do have a contract, it may take that long to set one up. Ideally, these contracts would cover long-term care but we recognize that this may be more complicated than covering other more acute care services

under Medicaid.

On the second bullet there, in the meantime you might want to require dual eligible SNPs without a current state contract to limit their cost-sharing for their enrollees to no more than those enrollees would be charged under their state's Medicaid program.

And third, to address the issue of attracting the Medicare Savings Plan only duals, which we discussed on the previous slide, you might want to limit MA organizations to offering only one dual plan in each area. They could decide for themselves whether they wanted to offer it to all duals or just the full duals, but they couldn't do both in the same county.

The next policy option is on the chronic condition SNPs. CMS decided to leave the definition of chronic condition SNPs abroad because they didn't want to limit innovation. As a result, not all chronic condition SNPs may be sufficiently specialized to warrant formation of delivery systems and disease management strategies. For example, there is a chronic condition SNP for beneficiaries with high cholesterol, a condition that affects so many beneficiaries one would hope that any MA organization could effectively

treat it.

If you would like to see a more focused definition of chronic conditions SNPs, it would be possible for CMS to convene of clinicians and other experts to create a list of eligible chronic conditions for SNPs to focus on. In the meantime, a more focused definition than occurs right now could be used, such as requiring chronic condition SNPs to serve beneficiaries with medically complex or advanced late stage chronic conditions that influence many other aspects of health, have a high risk of hospitalization, or other adverse health outcomes, and require specialized delivery systems.

So this is it, the final policy option. It's the inherent question of whether to extend the SNP authority pass the 2008 deadline, which I mentioned. We find that there may be sufficient reason to make some types of SNPs permanent after making the changes discussed earlier, such as requiring state contracts for dual SNPs. However, there are two exceptions that may require a temporary extension to allow further study.

The first is the chronic condition SNPs. These may be able to better care for beneficiaries with certain

conditions and even improve their health outcomes. However, it is not entirely clear why these disease management functions could not be carried out as well by regular MA plans. That said, on the other hand, there is probably some potential benefit to organizing care around significant chronic illnesses and thus, they should be further studied.

The second one are a specific kind of institutional SNP. Institutional SNPs are permitted to serve both beneficiaries in nursing homes as well as those who are nursing home certifiable but living in the community. There are fewer existing in the program right now of that latter type.

These plans, like their brethren, may have the similar potential benefit of avoiding hospitalizations and improving care for the enrollees. However, they have less experience and have been less evaluated. So it might be reasonable to extend them on a temporary basis to allow further study.

That's it. I look forward to your discussion, and especially if you have any questions or information that I didn't share that you'd like to see.

MS. DePARLE: Good work. And I'm glad that we're

taking this issue up. I think it's an important one.

I had two or three points. I guess I'll start with the last one, which is I'm glad we're thinking about making recommendations here. And I would say that if we're going to make recommendations, it would be great if we could do it now, as opposed to -- is this on a track to come out in January? March?

This is a topic, as everyone knows, that's being discussed right now in Congress. I think if we have a view of it, it would be good to have it out there now. I, at least, would be prepared to do that.

MR. HACKBARTH: Of course, the formal publication would occur, I assume, in March or June.

MS. PODULKA: I hope no sooner than March for publication, but I think, in part, that's why we're here right now in October talking about this.

MR. HACKBARTH: Just for the sake of argument, let's assume that we're talking about March publication. We would have draft recommendations in December. And that would be sort of the earliest, which may or may not be timely for congressional deliberations on a Medicare bill this year.

I would bet that it would be timely, given their Christmas Eve resolution of these issues in recent years. But under the best of circumstances it's going to be pretty difficult to be timely for this year.

MS. DePARLE: I'm only one voice here, but I would urge you to consider whether or not that makes sense in this particular context because --

MR. HACKBARTH: We'll look at what we can do.

MS. DePARLE: It might not need to be in the form of our formal report, but you might be asked to testify about this or to say what our view is. And I don't know that we do have a view. I haven't heard from my fellow commissioners. But if we did have a view, for example, that chronic care SNPs should be extended or extended for three years, as this recommendation kind of contemplates, I think it would be good to put that out there.

I was a little bit lost in the section about dual eligibles. I guess I honestly don't see that as being a SNP. So you almost have to go back to first principles for me to understand why -- to me, that -- while there is certainly a crying need for attention to the people who fall into that category of being dually eligible for Medicare and

Medicaid, to me their primary needs are around their conditions and diseases. As opposed to what I think this SNP has become, and as I understand it it's the one that has grown the most and has been the biggest from the beginning, it's more of a financing mechanism to me. It describes where their financing comes from rather than describing their condition.

So if I were looking at it, I would prefer that a person who is a dual eligible who has diabetes be treated in a SNP that meets the definition you just described for chronic care SNP, that truly does something about diabetes. As opposed to just signing up for a dual eligible SNP, which I'm not sure that tells me anything about what they're actually going to get. So I would make that point.

And on the chronic care SNPs, too, one more point that I think is not mentioned in the paper, I have become convinced that there needs to be a separate special needs plan for chronic care. Some have argued well, it's the same thing that Medicare Advantage plans were supposed to be already. They were supposed to be able to treat chronic conditions. And I see that point.

But if you understand the way Medicare Advantage

plans have to provide benefits to beneficiaries, it is very hard for them to say if a person with diabetes needs the special shoes that are very expensive, it's very hard for them to say we're going to provide those without basically providing them to the entire population that they serve. And this is a way of focusing in.

Now granted, we need lots better definitions of what it means. I don't think high cholesterol should define a SNP category. So we need better definitions of what it means to be a SNP. And we need better metrics and requirements for what they're going to achieve. But I do think there's a basis for that and so I would hope we would take a position about that.

I don't know if you have any thoughts about my reaction to the dual eligibles SNPs, but I have to confess I just don't get it.

MS. PODULKA: I, at least, have gone back and forth a lot on this, all three SNPs. It's true, we've done some work previously on the Commission on dual eligibles. As a group they tend to be somewhat less healthy, to have somewhat more rates of chronic conditions. But the current definition of a dual eligible SNP requires nothing other

than you be dual knowledgeable. They could be healthy.

Just as I said in the presentation, if there isn't that state contract where they're at least promising to coordinate the two financing streams and do some sort of benefit coordination, it is really unclear what they're doing that's different. Just my thought on that.

MS. DePARLE: Again, I'd rather see them evaluated. We do need to be doing more with and for that population. But have them evaluated and then maybe they need to be in, maybe they don't need to be in any special plan. But maybe they need to be in a plan that focuses on their particular disease.

DR. CROSSON: On this point, just talking about our own organization, the only SNPs we have our dual eligible SNPs. And they're not established because we're going to give different care to the members of this SNP than we give in our regular MA plan. They're established simply because if we don't do that we have no other way to essentially lower the premium and copayments to the dual eligibles, to pass through in fact to them the benefit of the coordination of the financing with the state. Because if we give them differential premiums or copayments, then we

violate the strictures of MMA that say that we're inducing these individuals to join our regular MA plan.

So whether that's what you said is basically a financing purpose or not, it is. But from our perspective, it's a legitimate one and one that we shouldn't lose I think.

DR. KANE: I'm on the board of a group that has a dual eligible scope, but I guess we're calling its SNP because Medicare kind of came in with that terminology. A couple of things.

One is it takes a long time to get all the pieces in place for the really frail people. I'm just looking at the time frame and saying wow, you're expecting a lot awful fast.

For instance, we just got caught because our coding hasn't -- we're probably risk-adjusted much more expensive than we look right now because we haven't even learned to code for the new risk-adjusted methods. We just got caught not knowing how to tell people to code properly. So I'm just thinking it takes -- it took us five years to get a Medicaid contract in place. So they don't happen overnight.

The other thing about the dual eligibles that we serve is there is no one chronic disease. They have lots of problems. They are really sick. We also have the institutional SNP with Evercare. A lot of those people could be in either place. So they have a lot of problems. We have the house calls.

There's a lot of things that they need a lot of care around multiple conditions. So I don't know that you could pick any one chronic disease, if they wouldn't be jumping across different plans to treat their different diseases. So they're a very expensive group to take care of.

I guess my last comment is if you're going to look at their payments relative to fee-for-service, for the dual eligibles to be fair you have to put in their Medicaid fee-for-service equivalent. You're really managing the bundle and you want to see how you do relative to the bundle of Medicare and Medicaid fee-for-service, not just one of the two parties. Because you may be playing off -- you may be using one funding source more heavily than the other to avoid spending more on the other.

So I don't think you can evaluate them in the same

way that you do -- I think you have to put the Medicaid expenditure for fee-for-service in there, too. And I know how hard that is, so it may be really hard to evaluate them. But those two bundles go together and get managed in a very different way in a dual plan.

DR. MILLER: I don't dispute any of that, and actually I think our -- I'm looking at a couple of people over there, Carlos and Scott and Sarah. I don't know technically whether we would be capable of building that in in our lifetime in any case.

But I think the point of why we brought it up here, which I just want to reinforce this point. If I get this one, don't tell anyone.

But I think the reason we brought this up here is we were saying actually, given all the questions about SNPs that we were raising and what are they actually doing and should we be setting these requirements, we're also saying this is kind of an organized network of care which a lot of growth in MA plans right now isn't.

And incidentally, they look sort of like the HMOs, if I recall the table correctly. Do I have that correct?

So I realize part of that equation isn't there but

we were sort of saying hmm, they do kind of have organize systems which, when you talk among the Commissioners, the Commissioners kind of like that idea for managed care plans. I think that was really the point.

Now this is not to dismiss your point, but analytically I don't think we could get to your point in any real way.

DR. KANE: Probably not but it makes it a lot harder to judge them that way because you're not looking at the total.

I guess my point is there probably does need to be greater definition around who's going in and what they're doing and I don't disagree with that. I'm just saying it takes a long time to get these pieces together and the provider groups that do it aren't the most sophisticated at doing all of the risk-adjusted -- the recordkeeping for all these new risk-adjustment systems.

So it may just take a while to be able to fully evaluate what their real risk-adjusted expected costs would have been.

DR. DEAN: What little exposure I've had to these plans, I've been thoroughly confused, especially by this

table. The only one that's really been pushed in our area is a cardiovascular plan. And they aggressively marketed that to people that I would consider basically pretty high risk. And I assumed it was because they were getting some fairly rich subsidies to do that. But at least according to the payments you've got up there, they're really not that rich. Is that true or what am I missing?

MS. PODULKA: It's a ratio and so it's standardized. It either does or doesn't include risk-adjustment. Risk adjustment is the same on both the denominator and the numerator. So they do get additional payments for the risk adjustment.

DR. DEAN: Okay.

DR. MILLER: Don't forget the situation in MA right now. They're being paid on average, by our analysis, 12 percent above fee-for-service.

DR. DEAN: I assumed that these plans were getting something in addition to that.

DR. MILLER: You assume correctly there, as well.

DR. DEAN: This plan, at least, certainly didn't -- all they needed was a note from your doctor saying you've got a heart problem and you could get into the plan.

They're getting some pretty good benefits, for sure. It never made sense. Even when the representative came and spent a half hour explaining it to me, I still didn't understand it.

MR. DURENBERGER: He didn't want you to.

DR. DEAN: That's what I figured, that he really wasn't telling me what I wanted to know.

MR. EBELER: I just want to build on Mark's comment a little bit. We talked earlier about frustrations with transactional fee-for-service and which direction we want to go. I think one of the reasons it's important to look at these recommendations -- and I like the direction of these recommendations, is that when you look at the other end of that spectrum, you need to make sure that those entities are doing the things that we expect to happen when we go that way. So it strikes me that this is a very positive set of directions. I agree with Nancy-Ann, the sooner we can get them out, the better.

I guess the one question I would ask is at some point maybe screen these recommendations and see -- some of them are special need plan specific. But some of them may well be equally relevant and may program more broadly. So

again, in the context of looking at the organized capitated end of the spectrum and make sure it's delivering what we're hoping for, it might be worthwhile just doing that policy screen.

MR. HACKBARTH: Let me be the devil's advocate for a second, Jack. And I'm focused now on the chronic condition SNPs.

Let us set aside for a second the issue of skimming. Clearly, if they're getting paid, overpaid for the actual risk they're assuming because they've figure out some way to beat the system, that's bad and we want to deal with it. I'd like to know exactly how they're doing that or how we think they're doing that before we assume it.

But let's set aside skimming for a second, and say the only issue is whether these plans are really offering anything different than is available through a regular MA plan. So take a heart condition SNP. They're saying we want to focus on this population. They're getting appropriately risk-adjusted payments for the patients who enroll. And let's say they're no better than Kaiser Permanente in the same market. Why is that a problem?

They're just doing the same thing as a general

Medicare Advantage plan but they've just chosen to market themselves to a particular population. They're not offering poor quality care, it's just no better than Kaiser Permanente offers heart patients. Why is that a problem?

DR. MILLER: Can I take a shot at this, and I really need some close air support here.

I think when we went through this, because I've got to tell you, we spent a lot of time banging our heads against the table and exactly what we were trying to get out of this. And in a sense the answer to your questions I think it begins to get to what you demand in terms of disproportionate share. So you guys see where I'm going?

What you're saying with a SNP is you can select people. So you can say I'm looking at two people and I'm going to take you and I'm not going to take you, on some basis. And to the extent that, for example if your disproportionate share requirement is relatively low, I can continue to select across a regular population which is not something that's open to other MA plans.

Did I say that right? And it may be if somebody else said it it might help. You know if you hear the same thing twice.

DR. REISCHAUER: If risk adjustment were perfect, why have you been advantaged by doing that? I'm going to argue that you shouldn't be allowed to do that for other reasons. But this is a problem with imperfect risk adjustment.

DR. MILLER: I think that's it. And what we're saying to the regular MA plan is you have to take all comers. We're saying to this plan you do not have to take all comers. And to the extent there is any imprecision in there, we're creating an opportunity for them. Unless we say disproportionally you have to make 90 percent of your population --

DR. REISCHAUER: I'm going to make an argument on why you should.

MR. HACKBARTH: You're not allowing them to skim within the heart category. You're saying you have to take all comers within that category.

DR. REISCHAUER: I want to answer her questions, and in a way get back to this. Because I'm a believer that in theory the SNP concept is right, a good one, and it hasn't reached its potential. and we should pursue a set of recommendations that nudges it along in the direction of its

potential. And those recommendations would be let's extend it permanently, let's say. Let's say you have to have a mission statement that lays out the special things you're going to do. Let's say you have to focus. You don't have to be 100 percent, but my view is it shouldn't be much below 90 percent of whatever you're aiming at because I don't want to be -- this is a little like hospice. A few people are going to live a long time but let's not get too excited about it as long as it's a very small group.

And what is the theory behind this? It is that if you focus on one particular group, you can design delivery systems that provide better quality care more efficiently.

Well, let's have a requirement that you have special quality measures and report those out. And if you are no better than Kaiser for those special ones for heart folks, then that's sort of the floor. But if you're below Kaiser on those special heart related ones, then we're concerned about you. You really aren't fulfilling your mission.

Now I'm a SNP and I'm coming along and I'm saying, wait, you're asking me to do a whole lot of extra stuff that these other guys don't and you're only going to pay me the

same. There will be risk adjustment but he gets the risk adjustment, too. That doesn't seem fair.

So the theory behind this that makes it work supposedly is by focusing on a specialized group like this you have to be more efficient. There has to be economies of doing this. And that's an untested hypothesis. I believe that it should be true. And if we ever get pay for performance, you should be getting an extra bonus because of quality factors, as well.

DR. MILLER: So what are we disagreeing on?

DR. REISCHAUER: No, I was just articulating in a comprehensive way what you were stumbling around trying to say.

[Laughter.]

DR. REISCHAUER: I was answering her question. She wanted to know where we'll sat and I sit with Jennifer's -- they aren't recommendations because you're giving them options but I'm down at the bottom on all of those.

MR. HACKBARTH: And I agree with everything you said, and I'm not sure if this is a difference or not. Like Nancy, I think that these things take time to organize and develop. And I just caution being careful about too early

being too prescriptive and preventing the natural development of it.

DR. REISCHAUER: We haven't even asked them to do this at this point. We haven't asked them to say they're going to do something special, set up some measures, things like that.

MR. HACKBARTH: Again, I'm saying I agree with that. I just think you need to be careful at the front end about trying to draw it too tight and make it too demanding or the entrance requirements too great if you think that they're not doing harm relative to the generally unavailable MA plans. If you think they're doing harm, then you club them right at the beginning. But if you think they're as good as but not achieving what we aspire to, be expansive early, say this is what we want you to become, set targets for it. But just don't close the gate too quickly too early.

MS. THOMAS: We were talking about this internally and specifically around the requirement to have a contract with the state, which we think is kind of the hardest thing from what we've learned.

And we said, you know, just because you can't be a

SNP right away doesn't mean you can't be an MA plan right away and be getting all your ducks in line to go to SNP. I mean, you can't choose your target population but you could start negotiating with the state --

MR. BERTKO: But Jay's point is one of the overriding -- I mean, there are really two populations here. There are the duals, for which you need to have the special benefits and the contract with the state and everything organized. And then you have the chronic condition ones.

And you maybe offset a little bit one of the things Mark said here, these people are first sick, I mean poor, and then sicker. So they're somewhat sicker.

Rick adjustment generally works that the sicker you are, the less close you are. that is you may be a little underpaid to a lot underpaid, depending on how sick you are. So if anything, in the sicker population you're less likely to be selecting against in that direction.

The other point I wanted to make here is on the chronic conditions one. Here's the one I think we need to give a little more scrutiny. I think if they're going to be chronic condition ones, they ought to be ones to which clinical help could actually come to play. And they ought

to be scrutinized. I think Jennifer made exactly that recommendation. And we ought to follow up with that.

MS. HANSEN: I appreciated the dialogue and I really appreciated the paper, Jennifer, teeing this up. I think this is probably the one area I do some background in relative to some of the complexities.

Just by way of the context, but I do have three points out of this context, is that the PACE program does represent probably that example of the dual eligible most frail. We are part of the whole rate setting and risk adjusting that the MA system is there. So it's mainstream. What is different is the frailty factor that is a multiplier on top of that for this particular population.

And so it's actually based on two things. It's a financing mechanism, but it's also a delivery system model.

And so the concern I have, and we have actually probably negotiated with the equivalent of I think about 25 states now. So we have state work developed to deal with the Medicare and the Medicaid relationship.

A little footnote as I think, Bill, I don't know whether you were at GAO at the time. But I remember when PACE first came to the table it was the first time, at that

point HCFA, Jack, that both Medicaid people and Medicare people sat in the same room. So that difficulty of doing that, but that's been a 15 year effort for us. But we have about 25 states.

So the dual eligible is the section that I want to speak to. And that is the ability to have a state contract, as difficult as it is -- and I know because it oftentimes takes five years to develop a state relationship and contract.

But unless than piece is done for this most vulnerable population, there's a lot of tossing back and forth that occurs. And I know that, as part of the Commission, I've raised it before and the idea of the Medicaid population is always the -- that's when the curtain kind of comes down. But the reality is these are people who happen to just fit two categories, but they're Medicare beneficiaries.

So somehow I think that kind of -- and I hope it's within our lifetime that we can get to some of the issues that Nancy brought up, but you still have to look at the totality of this, that ultimately some of the care coordination systems -- my one point here, when I first

looked at this, that some of the SNPs on the surface of just the report and the way they've evolved, they've taken the financing mechanism part.

It looks like the early stages of the physician hospital organizations, there's a funding opportunity and you get there. But it's not as simple to say we have a home health agency, we have all these services. And on the surface of it, it looks really good. But it's the same kind of issue about culture change, of making sure that you really are there for the beneficiary.

I think one of the examples was transportation. It's great that an MA program may say that we have a service there. But if you don't connect the Medicaid part and coordinate it, then the beneficiary can't get to that provider who's far away.

So I think that issue, number one, of just making sure that -- the bottom line is I support the direction that we're going. This is definitely really good. But I do want the conditions that were specified to make sure that the quality measures are appropriate. And I know that NCQA is doing some of the added measures that may look at this. NCQA has not typically focused on this kind of population.

The metrics that they've had for measures for Medicare are broader level. They do not address this population. The University of Colorado was given a contract by HCFA at that time to really look at kind of the complexity of frail populations. And that might be something to take a look at, as to how far that has gone.

And then the Medicaid contracting, I guess is my final point, is that it's just for that particular area. I think it's something that still has to be looked at because otherwise the beneficiary does get bounced between the two systems. If the savings happens on the Medicaid side will be done in a way that you dump it back onto the Medicare side. So with the duals, especially for the medically chronically complex, I do think that has to be really looked at much more carefully.

And just the caveat that I support the direction but I do want some of these quality benchmarks and the Medicaid contracting to still be looked at.

DR. CASTELLANOS: My comments are pretty much like Jennie just said. This vulnerable set of Medicare population is really undermanaged. And to my opinion, they're probably undertreated. And here we have an

opportunity perhaps to get some coordination of care and setting up maybe a medical home as a definition for this segment of the population. I would certainly set up some quality measures so we know what we're getting and hopefully get it.

Everybody said it, but it's not been put. I definitely would get an expert panel for the chronic illnesses.

The question I have is that some of these are not required to contract with the states to provide Medicaid benefits, Jennifer?

MS. PODULKA: That's correct.

DR. CASTELLANOS: Why?

MS. PODULKA: The why I can't answer. It seems that the original enabling legislation -- it was very short so it's broad and vague. And it seems as if at many instances CMS has chosen not to further focus it. So a dual eligible SNP means that you can enroll dual eligible beneficiaries. And it doesn't really require anything past that.

DR. CASTELLANOS: Do you think we should address that issue?

DR. MILLER: That's one of the recommendations, is that it would require it.

DR. CASTELLANOS: [off microphone] I hadn't heard anybody say that.

DR. MILSTEIN: I am, I think along with others, inherently worried about participation in what I think is a program that offers a lot of opportunity for Medicare that would be geared purely to structural characteristics. I think I heard implicit in some of the prior comments this notion that since this is an area of potentially a big opportunity for Medicare, that is better management of this population, that our hurdles for entry at some point in the future would not only be structural, including reporting, but also distinguish performance both on quality and efficiency.

I think among other things it might mobilize current deliverers to realize that their ability to continue to be the Medicare Advantage type plan for these patients would depend on actual results in reduced total spending and improved quality.

One question, Jennifer. One of the existing quality measures that Medicare Advantage plans are asked to

report is just beautifully tailored to this population but it's not one I think that's currently routinely publicly reported. It's the so-called HOS, Health of Seniors -- maybe it's called Health Outcomes Survey. But it's really a focus on the degree to which health status changes in an enrolled population over a 24 month period. It's sort of the ultimate measure of impact of all of these process measures on patients' ability to function in life, which is the purpose of health care, is to raise that.

I wonder if we might, the next time we meet, be able to see some results from the HOS survey that perhaps if there's sensitivity about it being health plan specific might at least show us that those numbers are moving more favorably for SNP plans than for the equivalently high risk enrollees in regular Medicare Advantage plans. It's an early window on whether or not meaningful change in improving patients' health is actually occurring as a result of SNP plan enrollment.

MS. PODULKA: That's actually a very good suggestion, and I can say that because we've started trying to explore that. We're facing a data limitation with the HOS survey. I need to clarify this, but I think there's an

issue where the current data are available at the contract level but don't necessarily -- and I need to confirm this -- distinguish at the plan ID level.

So in instances where a parent organization, which is the majority of them, offer SNPs along with regular MA, we're not going be able to distinguish -- and this is just preliminary. We're trying to see if we can get around this if there's something to do. But we're definitely interested in the HOS.

DR. MILSTEIN: Maybe at least we could focus in on the SNP-only plans, so we don't run into that problem.

And also, it seems to me if we have information on the ratio of SNP enrollment in plans, which it sounds like we did based on the statistics, we could show comparative results for plans that only enrolled SNPs and/or SNP enrollment was over a certain percentage, as an early indicator of whether or not the needle is being meaningfully moved with respect to patients' ability to function in life.

MR. HACKBARTH: Any others?

MS. DePARLE: I really liked Ron's idea, when he brought up the medical home. I just wondered if there's any way to import that into this in some way?

MR. HACKBARTH: As a requirement?

MS. DePARLE: Yes.

MS. PODULKA: Actually, there was -- on the first set of policy options that applied to all plans -- I didn't express it as eloquently -- but there was a recommendation that there be a mechanism to link enrollees to a health care advisor or health advisor coordinator. But perhaps that's sufficiently close to medical home and we could move towards the medical home idea.

MS. DePARLE: I don't know if others like it, but we've been struggling with that idea and we all think it has merit and struggling with how we would do it in fee-for-service. It seems to me if we can't do it here, then we know it's going to be really hard to do it in fee-for-service. It seems like a natural fit to me.

DR. CASTELLANOS: I'm going to tell you that in clinical practice that this population, nobody else is going to look at. This is an underserved, undermanaged population. And most people try to avoid the Medicaid patient.

DR. DEAN: I was just going to say, I don't know any of the details but apparently North Carolina has

structured their Medicaid services around the medical home concept and, what little bit I've heard, were very enthusiastic that it really did make a difference. But I only know the most preliminary --

MS. DePARLE: They came and presented here.

DR. DEAN: There apparently is some benefit.

MR. HACKBARTH: Thank you, Jennifer.

We'll now have a public comment period with our usual ground rules, which are number one, identify yourself and your organization; and number two, keep your comments to no more than a minute or two. And number three, don't repeat one another.

MS. SMITH: Hi, I'm Sherry Smith with the American Medical Association. I staff the RUC.

Just a few things in defense of the RUC, first of all, that the slide about the five-year review and the codes that had been reduced is a little not representative of the RUC in terms of its overall work through reviewing new and revised codes, et cetera. Over 400 codes have been reviewed through that process for overvaluation.

As Kevin mentioned, the RUC Iraq developed a new technology flagging system in '05, and those codes are going

to start coming up for review as claims data is available.

Having said all that, the RUC agrees with the Commission that the next five-year review does indeed need to be different than the previous five-year review and has therefore created a five-year review work group. They have already been developing codes for immediate review. A letter is going to CMS tomorrow that 100 codes should be reviewed for site of service anomalies. So the RUC really is making some significant progress since the last time you met and spoke about this activity.

There was a number of other screens on the RUC's agenda that they will be working through in coming meetings to identify codes.

Having said that, the expectations about how much money is really in the work RVUs for redistribution is something that the Commission really needs to consider. There are 6,500 codes with work RVUs, 3,000 have been reviewed by the RUC. Of the remaining 3,500 codes, 2,400 are only performed or performed less than 1,000 times per year on a national basis.

So another little factoid that we like to put out is that even if Medicare were to cease payment for all

advanced imaging and redistribute that money back through the system, there would only be a 6 percent increase in E&M payment. So the expectations about how much overvaluation is really in the work component of the RBRVS needs to be considered.

MS. GORENC: Hi, my name is Theresa Gorenc. I'm Director of Health Policy at the Medical Imaging and Technology Alliance.

I wanted to comment on Mr. Winter and Mr. Stensland's presentation from earlier this morning. Unfortunately, just because of the brevity, did not have an opportunity to get up here and speak about it.

MITA commissioned a study on the Medicare 2005 claims data specifically looking at the incidence of physician self-referral. That was done by Direct Research LLC.

The analysis that came out of that -- and I'd be more than happy to share, we have hard copies available as well -- was that the 2005 Medicare data suggested that there is not widespread practice of self-referral in Medicare. In fact, specifically looking at referrals for CT, MR, PET, and SPECT, it was an average of 94 percent of the time the

physician that was performing that test was not the ordering physician.

A couple of other things that we found in that was that the majority of referrals for imaging services are made by physicians who do not stand to realize a gain from that referral.

And then lastly, looked at most imaging for Medicare patients was actually done in hospitals, most of the time in the outpatient arena, but was not done in the physician offices.

So wanted to provide this data to you today, would welcome the opportunity to discuss it further with Mr. Winter and Mr. Stensland and the rest of the Commission, but wanted to make sure that you had that available as you're moving forward in your analysis of the Medicare claims data.

MS. BAJNRAUH: This is part two. I'm Heide Bajnrauh with Arnold & Porter, but I'm here on behalf of MITA, just on the packaging and bundling issues.

I wanted to point out that MITA commissioned an analysis by an external research organization which conducted a review of selected services that were proposed by CMS for packaging. The analysis was conducted using

solely without HOPS limited dataset released by CMS and derived from 2006 outpatient claims data up through December 2006.

The data showed a very large range in how often a dependent HCPCS code is actually billed with one of the independent HCPCS codes and vice versa. Our analysis illustrate the percentage of independent codes that have a dependent service billed with it.

It is important to note that although numerous independent codes were billed with dependent services, the dependent services were not necessarily the same HCPCS code. The extreme variability we uncovered in the pairings of dependent services with independent services demonstrates the need for great caution in proceeding with any further packaging until the large number of services and underlying HCPCS codes can be examined to ensure that payment rules do not disrupt appropriate provision of clinical services, they maintain integrity of the payment structure, and ensure that patients and providers can have confidence that Medicare payment policies are equitable.

I have copies of the actual report, if anybody would like to see them.

Thanks.

MS. WILBUR: Hi, I'm Valerie Wilbur with the National Health Policy Group, and my organization represents the SNP Alliance, which has about 30 special needs plans organizations affiliated with it, including all three kinds of SNPs across the country and the demonstrations that were the predecessors of SNPs.

I promise I'll try to keep my comments brief and submit some comments in writing.

But one of the first issues I wanted to raise is about payment. When you look at the benchmarks and the payments going to SNPs across the board, the question I have to raise is isn't the payment structure as it's currently set up providing an incentive to have SNPs not target specifically the sickest population?

Two examples I'd like to give us we have a member that wanted to set up a chronic condition SNP, and they wanted to target three particular -- people that have three or more chronic conditions out of a list of 130 that Hopkins came up with. But based on the research done by their actuaries, it indicated that if they focused on the people in the top third of the highest risk category, they wouldn't

be financially viable. In fact, they'd lose about $700 per member per month after they reduced hospitalization by 40 percent and nursing home placement by 20 percent.

So actuaries that we've spoken with would tell you they advise their clients not to target all the people at the highest end because the current payment methodology doesn't sustain it.

What we've been asking CMS for for a long time and what we'd ask you look at, as well, is instead of looking at SNPs across the board, if you could focus in on some of the programs like the demonstrations that have risk scores anywhere from 1.5 to 2.6, and look at how the current MA risk adjustment system works for them, I think you'd see the reason why there are a lot of SNPs out there that aren't really targeting the high-risk population. So that's one issue I wanted to raise.

The second issue I wanted to talk about is quality measures. By the way, I think a lot of the recommendations are excellent and my SNP organization would be very supportive of them, including the quality measures. We think it's really important that CMS and NCQA is doing this work to identify some different kinds of measures that

really are going to look at chronic illness care needs and how well SNPs are doing to really focus in on this special things. And if we don't have good quality measures that are SNP specific, we're not going to really be able to show whether they're doing what they're supposed to be doing, when Congress expects. So we're really glad to see those recommendations.

On the dual contracts, one of the gentlemen asked why doesn't CMS require Medicaid contracts for the dual SNPs? What CMS has told us is it's straightforward. It's a Medicare Advantage product. Congress didn't require them to have a contract. And as Jenny and some others around the table pointed out, it's very challenging. There's a number of demonstrations, three in particular, that have focused on integrating Medicare and Medicaid for the duals that, as has been pointed out, has taken five years or more to get good contracts.

We support contracts for dual SNPs. We think they should be doing coordination. Some of the challenges that have been mentioned could be addressed by, in the short-term, allowing Medicare only SNPs until states get up to speed. But we also think that there should be some

incentives for states, like sharing some of the CMS savings from the Medicare rebates with the states to help them set up that infrastructure.

And also, we think CMS should be doing more to support states and SNPs that want to develop integrated products.

One of the discussion points that was made is are dual SNPs really that important? Are they special? Should we continue them? And I think the integration function is critical. Beneficiaries that are dually eligible have tremendous administrative challenges in terms of having two different enrollment processes, different marketing materials coming at them. It's very confusing. And we've seen some good progress on the integration side with these three demos, but they're starting to slip.

Somebody mentioned about the duals being a financing vehicle for integrating Medicare and Medicaid. But because Medicare requires this new bid process, it's not as easy to combine those financing mechanisms and use those pool of dollars, so to speak, for whatever the beneficiaries' needs are because you have to account for those two different products separately. So it's not as

easy to do that as it used to be before the bidding process came along.

The last point I'll make, and excuse me for taking so much time, is on the chronic condition SNPs, we've had, among the Alliance, so much conversation about how do you define a chronic condition SNP. We finally came down to the idea that we don't support the idea of a list because it's too limiting if somebody -- you'd have to go back to Congress every time you wanted to have different kind of a chronic condition SNP.

The other thing is we like the second idea that Jennifer talked about, where you have complex care management criteria to define what is a chronic condition SNP. In fact, we recommended, along with what the House said, either a risk score of 1.35 or that somebody would have a chronic condition plus comorbidities as an indication of complexity. Or that somebody is eligible for Medicare because they meet the ESRD or the disability criteria. So we would be supportive of that.

And with that, thank you very much for your time.

MS. SUPER: Hi, I'm Nora Super with AARP.

I just wanted to follow up on the SNP discussion

and agree with what Jack Ebeler and Nancy-Ann DeParle said. If you all can come out with recommendations before March, that would be very helpful. We don't have an opinion or an official position as an organization yet on SNPs, although we've been asked to do so.

The legislation, as you know, has been passed in the House and has very strong provisions on SNPs. The Senate is moving through quickly to come up with their own. And they may be finished before December, maybe not, but they probably will decide whether to reauthorize them before the end of the year.

So if you want to have an impact, there are many organizations that look to MedPAC, including ours, for recommendations on these types of policy questions. So we would encourage you to please make some sort of statement before March.

MS. FISHER: Hi, I'm Karen Fisher with the Association of American Medical Colleges.

For those of you who are newer to the Commission and aren't familiar with my organization, we represent all of the allopathic medical schools in the country but also of the major academic medical centers, the major teaching

hospitals. Hence, why I'm at the podium today.

I wanted to talk a little bit about outliers and very theory because I think what we'll do is do some follow up discussion with the staff.

First, let me say that I think it's an appropriate time to talk about outliers, given the implementation of new Medicare severity DRGs. It's an important discussion to have and we welcome that.

We'd like it to be a little bit broader than quickly moving to what the marginal cost threshold should be. I think everyone would agree how important outlier payments are to any payment system. You do not want to have a payment system that has incentives for hospitals to avoid very costly patients. And you also want to have a system, I think, that helps compensate those hospitals who are going to treat the patients regardless. So we welcome that discussion.

I did want to emphasize what Dr. Reischauer pointed out, that at least for teaching hospitals that treat a lot of cases that end up being outliers, what we hear anecdotally is they can tell them coming in the door, that they are train wrecks coming in the door and they know they

are going to be an outlier case. And it's worth emphasizing that a teaching hospital does not receive an outlier payment for a case they treat until they receive the DRG payment, plus the IME, plus the DSH, plus incur $25,000 in net losses.

So while people may think that DSH payments are being used for uncompensated care, one needs to remember that for many teaching hospitals DSH payments are actually going to treat complex patients in these scenarios.

We would suggest that as you continue to think about this, that you look at the fixed loss threshold. Is $25,000 reasonable? Maybe the pool should stay the same and the fixed loss threshold should be lowered. I don't know the answer to that but I think it's a discussion worth having.

And some additional datapoints, such as CMIs associated with outlier case, what is the average loss associated with an outlier case? We know it's at least $25,000 plus 20 percent. But it may be much more than that.

What about transfer cases? How many transfer cases turn out to be outlier cases? That type of information we think might help your discussion as you

continue to think about this issue.

Thank you.

MR. HACKBARTH: Okay, we reconvene tomorrow at 9:30.

[Whereupon, at 5:44 p.m., the meeting was recessed, to reconvene on Thursday, October 4th, 2007 at 9:30 a.m.]

PUBLIC MEETING

The Horizon Ballroom

Ronald Reagan Building

International Trade Center

1300 Pennsylvania Avenue, N.W.

Washington, D.C.

Thursday, October 4, 2007

9:35 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, J.D., Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
MITRA BEHROOZI, J.D.
JOHN M. BERTKO, F.S.A., M.A.A.A.
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AGENDA PAGE

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P R O C E E D I N G S

MR. HACKBARTH: The first topic for today is hospice.

DR. MATHEWS: Good morning. It's been awhile since I've been up here.

My discussion this morning will be the first in a series of presentations that we'll cover through the fall on Medicare's payment system for hospice. These presentations will look at a number of issues, including payment adequacy, definition of the hospice benefit, changing demographics of hospice patients, and the effects of the aggregate average per beneficiary payment limit which is better known as the hospice cap. The cap, as you know, has been considering a greater amount of attention as greater numbers of hospices are reaching it.

This morning we will look at the cap in some detail. I will describe which hospices are reaching the cap, offer an explanation as to why they're reaching it, and lay out a couple of different analysis that we plan to pursue throughout the fall. I'll also try and put this information in the context of the larger hospice payment system.

Before I begin discussing the analyses specific to the cap, I wanted to take a minute and review some of the basics of the Medicare hospice payment system. Hospice is an end-of-life benefit available to beneficiaries with terminal illness and a prognosis of likely death within six months.

In electing hospice, beneficiaries can receive a wide range of palliative care and other services both for themselves and their families. In exchange, beneficiaries electing hospice relinquish further curative treatments for their terminal condition. Beneficiaries elect hospice for defined periods, each of which requires physician certification of the patient's prognosis. Medicare pays per diem amounts for each of four types of hospice care, which you see on this line here, and the program makes these payments for as long as the patient is covered by hospice, regardless of whether a visit is actually provided on a given day.

There is minimal Medicare cost-sharing under hospice.

Medicare spending for hospice grew at on average annual rate of about 23 percent between 2000 and 2005,

reaching $8.1 billion in that year. Spending is projected to exceed $10 billion in fiscal year 2008. Spending is driven by greater numbers of beneficiaries electing hospice and by more spending per hospice patient. Both of these metrics increased by about 11 percent per year on average between 2000 and 2005.

Since Medicare pays for hospice on a per diem basis, spending per enrollee is largely, albeit not entirely, a function of the length of time a patient is enrolled in hospice. We have previously pointed out that there is a lot of variation in hospice length of stay for patients who died in any given year and that longer stays are increasing, both in length and as a percent of total stays. Between 2000 and 2004, hospice lengths of stay at or below the national median were flat or had declined very slightly. Stays above the median increased in length, especially very long stays.

Our preliminary estimates for 2005, which you do not see on this slide, reflect a continuation of these trends. Length of stay at or below the median were virtually unchanged from 2004, while stays above the median continued to grow rapidly. Length of stay for decedents at

the 90th percentile of the distribution now appears to exceed 200 days.

As a point of reference at the very extreme end of the curve, at the 99th percentile length of stay is about three years for both 2000 and 2005.

As I just mentioned, length of stay is a primary driver in the increase in spending for beneficiaries. Spending -- or from the hospice's perspective payments per beneficiary -- is important because it can trigger one of two Medicare hospice payment limits. The first of these limits the share of Medicare inpatient days to 20 percent of a hospice's total Medicare days. Beyond this threshold, the program pays for all days of care at the routine home care rate. This payment limit was implemented to ensure that hospice did not become a substitute for inpatient care. I'm not going to spend any more time talking about it this morning, since this limit is rarely if ever triggered.

The second one is going to be the subject of the rest of my discussion this morning. This is the aggregate average per beneficiary payment limit, and I'll refer to this as the hospice cap for the rest of the presentation.

Medicare limits the average payment per

beneficiary fungible across all of the hospice's patients. The limit is $21,410 in the current cap year. For example, if the hospice had 250 Medicare patients in a given cap year it's Medicare payments would be limited to just over $5.3 million. The hospice would have to return payments in excess of this amount to the Medicare program.

A small but growing number of hospices reach the cap each year. Last year the fiscal intermediaries that process Medicare hospice claims reported that about 5 percent of hospices reached the cap in 2004. To investigate the characteristics of these hospices so that we can better understand why they reached the cap, we created a payment and utilization model using Medicare claims and provider of services data and Medicare hospice cost reports. This model allows us to go beyond the aggregate FI numbers and describe these hospices in more detail. I want to state that these and the following numbers are preliminary and subject to revision as we refine these analyses in the months ahead.

On this slide you see first order results of our model. The number of hospices reaching the cap increased from roughly 2 percent of all hospices in 2002 to about 6 percent in 2005. Hospices reaching the cap represent a

smaller share of overall payments for hospice, however, only about 1.5 percent in 2005, indicating that these hospices are generally smaller on averages than those hospices that did not reach the cap.

We also compared cap hospices and non-cap hospices by several other characteristics. This is a very busy slide, and I apologize, it's sort of information dense. I'll try and tease out the salient points as best I can but please bear with me if it bogs down.

The top row of this table shows the number of hospices reaching and not reaching the cap in 2002 and 2005. Again, about 2 percent of hospices reached the cap in 2002 and just over 6 percent in 2005.

Urban/rural status does not appear to have much effect on whether a hospice is likely to reach the cap. Ownership does seem to be a major factor, however. In all years from 2002 to 2000 nearly all hospices that reached the cap were proprietary, making up about 1.7 percent of all hospices in 2002 compared to cap hospices compose a 1.9 percent of the total. You can see those numbers highlighted in yellow in the leftmost column.

In 2005, proprietary hospices reaching the cap

made up about 5.3 percent of hospices. That's the number in green about halfway down that chart. Again, a large share of the 6.1 percent of cap hospices overall.

These trends are similar for freestanding providers and here what we'll consider in the future analysis is the role of the parent provider in discharging payments to hospices. It might be skewing the freestanding versus provider-based representation in the cap hospice population.

Lastly, these data show average annual caseload and, for freestanding facilities, average length of stay for cap hospices compared to hospices that did not reach the cap. Hospices reaching the cap tended to be smaller in terms of their average patient count, 190 patients on average in 2002 compared to 308 for non-cap providers. And for 2005 about 220 patients on average compared to 339 for non-cap hospices. They also had lengths of stay that were about 54 percent greater than non-cap hospices in 2002 and 107 percent greater in 2005.

So again, a very dense slide, but there are three take away points that I'd like to bring home. One, the hospices that reach the cap are disproportionately

proprietary and freestanding. Two, they generally have a smaller patient load. And three, they have a longer length of stay, on average.

We closely examined cap versus non-cap hospices length of stay, given the impact of this metric on hospices' likelihood of reaching the cap. Here we used claims data, which permitted us to calculate length of stay for all hospices, not just the freestanding providers that we displayed on the previous slide. The different data source is also why the numbers are somewhat different between the two slides. If you want, we can have a conversation about the specific elements of each of the data sources that we've used here and their strengths and limitations.

Here we compare several measures of length of stay for hospice patients, cap hospices compared to others in 2005. Patients at cap hospices had median lengths of stay over three times that of patients at non-cap hospices, 71 days compared to 19 days; and twice that average length of state -- 111 versus 55 -- relative to non-cap hospices. Further, stays of more than 180 days -- and this is the presumptive eligibility period, a six-month prognosis of likely death -- represented about 40 percent of episodes at

cap hospices compared to less than 15 percent of episodes at non-cap providers.

Given these fairly striking differences, in length of stay by cap status we investigated further as to why this might be the case. Again, another dense slide here. My apologies.

As I mentioned earlier, a major factor that drives hospices to reach the cap is patient length of stay. Length of stay is highly correlated with the diagnosis that is the primary cause of admission to hospice. Some diagnoses as you see here, such as Alzheimer's disease and chronic ischemic heart disease, have relatively long lengths of stay. Further prognosticating the likely remaining life span of patients with terminal stages of these diseases is something of an inexact science.

By contrast, patients presenting with diagnoses of renal failure or sepsis, down at the bottom of the screen here, have much shorter lengths of stay on average.

Because of the association between diagnosis and length of stay, we hypothesized that cap hospices may be treating a disproportionate number of patients with conditions that typically have longer lengths of stay. If

so, the caps may be unduly impeding access to hospice for these patients and adversely financially affecting the hospices that treat them.

When we compared the patient mix of hospices that did not reach the cap to those that did, we made two significant findings. Again, this slide and the next slide are going to have a lot of numbers here but I do need to spend a minute or two with them, so again please bear with me.

Going back to the two findings, first we found that the eight highest volume admitting diagnoses for cap hospices were the same as for non-cap hospices in 2005, albeit in a slightly different order. These eight diagnoses represented 46 percent of Medicare admissions to non-cap hospices and 53 percent of admissions to cap hospices. So mix of services alone doesn't appear to account for hospices hitting the cap although again, as I mentioned previously, the cap hospices are on average smaller and so even subtle changes in the proportional representation of these diagnoses could have a disproportionate effects relative to hospices with larger caseloads. We're going to pursue this further.

The second significant finding is that despite the similarity of service mix across the two groups of hospices, cap hospices had significantly longer lengths of stay across all eight of these diagnoses, ranging from 29 percent longer for lung cancer to 162 percent longer for patients with general cerebrovascular disease. In fact, of the 50 highest volume diagnoses that made up 85 percent of hospice volume in 2005, cap hospices had length of stay that exceeded those of non-cap hospices for 47 of these diagnoses.

We do not yet fully understand what accounts for these different patterns of care, but again it does not seem to be patient mix per se. Other factors that could push a hospice to reach the cap include the mix of visits hat it provides. A hospice for which patient care composes 10 percent of its patient days has a greater risk of reaching the cap than one for which inpatient visits represent 2 percent of its total days.

Patients who use more than one hospice may also affect a hospice's likelihood of reaching the cap. The cap is proportionally allocated by the number of days of hospice care a patient receives, so the hospice treating a patient who, either previously or subsequently, has a very long

length of stay at another hospice may be pushed towards the cap for reasons above the short stay hospice's ability to control. Again, I can talk about this in a little bit more detail under the context of technical fixes to the cap.

Hospices may also reach the cap because they are unable to admit a mix of short and long stay patients. Alternatively, hospices may seek out and promote long stay patients out of belief in the value of hospice care at the end of life or as part of an explicit business strategy.

We've heard anecdotal evidence that the length of time that a hospice has been a Medicare participating provider in a specific market may also factor in to whether it reaches the cap as well as the saturation of individual hospice markets. We plan on analyzing the patient mix of all hospices in markets where there are significant numbers of providers reaching the cap to further assess these questions. There may be other factors, as well, and I would be happy to entertain ideas you have about directions we should pursue over the course of the next couple months.

We also modeled how constrictive the cap is in terms of limiting hospices' ability to provide care for patients with long lengths of stay. Here we took half a

dozen diagnoses, each of which has among the longest average length of stay, and which account for a notable share of hospice volume. For modeling purposes we took a point at the high end of the length of stay distribution for each of these diagnoses, the 75th percentile, which is the second numeric column up there. We also calculated payments in a high wage area, New York City, and assumed that the mix of care roughly followed national averages, in this case 95 percent of care being routine home care and 5 percent being general care.

The high wage component here is important because, as you'll recall from your paper, the cap is not adjusted for differences in local wages, whereas payments are. So hospices in a high wage area theoretically would be able to provide fewer numbers of visits than hospices in low-wage areas, all else being equal.

So this group of patients with lengths of stay at the high-end of the distribution for diagnoses with typically longer than average lengths of stay in a high wage area would generate just over $7 million in payments, well under the applicable cap limit of $7.5 million.

So it's true that in no circumstance, based on our

analysis, does the cap accommodate the full 180-day presumptive eligibility period. But when you look at the empirical distribution of lengths of stay by diagnosis, the cap does give providers a fair amount of room to provide care to long stay patients. In essence, under this model here nearly all of the hospice's patients could fall into this category and the provider would still remain under the cap.

That said, there are some technical problems with the cap that could and probably should be fixed and these are, again, outlined in your paper in a little bit more detail. These fixes would improve the equity with which it's applied to the hospice provider community.

In evaluating how to address the hospice aggregate per beneficiary payment limit, it is important to consider these potential actions in the context of the broader Medicare payment system for hospice. This is a payment system that is ripe for a major overhaul and there are many different forms that this overhaul may take. You may wish to start thinking now strategically about what the hospice payment system should look like in the future and the kind of steps that would need to be taken in order to achieve

that vision.

Again, as I mentioned earlier, over the course of the next couple of months we've got half a dozen, eight or 10, different analyses of hospice payment that we'll be looking at and we'll be bringing these to you over the next couple of meetings.

We will continue to look at cap issues. We will also continue to refine our payment model, especially with respect to these patients that I mentioned earlier who receive care from more than one hospice because they do present some particularly acute potential inequities in treatment of hospice with respect to the cap.

Additionally, we will be analyzing the adequacy of Medicare's payment to hospice including hospice margins. We will be analyzing the composition of hospice's costs and look at patterns of utilization among different demographic slices of Medicare population.

We are also planning to but have not yet embarked on analyzing certain physician issues related to hospice care. As you'll recall from a previous discussion, of all of the services covered under the hospice benefit, spending for physician services has been growing faster than any of

the other ones and so we'll be looking at some of the factors driving that growth.

I hope that these analyses will be helpful to you as you do consider how the hospice benefit should evolve.

Lastly, just one note I want to make is that, as noted in your paper, over the summer CMS issued new guidance to hospice providers that requires them to begin reporting detailed information on the services they provide on their Medicare claims beginning in 2008. MedPAC has previously recommended that CMS collect this kind of information and we believe that it will be essential for informing the evolution of the hospice payment system. However, the hospice community has expressed some concerns about the specific data elements that CMS has asked for and the timeline on which the hospice providers have to provide this data. So we'll be working closely with CMS and the industry as appropriate to monitor how this process evolves and ensure that the goal of the data collection effort which we do support achieves its desired result.

With that, I will end my presentation and stand by to answer any questions you have or otherwise facilitate any follow-up discussion.

MR. HACKBARTH: Thank you Jim. Well done.

MS. DePARLE: Thanks, Jim.

We've talked about this a couple of times and this was a great paper. It had a lot of interesting information in it, especially on the cap. My concern has been that through no fault of their own some hospices are serving patients in the way they're supposed to be serving them and then getting hit with this cap.

In particular, I've been concerned about the retrospective way that it operates. You alluded to technical problems or things that maybe could be done better. And I would hope that we look at the administration of it, depending on where we go with this. But it is unpleasantly reminiscent of the home health interim payment system to me, in the sense that you're going back to providers after they've provided services -- I don't know, is it a year later or 18 months later? A long time.

Especially, as you point out in the paper, these providers are, in general, very Medicare dependent. Much of their caseload is Medicare. And you're going back to them and saying you owe us millions of dollars. And that is just not a prescription for a good system or relationship. So I

would hope we could look at that.

The chart on page seven I had a question about, which is this is in your analysis of hospices reaching the aggregate per beneficiary payment cap. I wondered if this is consistent with what CMS says about the number of hospices reaching the cap?

MR. MATHEWS: These numbers are a little bit different. The numbers that CMS reports, I believe, are the ones that are derived from the fiscal intermediaries, who are responsible for keeping track of which providers are reaching the cap and then issuing the subsequent demands notices for repayment for those providers who have exceeded the cap.

In the past, we've only had access to the aggregate numbers that the FIs have provided, which did not permit us to kind of dissect them at an elemental level to kind of see what kind of characteristics they had. So we constructed this model independently using our own data. Again, I mentioned we used claims, we used cost reports, and we used provider of services data.

In order to get into our analytic dataset for purposes of presenting this information, a hospice had to be

represented on all three of those files for purposes of being able to complete a complete record for that provider.

As a result, we lost -- I want to say, if I remember correctly -- about 15 percent of providers that did not have at least one of those datasets. So the numbers that we generate here with respect to the counts of providers and the dollar amounts are somewhat lower than what CMS has reported that the FIs have told them.

So I've tried to inflate the number of hospices subject to the cap and input the payments associated with them. But those are estimates and they do fall into the category of things that we'll continue to work up.

But these numbers are, at least with respect to the counts and the dollar amounts, a little bit lower than what CMS has reported.

MS. DePARLE: Just somewhat lower.

DR. MILLER: [off microphone] [inaudible] ...we were getting 4.8 in 2004; is that right? And CMS was getting --

DR. MATHEWS: About 5 percent. They're close.

MS. DePARLE: That's close enough for me. But the thing I'm wondering about is different, is it grosser?

Because I have met with some not-for-profit and some for-profit hospice providers and trade associations and I know you have. You may have a better recollection of their data than I do.

I recalled a chart that showed a much bigger percentage of all hospices. They weren't breaking it down like this, I don't think, that were getting cap letters from the intermediaries or subject to the cap. Glenn, does that ring a bell to you, too?

So I'm trying to put those two together and figure out why their number -- it may be a problem regardless, but it certainly seemed like a much bigger problem based on the numbers they had than what you seem to be finding.

DR. MATHEWS: I can't recall the number of providers, but the dollar amount that I have seen reported in the media is about $200 million. I cannot recall if that's 2005 or 2006.

MS. DePARLE: Maybe I'm just wrong then.

MR. HACKBARTH: I don't have a specific recollection, Nancy-Ann, but I do know that the one association that we both met with, one of the calculations they did, as I recall, excluded certain types of hospices,

provider-based hospices, and they tried to focus on the freestanding and got higher percentages exceeding the cap as a result of that. It may be that number is sticking in your head.

MS. DePARLE: That could be. And the other thing -- and you alluded to this in the paper -- but it appeared that there is one fiscal intermediary that has a very large percentage of agencies reaching the cap. I think that's also something that you want to look into further, you said, and I'm interested in learning more about that.

DR. MATHEWS: We'll definitely talk to all of the intermediaries who process hospice claims. But again I would point out here that the model we put together was unconstrained by FI and we're still getting estimates that are defensibly close to what has been reported previously, close enough that I feel comfortable putting them up in a public forum here.

So to the extent that one FI is acting differently in how they calculate the cap, I would have expected to see a somewhat different and broader set of numbers than in this analysis.

MS. DePARLE: And then finally, on page eight in

that chart, you do the breakdown of the different types of hospices and this was very helpful. It appears that those that have a higher average number of patients per year are less likely to be the ones hitting the cap. So just for example, this 339 average number of patients, do you have a breakdown of how many of those patients are, on average, cancer diagnoses versus the other diagnoses?

I'm surprised that you seem to have found differently than what I have been told, that it's the trend towards non-cancer patient population in hospice that seems to be driving this problem with the cap. It sounds like you have not found that to necessarily be the case.

So I was just wondering what is this average number of patients? Does that show a higher number of cancer diagnoses when you have a larger number of patients? Or does it not show that.

DR. MATHEWS: I would refer you to slide 11 that breaks out number of diagnoses and share of total cases by cap versus non-cap status for the top eight diagnoses here. We have this information broken down all the way to the top 50. What I could anticipate doing next time, if you'd like, is I've written some code to roll these up according to

certain categories. So rolling up all cancer diagnoses, rolling up all chronic heart diagnoses. And I could show you how that breaks out by cap versus non-cap. And that would get rid of potentially some of the noise that occurs with breaking out lung cancer from pancreatic cancer to prostate cancer, that sort of thing.

But here you can see, when you roll up these top eight diagnoses, they represent a comparable share of total patient cases for cap versus non-cap hospices. Now again, there are some differences in the relatives here that, for example, congestive heart failure, which is one of your longer stay diagnoses, represents a greater share of cap patients then non-cap patients. Again, if cap patients are smaller, those differences in share can have disproportionate effects that might cause them to be more likely to hit the cap.

Again, we'll pursue this further. And one of the analyses that I mentioned that we're embarking on now is on a market-by-market basis looking at the composition of diagnoses for cap hospices compared to non-cap hospices in that specific market. So we'll look at are there differences relative to the mortality profile of the market

that can be observed between hospices that hit the cap and those that don't.

MS. DePARLE: And that's reminding me of one more point which, Mark, you and I have discussed. If you have the time or the ability to do this, it might be interesting to look at the availability of other venues of care that might be viewed, perceived as being analogous or a substitute for hospice. We've talked about this.

DR. MILLER: I've been looking for a way to get more of Jim's nights and weekends picked up by MedPAC.

But I think your original intuition is the point that kind of came out of this. What you hear in the media is the mix of diagnoses is driving people over the cap. What Jim is at least raising a question about is when you look across diagnosis, you see a difference across all diagnoses in terms of length of stay. And so it's not quite what we've been hearing, and that's what we need to delve into more deeply.

But I'm not missing your last point about looking at supply.

DR. CASTELLANOS: Jim, I thought that was a great report and I happen to be very involved in the hospice from

a clinical viewpoint.

One of the issues that I see is what Nancy-Ann said, there's some variability as to what care each of the hospices provide. I'm not quite sure if the guidelines are as clear, specifically on palliation for using radiation therapy or chemotherapy. That's really important, especially in cancer patients. It seems to me that some of the hospices do it and some don't. I'm not sure if it's a guideline issue or what, but you may want to look into that.

Specifically, maybe looking at why patients transfer from one hospice to another. Are they transferring for that reason or other reasons? That may do that.

Another issue you brought up, and it needs to be clarified, as you know CMS is now requiring them, in their cost report, to provide the additional information in January. They are just asking for RNs and aides. But as you know, hospice is a team effect. It's not just nurses and aides. It's bereavement, it's pastors, it's social workers. And these are all cost issues and they're not seem to wanting to capture than data. And I know that's a cloudy issue, but you may want to look into that.

Again another issue, and I'm not sure if it's

appropriate, but there seems to be four or five large chains of for-profit hospices and there's some feeling in the industry that these chains -- excuse my language -- but take easier patients. You may want to look specifically at whether the chains really do have a significant difference than perhaps the nonprofit or the community-based hospices.

Thank you.

DR. MILSTEIN: Is there any research evidence that would shed light on the following question: if Medicare reimbursement of hospices were to shift in the direction of encouraging longer lengths of stay across all diagnoses and toward shifting mix toward diagnoses that have less determinable prognoses, whether or not Medicare total spending would likely increase or decrease? I'm a little unclear as to what other services we're substituting for if we were at the margin to modify reimbursement to encourage the two underlying trends.

DR. MATHEWS: Let me see if I can parse out the question a little bit. By way of Medicare policy encouraging longer lengths of stay and encouraging the admission of patients with diagnoses that typically have longer lengths of stay, I don't know that we could

effectively say that the current Medicare payment system discourages those types of patients, given the fact that it is a per diem system and that as the presumptive eligibility period works and the patient's eligibility for subsequent hospice election periods, apart from the cap there is nothing that would prohibit them from continuing to receive care, as long as they were certified.

MR. HACKBARTH: Could I ask Arnie's question in a different way? In fact, we've seen over time a shift in the mix of patients away from cancer and towards diagnoses that have longer stays and less definitive endpoints. Can you do a time series analysis of the comparative cost of hospice versus other, and look at it when it was predominately cancer patients and then look at it more recently after the mix has shifted?

DR. MATHEWS: I got the feeling there might have been two words missing from the question you just asked: comparative cost of hospice relative to...

MR. HACKBARTH: To non-hospice for the same diagnoses.

DR. REISCHAUER: Let me suggest an alternative way of trying to do this. Whether you could compare folks with

the same diagnoses in for-profit and not-for-profit, because you have two groups with very different lengths of stay. And for the people who are in the nonprofit, go back to the period before they were in hospice to make the lengths of stay, in a sense, equal and compare total hospice expenditures plus Medicare fee-for-service expenditures in both groups with each other. And then you could get a rough answer to that question, I think.

DR. SCANLON: There's a big selection issue here, in terms of people that have chosen to join hospice verses who the controls are going to be in traditional fee-for-service. Our level of diagnostic information is very high and we don't know the specifics about these people's condition. So I'd worry that the comparison -- whichever way it came out -- wouldn't be definitive in terms of telling us what's happening here.

DR. REISCHAUER: But you'd be getting a pool of two different groups, both of which went into hospice at the end.

DR. SCANLON: But Glenn is asking for compared to fee-for-service.

DR. REISCHAUER: But the point is whether are you

saving money -- I thought the question was if we extend or if we relax the requirements so that people get in earlier, do you end up saving Medicare money or costing Medicare money? There's the RAND study that answers a slightly different question.

DR. MATHEWS: There is a reasonable body of literature on this specific question and it runs the gamut. There are three or four studies that say hospice saves the program money relative to traditional Medicare, and other studies that say it costs money. I've sort of deliberately avoided having a detailed discussion of the cost-benefit aspect of hospice given that inability --

MR. HACKBARTH: You tried to avoid it, rather.

DR. MATHEWS: Yes. I get dragged kicking and screaming into it.

But for this set of exercises, we've sort of been looking at what's been going on internal to the hospice benefit. But if you wanted to specifically invoke this cost savings aspect of it, which arguably was one of the integral pieces of the rationale for the Medicare benefit when it was established, that would have implications for the rate of payment. If you wanted to ensure that hospice payment rates

were set in such a way that would continue to live up to that early expectation of the payment system, we could look at that.

But again a lot of people a lot smarter than I am have looked into this issue and they're all over the map. So if you want me to go into it, I'd be happy to do so.

DR. MILSTEIN: I'm not asking for a cost-effectiveness analysis of the benefit, but rather the impact on Medicare spending of essentially encouraging longer lengths of stay and higher -- and accepting a higher frequency of diagnoses that have a less determinate endpoint.

DR. MATHEWS: I can synthesize some of the literature and I can give you a couple of data points that would be useful for answering that question.

Most recently there was a study, I think it just came out last month, by some folks at Duke University who looked at cost of hospice use for patients relative to a cohort of patients both in their last week of life, in the period between their death and the election of hospice, and in their last year of life. And they kind of had some interesting observations about the cost effects of hospice

use relative to non-hospice users. I think they found that for decedents with cancer, hospice use was more cost-effective up to 233 days of care. And for non-cancer patients, hospice use was cost-effective up to 154 days of hospice care, above which the cost for hospice patients was greater than non-hospice.

But again, this is one study and there are a bunch of others ones out there. But I can include a synthesis of that literature.

MS. HANSEN: I think some of the questions actually have been addressed. Just the intuitive observation that some of the non-cancer type of diagnoses, the dementias as well as the cardiac diseases and perhaps even diseases like Parkinson's that's not specifically alluded here, have become a chronic care approach to a benefit that was originally for -- the way it was set up back in the mid-80s -- for the cancer diagnosis that we've been talking about.

So I was interested in kind of the continuum that you were looking at that has been discussed for sure, but it's just whether or not there's kind of that shift, is that since Medicare typically doesn't provide long-term chronic

care this is implicitly how the benefit can be used, emphasizing more the palliative side than necessarily the hospice side. That's one observation.

The other question I had relative to again the break out between people who are dually eligible and how that payment process occurs when you have somebody who is a dual in a hospice program and what the state responsibility is.

And then the other side of it is whether or not long-term care insurance also enters into this with when people go into benefit, do they get to use their dollars to help offset some of their co-pays, even though their modest, whether that's also used to help in the payment system.

So it just gives a bit of a profile from the public sector as the private paying responsibility and the shift in diagnosis.

DR. MATHEWS: For the next set of analyses that I anticipate presenting, we'll look at hospice utilization by a number of demographic characteristics including insurance coverage, fee-for-service, Medicare Advantage, and duals. I had not specifically looked into how the payment system for duals works but that's something I can try and pursue, as

well as the effect of long-term care insurance.

MS. HANSEN: Just related to my first comment about the trending, it's interesting -- and I'm not current on this at all. But when I was involved with some of the diagnoses with the ICD-9s one of the issues that we had for getting payment for a diagnosis of Alzheimer's or dementia was really not an ICD-9 code that we could bill on. So that was never a Medicare code. So I don't know.

What happened was I know there were some research studies done by a number of policy groups to say that in order to come to the right risk adjuster for somebody like that there were some other kind of corollary diagnosis that you can get the profile of the impact of dementia.

So it's just interesting that the opportunity to use hospice this way actually embraces the diagnosis without having to do the split out of the ICD-9. So that's the other thing about just the shift. It's just another way, frankly, it seems that the opportunity to care for people who have this chronic long-term condition.

MS. BEHROOZI: On the issue that you identified, Jim, about the cap not being adjusted by the wage index but the payments counted against the cap and presumably the

costs to the provider are adjusted by the wage index.

Being from New York you know I have to say no fair. The chart on page 22 -- I figured you were all waiting.

That chart on page 22 shows that my next door neighbor here, his neck of the woods gets like 50 percent more in terms of the maximum days that a beneficiary could receive that the provider could be paid for over what New York would get.

So okay, that's not fair to the providers. But I'm really concerned about beneficiary access then, as providers recognize this is happening. And as the cost and wage index continues to go up so the payments continue to go up and the caps don't get adjusted that way, are providers in New York in particular -- or any other high wage index MSA -- is going to start dropping out. And then when it's my turn I won't have one to go to but Tom and his buddies will have plenty of options.

DR. MATHEWS: The geographic adjustment is a technical fix that I think there are there some very compelling arguments that support fixing that one. There are a couple of other technical fixes that fall into that

category and we're looking really hard at those.

MS. BEHROOZI: And so maybe an analysis of how the impact is working might support -- especially to the extent that it might implicate questions about higher spending and things like that. It might be good to show beneficiary impact.

DR. KANE: In looking at the differences between cap and non-cap and proprietary and freestanding, are the measures of quality that would be relevant or patient satisfaction and family satisfaction? I just kind of get a feeling we're just looking at the economics but not really whether the effect is -- what people are saying about their experience.

DR. MATHEWS: There are -- the National Hospice and Palliative Care Organization conducts surveys of patient and family satisfaction, and independent researchers have also kind of looked into this and have published their findings.

I do not believe there are any formal quality measures of hospice being used in the Medicare program right now.

MR. HACKBARTH: So that's something we may want to

think a bit about for any recommendations. Tom, did you have a comment on that?

DR. DEAN: Just to follow up on what Nancy just said, I don't know a lot about hospice but it strikes me that looking at some of these conditions and the lengths of stay, we're really not providing what at least I understand hospice care to be, which is difficult pain control, palliation of unstable conditions, bereavement and that kind of thing.

And so I just wonder is this truly just a substitute for nursing home care, which it sort of looks like it is in some cases. I don't know. Like I say, I certainly don't know.

MR. HACKBARTH: Which, I think Jim, you pointed out in the paper, was at least part of the rationale for that cap originally was that there was this boundary where potentially this benefit could evolve into long-term care and there was some concern about that and the cap was a means of stopping it at some point.

DR. BORMAN: In your chart -- as you looked at this you said at the beginning that the overwhelming majorities are the routine daycare things. But if you look

at the categories and what they match up to, pretty clearly general inpatient care day and continuous home care will markedly alter how quickly you get to a cap if you deliver more than those.

Now you mentioned that no more than 20 percent of your days could be inpatient to start with. What about the continuous home care? Is there a limit on those kind of days in the benefit? And is there a difference in the providers reaching the cap? Are they more often providing more of these continuous home days? And does that somehow link to the patients that are now moving into hospice, the kinds of patients that move into hospice?

That would seem to be the other big driver that's not controlled independently. Do we know something about that?

DR. MATHEWS: I do not believe that there is a limit on continuous home care. If colleagues in the audience from CMS, they could correct me on that if I'm wrong.

But that would be a driver in a hospice reaching the cap faster, given the expense of that service relative to routine home care. If they provided a higher than

average level of continuous home care it would be a factor. But we don't have that on a diagnosis by diagnoses basis.

DR. SCANLON: Jim, thank you very much. This has been very, very helpful.

I am of a greatly mixed mind hospice. Having seen, as probably everybody has, personally how well a hospice can do in terms of providing benefits and it's something that you want to really protect and preserve. But from a Medicare payment perspective I, at the same time, felt so ignorant about what's exactly happening with respect to Medicare hospices, the trends over time, et cetera, that it's kind of hard to come to conclusions as to what the appropriate Medicare payment policies should be.

Like Nancy-Ann I have some flashbacks which really relate to home health, but it's actually a few years before Nancy-Ann's flashback which is the mid-90s when we were having a lot of growth in home health. it was geographically concentrated. We were having a changing industry. We were having a lot more small agencies come into place. And some of the data that you provided us are showing some of the same kinds of things, and trying to understand that more I think is a prerequisite to thinking about anything that we

should be doing.

Another part about this is that it's not just payment policy that we should be focused on. There's this whole issue of -- we've had 600 new hospices, according to your chart between 2002 and 2005. What are the entry requirements? What are we asking a hospice to demonstrate before we're admitting them to the program? And then once admitted, what are we asking in terms of continually showing capacity to provide the services that we expect?

These are the same kinds of issues we've had with respect to other provider types, and it was very true in the mid-90s with respect to home health. We had very low barriers and we were getting agencies that weren't fully capable of delivering the services that we expected.

So I think that it's important for us to look there.

The other issue, and this goes back to Tom in terms of what's the appropriate services that are being delivered and whether the people are really the right ones for hospice care. What about this issue of certification for hospice? How much of it is that we're relying upon solely upon a physician's signature versus having more

information? And I know this is a very dangerous area because again we have flashbacks to the mid-90s. There was the story about the retrospective examinations of whether someone that had been certified for hospice had died. That's not the way this should be approached. The approach should be prospective, which is that we look at a person's condition and make a decision as to whether or not they're appropriate for hospice.

So I think that aspect, in terms of a nonpayment approach to making sure that we're getting what we expect from the benefit is important.

I agree completely with Mitra. We shouldn't be having a national cap. It makes no sense in terms of equity. We don't do it in terms of payment levels. We shouldn't be doing it in terms of a cap.

Having said that, you raise the issue about how should we potentially readjust the cap. I think we need to remember that this is an aggregate cap and that not thinking about it in terms of what an individual patient can get, but where would this cap fit in terms of looking at the average mix that hospices provide and maybe pick out some percentile point on the distribution and say the cap is adequate so

that 90 percent, 95 percent of hospices could provide the services they're providing and they're not going to be influenced by this geographically adjusted cap.

That, I think, is the way you think about setting an aggregate cap, not in terms of a target for any single individual.

I don't know, I mean, if we were to take geography into account, would we have a different number today of hospices that are above the cap by any significant number? Or because we've had such a skewing of the people above the cap geographically would it not make much difference?

DR. MATHEWS: Mathematically, if you were to adjust the cap to reflect differences in area wages, as I think it through, this would have the effect of increasing the potential for hospices in high wage areas to provide more services and decrease the potential for hospices in low wage areas to provide those services.

And since, when you look at the distribution of where most of the hospices are hitting the cap now, geographically adjusting the cap would have the effect of increasing the number of hospices subject to the cap in those areas.

MR. HACKBARTH: Jim, could you just say a further word about that? As I recall, it's states like Oklahoma, Louisiana, Alabama that tend to have the disproportionately high number of hospices hitting the cap; is that right?

DR. MATHEWS: That is correct. Those three states do account for more than half of hospices hitting the cap. I'm sorry, Mississippi, Alabama, and Oklahoma.

That said, I think there are about 17 states that have hospices hitting the cap in the most recent year.

DR. REISCHAUER: Just reminding me about the distribution of growth in home health agencies in the late 1990s.

MR. HACKBARTH: In fact, that's the point that Bill made that I wanted to pick up on.

I've heard from people in the industry, Jim, that the entry requirements are pretty low, that the ease of entry is pretty high. And that often hospices are very small entities with only a few staff -- maybe often is not the right characterization. But there are many that are very small. Could you just talk about that for a second?

DR. MATHEWS: Do I have to?

[Laughter.]

DR. MATHEWS: I mean, I've heard the same accounts but I have not verified those independently. I mean, there are conditions of participation for hospice that have been in existence since -- I want to say very early on in the benefit, '83, I think. CMS did publish a proposed rule in the late '90s, I think, which was never finalized. But the conditions do include things like the hospice has to have a multidisciplinary team that operationalizes a plan of care for a hospice patient and establishes a number of other requirements.

I cannot assess how low or high a bar those conditions represent.

MR. HACKBARTH: That's fair, I understand. Bob has more questions along this line.

DR. REISCHAUER: First of all, I want to say I agree with Mitra and the observations that Bill has made on the issue of the variation in the cap across geography. But Jim, I thought this was a wonderful paper and a good presentation. When I read it, I was quite surprised that a disproportionate fraction of proprietary institutions are hit by the cap. That isn't what one would expect, especially in a world that strikes me as pretty

controllable. By just tweaking the diagnoses of people entering, you can make a huge difference in length of stay for your organization, more cancer, fewer Alzheimer's patients.

So it's not that they're totally out of -- that this is sort of forces beyond the control. And then you have the ability to turn the mix and quantity of services dials a little bit, also.

So I come out of this looking at the fact that the length of stay in proprietary organizations is longer for every diagnoses that you have here --

DR. MATHEWS: Can I make a clarification? It's not that the length of stay is longer for proprietary hospices. The length of stay is longer for hospices that hit the cap.

DR. REISCHAUER: Which are predominantly --

DR. MATHEWS: Yes, but again the hospices that hit the cap are predominantly proprietary but it's not necessarily that the obverse of that is true.

DR. REISCHAUER: The question is whether the profit maximizing point is a longer length of stay rather than a shorter length of stay. If that is the case, then

one would expect to see the pattern that we see here and some people are going to miss and go a little over and they're going to be disproportionately small ones because the controllability, the variation would be larger.

And so I was wondering if we could see the distribution of how close you are to the limit and whether is this something where the same organizations miss year after year or is it sort of a random pick of those?

DR. MATHEWS: The next presentation that I would anticipate doing will look at hospice payment adequacy and will include an analysis of margins by different categories, urban/rural, proprietary versus nonprofit. One of the things I'm looking at is margins by cap versus non-cap status. In the context of that conversation, I can kind of walk through what we know about the cost curve for a typical hospice episode where the costs are higher at intake and at the very end of the episode. I can also kind of a weigh out some of the -- lay out some of the theoretical incentives that you've just discussed.

DR. REISCHAUER: But if that's the case, then the longer middle period you have, the better the overall situation is.

DR. MATHEWS: I would not disagree with that, in theory.

DR. REISCHAUER: No, this is all theory. And hopefully you'll delve into this and come up with what the facts look like.

DR. MILLER: Again, Jim is being very careful. A different way to say at least one of the points that you're making is that the cap does represent a limiting and presumably something you don't want to exceed because it creates the financial problems. But there also can be a strategy where you operate very close to the cap. And so I think that's what, in a sense, you're trying to get behind. And I think that is something we're going to try.

DR. REISCHAUER: And that would lead one to admit earlier patients, I think, in the process.

DR. MILLER: I also don't want to be the person to make this point, but since it's been made so many times I just want to think about this a little bit. And I understand, any analyst that looks at this cap is going to immediately start asking questions about geography and case-mix adjustments and all of that. So don't get me wrong when I say what I'm about to say.

But also just keep two things in the back of your mind. One of the things that Jim demonstrated is even in this cap, in an area that should be penalized by this cap, which high diagnoses, you still have a fair amount of operating room. That was what he went through. We're talking about less than 200 hospices out of 3,000 that are getting hit at this point.

Now it's a growing problem, so don't get me wrong.

The other thing I want to say is think of your conversation yesterday about geographic adjustment where people were saying wait a minute, is geographic adjustment really working in some of the physician world that we were talking about? Different kinds of issues because it's physician work. But we want to think hard about how we go through this on geography, case-mix, and what other broader changes we want to make to the benefit at the same time.

I would just get you think about that, as well.

MR. HACKBARTH: Bill, the last word.

DR. SCANLON: I just wanted to put one more thing on the table and we can maybe talk about it in some of the future presentations and that's another area of my ignorance, which is the issue of what's happening with

respect to hospice and nursing home residents. Because it's not that hospice is precluded.

In fact, I heard that it's increasing in terms of the proportion of long stay nursing home residents that are getting hospice care. And how it relates to the care that the resident or the Medicaid program is paying for in the nursing home is something that I think we should be looking at as well.

MR. HACKBARTH: Thank you, Jim. Good job.

Next we have a panel of guests on value-based insurance design.

Welcome. Thanks for sharing your expertise with us. Rachel, you'll do the introduction?

DR. SCHMIDT: I will.

Last month we discussed some of the problems with fee-for-service Medicare's benefit design and looked at the potential effects of some of illustrative changes. Today we're going to continue our discussion about benefit design with a look at value-based insurance design, where copayment rates for drugs and services are set based on the benefits and costs of the individual therapy. We have a distinguished panel here to describe this concept and talk

about its usefulness and its hurdles.

We have Mark Fendrick. He's the Co-Director of the Center for Value-Based Insurance Design at the University of Michigan. He's also a professor at the University of Michigan in the Departments of Internal Medicine and Health Management and Policy. Dr. Fendrick serves on the Board of Directors of the International Society for Pharmacoeconomics and Outcomes Research, the Medicare Coverage Advisory Committee, and is the Co-Editor-In-Chief of the American Journal of Managed Care.

Jill Berger is the Vice President, Health and Welfare Management and Design for Marriott International. Ms. Berger is responsible for the strategy, design, and management of Marriott's benefit plans with an emphasis in health plan quality improvement. She serves on the National Committee for Quality Assurance Purchaser Advisory Council, is an active member of the Leapfrog Group for Patient Safety, and is also President of the Mid-Atlantic Business Group on Health.

Mike Chernew is professor of the Department of Health Care Policy at Harvard Medical School. Dr. Chernew is the other Co-Editor of the American Journal of Managed

Care and Senior Associate Editor of Health Services Research. He is a member of the Commonwealth Foundation's Commission on a High-Performance Health Care System and a member of the Congressional Budget Office's Panel of Health Advisers. In 2000 and 2004 he served on the Technical Advisory Panels for CMS that reviewed assumptions used by the Medicare actuaries to assess the financial status of the Medicare Trust Funds.

With that, I'll turn it over to Dr. Fendrick.

DR. FENDRICK: Thank you, Rachel, and good morning everyone.

We very much appreciate the opportunity to discuss the concept, the implementation, and the data that are available around value-based insurance design.

I'm a practicing general internist at the University of Michigan and spend most of my time looking at the clinical and economic implications of medical innovation from the cost of the common cold to Katie Couric's Today Show colonoscopy to the Internet and many other blockbuster drugs and medical services.

I view myself as a quality improvement person but, doing this now for nearly two decades, I've come to

understand that before we can talk about quality improvement and improvement in length and quality of life we, in every step of the way, need to discuss the issues and the economic implications of what we do. So much so I don't need to show you, but with Peter Orszag now basically saying quite clearly the nation's long-term fiscal balance will be determined primarily by the future rate of health care cost growth, and showing all of these slides that you've seen before. But I feel I need to present them. And the fact that almost all of these presentations by economists and fiscal analysis tend not to talk about the health gains that come along with those health care expenditures.

I think the main thing as we talk about value-based insurance design is to, in fact, acknowledge this very important cost quality divide and that, starting out as a quality improvement person, I have now increasingly been forced to become a cost-containment person. I think the very first point that all if you deal with on a regular basis is that there is often a conflict between what we try to do on the quality improvement side, which often costs money, and the pressures to constrain health care cost growth.

I find it intriguing at minimum and frustrating at another end that if you look at most surveys in the private sector and looking at those employers that are doing well are high-performing employers, that they are measured in terms of how much money they're spending on health. Those that spend the least amount of money are the ones that are doing best. And if you look at any other aspects of their business or the economy that's usually not the case, where people are frequently being driven to spend less, spend less, spend less without an equal attempt to look at what we're getting in terms of health for those beneficiaries in the design.

So if I saw that a high performing plan was, in fact, spending less money but achieving all of the quality metrics that you all deal with on a regular basis, then I'd be happy. It turns out if you look at report, after report, after report in terms of health care cost and health care cost containment, there's no discussion as costs go down are the service that are not being performed those that are viewed as high valued ones, such as immunizations, cancer screenings, and the use of high-value services like chronic drugs for medical conditions?

This idea of the pressure is extraordinarily important as we hear about cost-containment when, if you look at the work from our literature -- and that's the Health Services literature -- that every study ever done has shown that we're doing a suboptimal job in terms of achieving those things that we view to be the most important in health. For whatever field you come from, whatever subspecialty, a 75 percent rate in terms of adherence is viewed as extraordinary.

And most of the work from Elizabeth McGlynn at RAND and other studies out there in the published literature would show that 60 percent is considered a relatively high bar for immunizations, glucose control in diabetes, beta blocker use after heart attacks, colon cancer screenings across the board. So as long as we acknowledge this idea of underutilization and our need to spend more, we have to understand -- at least from my perspective -- that the pressure is exclusively on cost and less so on health.

And I think if the one point I have tried to present to multiple audiences over the last couple of years is we need to bring the term health back into the health care cost debate. Because as we look in every stakeholder

discussion, it's cost, cost, cost. And no one's actually asking what are the clinical implications of reducing expenditures in certain areas.

So all of you know and it's quite easy, and I'm not a financial person, that the interventions that control costs are quite clear. I think some of you might know that, thankfully, prior authorization has pretty much gone by the wayside. The number I have to dial in Michigan to get prior auth is 1-800-no way, where a high school student tells me on her after school job that she knows the drug to use instead of me in that situation.

And all if you acknowledge that, in every situation of prior authorization, it tends not to be driven by quality improvement. These are areas to try to understand and do a better job in terms of allocating our resources to health care interventions.

Disease management has been a big topic, I imagine, in this group among others. I think that the disease management evolution is quite illustrative of the malalignment of certain incentives. I think most of us know now that roughly 50 percent of employers are offering some type of disease management program. It is quite pervasive

in Medicare as well.

It's intriguing to me as a quality improvement person that disease management has not been sold as a quality improvement tool. It's, in fact, at least in my anecdotal experience, being sold as a way to save money on health care. And I find it intriguing that an intervention that actually gets individuals to do more of the right things in medicine, of which those individual services do not save money, it's expected that a program that will get more of those services to be used will actually save money. And that kind of reminded me of the early days of Amazon.com where they lost money on every book and made it up on volume.

So I think these issues that we need to again turn to the concept of value and not of just cost or quality as we move forward. Mike and I pretty much believe that by getting individual patients to do what's considered the right thing medically will, in fact, improve outcomes. There are several studies to show that.

Given the situation that a great majority of the things we do in medicine do help people at an incremental cost, getting their rates of adherence to improve will

likely not lower cost net, although they will provide high levels of value.

But from the financial perspective, the reason why we like to focus on disease management is that here are many payers investing in services on one side of the equation. At Michigan we pay a nurse $65 an hour to call our patients with heart failure and ask them to take certain drugs, to weigh themselves every day, and to follow up with their cardiologist.

At the exact same time, every single payer that we've looked at has increased patient copayments or coinsurance or out-of-pocket expenditures for those doctor visits and for those recommended drugs. So if you want to get attention, at least in my experience, with the chief financial officer of a large employer, tell them that you're paying money to get your employees to do something on one side of the equation and then creating a higher barrier on the other side to get them to do that.

Because, as an academic researcher, I like to say I pursue private interest at public expense, Mike and I published a paper a year and a half ago looking at was, in fact, this true that people who were in disease management

programs faced with similar copayments as those who were not in disease management programs. Until we started informing people about this serious malalignment of economic incentives, in fact it was quite easy to show that there were no co-pay differences for people in disease management programs and those who were not, suggesting that there was a way to better align incentives to get not only better clinical outcomes but a return on financial investment for disease management.

Clearly out of the area of my expertise is a great discussion that goes on now and in the future, that is physician and hospital payment reform. I don't think that we'll talk about that today, although all of us know that this will be a key component of cost containment in the near term. What we are here to talk about is the issue of increase in patient cost-sharing, or making beneficiaries pay more.

Formularies for drugs is an example, but as you look across the medical care insurance system, both in the private and public sectors, that cost-sharing -- at least as far as we've seen -- is based on the cost of the intervention, not the value. And the fact that people are

increasingly pushed to buy the lowest cost services, whether it's their drugs, their doctor visits, their hospital networks which, in many instances, do not have equivalently good data on the quality of care provided.

I have said for a long, long time that the most expensive therapy is the one that doesn't work. As I look around the table, I don't see any of the people wearing neckties or blouses that actually went out and purchased the lowest cost one every time. I have tried very, very hard to get multiple stakeholders -- what did I say wrong? I shouldn't comment about blouses, I guess, or neckties.

So I think obviously you're seeing the lead-in to the idea of value-based insurance design, benefit design, is in fact not just driving people to the lowest cost intervention but hopefully driving patients, through their copayments, and hopefully physicians, through their reimbursement, to do the thing of highest value, that being the health per dollar spent.

Clearly everyone knows that both in the private and public sectors copays for all tiers of drugs have gone up substantially in the last decade. To be honest, I would not be here today if the market-based reformers were right

in the fact that they believe that Americans would be able to spend their money wisely on health care services and the fact that when the money was put in the hands of the average informed consumer, they would buy the things that those of us in evidence-based medicine would feel to be high-value services and would stop buying the others. All of you know about the RAND health insurance experiment now over three decades old and every study ever done since then to show that as increasing cost-sharing has been put in front of the American consumer, they not only stop buying the things we don't want them to buy -- the nonessential services -- but they also stop buying those high valued services.

One example of that would be a paper recently published by Dana Goldman from RAND showing a substantial negative elasticity when copays are doubled for drugs for diabetes, high cholesterol, or hypertension that I imagine most of the clinicians around the panel and perhaps all of you would agree were things that we would strongly encourage our individual patients to adhere with. You see on the right side that this also goes for antidepressants, as well.

So my mother said to me I can't believe you had to spend $1 million to show if you make people pay more for

something they'll buy less of it. But I imagine that that is the beauty about being a grant-funded researcher.

This probably was the first paper that really drew direct attention to the impact of variable copays on drugs that are viewed to be highly valuable. Staten drugs are a $12 billion revenue producing class of drugs to lower cholesterol. Last I checked they are not addictive and they have no street value on the streets of Detroit. And people do not want to have high cholesterol and take these drugs if they don't have to.

You can see from this slide, not surprisingly, that my mother was, in fact, correct. I do not want to reopen the debate about whether money is the sole influence of adherence to drugs. It is clearly not. People have challenged us to say that there's lots of evidence that when drugs are free, people don't take them. You can look from this slide and now 15 other papers in literature. Sure there are lots of concerns about adherence to drugs even when they are free. But adherence is always better when they're free than if they're $25 a month.

So I think the issue about whether and how much the copay differential matters, I think the evidence is now

quite strong that individuals' out-of-pocket expenditures is an extraordinarily important component to adherence of both low and high value drugs.

So it is our opinion that the market does not work. We believe in not a hard hand but soft paternalism in that benefit design should, in fact, create a situation to nudge those individuals to do the things that would hopefully mitigate the negative clinical effects of increasing cost-sharing which, as all of you know, is probably the most widely used intervention now and a very successful one to constrain health care cost growth.

But value-based insurance design in its simple message needs to acknowledge a number of things. Most importantly, which I don't think is difficult for most to understand, is that medical services differ in the clinical benefit provided. Although, if you look at almost all of the health plans that are available to most individuals in the United States, there is no acknowledgment of this heterogeneity in terms of the out-of-pocket expenditures.

My patients pay the same out-of-pocket to go to see a dermatologist for the seventh time for a rash they don't have as they would to see a cardiologist for their

congestive heart failure follow up or their orthopedic surgeon to see their hip replacement follow up after this important intervention.

So I think it's not been difficult for us to get people to say yes, there probably should be a situation where the copayments for statin drugs should, in fact, as a class be less than drugs to make my hair grow back or to make my toenail fungus go away.

I'll just tell all of you that I've learned recently, dealing with a different stakeholder group -- employers, as represented by Jill Berger here today -- than in developing a term that I had not heard of before, the elevator pitch, to the CEO of large companies. I used to basically tell them in one sentence that do you know your employees pay the same money out of pocket for a drug that will save their life from heart disease or diabetes as opposed to one that will make their toenail fungus go away?

And I'll tell you that, as I see a couple of nods going on, this is something that draws immediate attention to someone who's paying the bills and has led at least to some momentum behind this concept of value-based insurance design.

One is it's probably easy for us to start thinking there are some services that we would encourage, perhaps others we would discourage. But what makes this even more intriguing, particularly to Medicare, is that even when you pick a high-valued service, the clinical benefit from a specific service really varies on who you give it to.

And while I applauded and was very much involved in the coverage of colonoscopy for Medicare beneficiaries and have been long involved in the value of colorectal cancer screening, I will tell you that I've been quite public in telling you that the data would suggest that if you have a first-degree relative with colon cancer, you should be paid to get a colonoscopy. Not just from the clinical aspects of your high risk, but now that the cost of treating metastatic cancer in the colon is so high that the economic implications of preventing this disease are extraordinary.

Fifty-year-olds and up should get it free. But if you're a 26-year-old fan of Katie Couric who's just worried about colon cancer and don't have a family history, it is my strong belief that you should pay full freight. Because while the evidence is so strong in this person, very strong

in that other group, and not there at all would allow us ultimately, in the era of a fully expanded information technology system, to set up a benefit design that is truly personalized in terms of information that might be available through a patient history, health status assessment, and electronic medical record.

So what the value-based insurance design packages do is they take this across-the-board out-of-pocket cost system which we believe does not reflect any of the multibillion dollars that we've invested in clinical research and sets coinsurance based on the assessment and the benefit achieved and, quite simply, the more beneficial, the less expensive it is to the patient.

I think it's worth commenting just for a minute or two on consumer-directed health plans, given that they are the singular most important initiative from the market-based reformers. High deductible consumer-driven health plans, in my opinion, connect the advantage of a better informed consumer.

So we love consumerism. I think this is a very important thing. I'm never sure how consumerism has gotten inextricably linked to the idea of higher out-of-pocket

expenditures or high deductibles. So while we like consumerism, I'm not so sure that it has to be always related to high deductible health plans.

Mike and I have long believed that the more you make people pay for something, the less they'll buy. And one of you should be a surprised that all of the data that are coming in regarding consumer-directed health plans are, in fact, doing a good job at constraining health care cost growth.

But what I've tried so hard to get people to understand is as the costs go down, we need to really look very carefully and seeing what are those services that would have been bought that weren't. And if you told me that it was always those things that we viewed to be as frivolous, I wouldn't be here today.

I'll tell you that if you look at the data that are emerging, this was a poster presented at the Academy of Managed Care Pharmacy last spring, looking and confirming once again that my mother was right. If you look at those individuals in the high deductible consumer-directed plans in the light tan compared to the traditional three-tiered copay that most of you probably have in your benefit

program, versus those few champion companies that have decided to make these essential classes of drugs for asthma, diabetes, cholesterol reduction, and high blood pressure reduction for free, you can see A, that money matters; and B, that money is not the only issue. That even in the setting of free drugs that there is not a single instance where three-quarters of the individuals are taking the drugs as the physicians recommend. So we need to do more on top of copay relief.

So what we have suggested as consumer-directed health plans move forward is that if we could redefine the services that are covered in terms of first dollar coverage, it would do a very good job in terms of our minds in mitigating the concerns we have about the negative health effects of high deductible plans.

I think most of us know that there is major initiatives, particularly here in D.C., around expanding substantially the monies available for comparative effectiveness research and information technology to allow us to better set up these plans to allow certain services to be covered and those not. Obviously, the added expenditures as you expand those services available under CDHPs, at least

you'd be able to know that those were services recommended by evidence-based medicine, HEDIS, NCQA, the U.S. Preventive Services Task Force, that we would finally be able to answer that question about what, in fact, are we getting for our health care dollar. You would know directly, as you saw expenditures on the first dollar covered services under CDHP go up, at least you'd be happy to know that those expenditures were exactly those things that we wanted to see spent on.

So we'll have a lot of discussion about the economic effects of value-based insurance design because I can't imagine anyone would argue that as we lower barriers for high-valued services we would see improved clinical outcomes. It's just the question is how much this is going to cost. Both Jill and Mike will likely touch on this, but I think conceptually, as we've been forced to leave the quality improvement side and look at the cost containment side, the first phase, of course, is that good medicine might prevent hospitalizations and ER visits and other types of things. Mike will certainly talk about that in a particular experiment that we've been involved in.

There are some data that would show that as

adherence rates go, in fact, up or down in this study by Mike Sokol in looking at diabetics, that it again should be no surprise that although you're spending more money on drugs, in the light blue, they are, in fact, offset by all cause medical and drug costs as people adhere to their drugs.

I think the most interesting area, which falls outside of my own expertise to really ultimately show the value of improved medical services and better health, is this idea of reduction in nonmedical costs such as absenteeism and disability and improvements in presenteeism. This is an area where I believe the peer-reviewed literature, the controlled studies, are just evolving although there have been a number of claims over the year.

I think going back through this literature I can only really find one control study, again looking at individuals with diabetes mellitus that does, in fact, show that patients with good control compared to poor are more productive and less likely to be absent at work, suggesting that there would be benefits to employers like Jill Berger in addition to what she's seeing in terms of her medical claims costs.

The last area, which is a tough one, is in fact subsidizing the incremental costs of the low copays of the high-valued services with raising coinsurance for those low valued ones. I'm happy to report thus far that we do not know of an employer or plan that's done this thus far, although from an actuarial perspective and those looking for a short-term return, this would be the easiest way to do that. Thankfully, there are a number of various consulting and actuarial firms who know very, very precisely how much utilization will change in terms of drugs or other nonpharmaceutical services as you change copays by very little amounts.

The last thing I'll say goes back to this nuance about the idea of the value of medical services not only depend on what you do to them but who you give it to. I'll just tell you that the better that you're able to find the individual who's likely to have the preventable expensive adverse event, the quicker you'll be able to achieve a financial ROI with copay design. I think the best example of this that's been understandable in my experience with lay audiences, the idea -- going back to the statin drugs and cholesterol reduction -- is if you target your copay relief

to only individuals who have had heart attacks, similar to a pilot study that Aetna has underway, because these people are at such high risk of another one, you're going to see the benefits of that heart attack reduction in increase in adherence of statins, which only subsidizing a very few people of statin use, which is around 15 to 20 percent who have already had an event.

that is very difficult to do from the administration standpoint. And if you were to expand your statin copay reduction program to everyone, obviously you'll see greater health benefits but it will take you a longer time and cost you a lot more money in terms of subsidized prescriptions and copays to achieve those clinical benefits.

This is a segue, I won't go to this because most people will agree that there probably is some merit in the concept of using our clinical nuances in creating benefit design. I really do believe that the challenge is not buying into the concept but making it happen. It's much easier for me, as opposed to going through this slide and I'll be happy to turn over the microphone to Jill Berger, who will be able to tell you her own experience and how to make a value-based insurance design implementation a real-

life reality.

Thank you very much.

MS. BERGER: Good morning. Thank you for this opportunity to speak to you all today.

We actually completely concur with Mark in many cases, although I never thought I'd say that.

But before I go into the case study talking a little bit about what Marriott has done for value-based insurance, let me tell you a little bit about Marriott.

We have about 91,000 eligible associates across the United States, about 71,000 participating, so about 160,000 covered lives. This is in almost 2,000 hotels across the country. The one takeaway, I think, from this is our challenges are we are very spread out. So as we think about ways to bring health and wellness to our associates, it is a challenge, certainly a challenge folks at CMS would understand.

We also have a very diverse population, another thing I think everybody can relate to. So when we talk about consumerism, our goal really is to work with our associates to give them tools to understand and take a more active role in their health care, certainly that presents

challenges as well.

We offer 50 HMOs across the country and three national PPOs. What we try to do is give our associates a choice between an HMO and a PPO. About 70 percent of our associates are in the HMOs. So they like the plan design. It's a lower paid population. They want the predictable out-of-pocket costs. And 70 percent of our plans are self-insured, which gives us a little bit more flexibility in what we offer.

To give you a sense of our strategy, one of the arguments I always have with Mark is where he says employers want to pay less. I actually think employers don't necessarily expect -- we're realistic -- to pay less. We're trying to mitigate the cost increases. Although I think you've drunk the Kool-Aid on that.

So what are we trying to do? We are trying to attract and retain talent. This is why we offer benefits. This is why we're not looking to get out of it. We know it's a reason that people come to Marriott. But we are experiencing large cost increases. And in the past our way to deal with that was -- and granted, we got a lot of this advice from consultants -- raise your copays. If you raise

your copays, you'll decreased utilization, you'll save money, and everybody will be happy.

So we did that. And we gradually increased copays over the years. And then we started to see the results on the other side. So where some things became expensive, if you have a chronic condition you have lots of meds, you have lots of doctor visits, the copays become unaffordable.

So one of the things that we have learned over the past few years and working with people like Mark and Mike, we have to become smarter in our plan design. Our goal really is to incent the essential care. We're actually in the midst of defining what essential care is. But we're starting to. Once we define the essential care and we even figure out a way to identify those who need the essential care, the administration on the other side is difficult. So this is going to be a journey, not a destination.

And so we are developing longer-term strategies to identify our associates who have a high risk illness and work with health plans actually who can identify them and manage the high risk illnesses, can improve patient safety and increase productivity.

So that gives you a sense of our strategy. One of

the ways that we can get to where we want to go is we have to work with the right partners. And so a lot of what Mark has talked about, when we look at somebody, when we really want to target -- if we start to look on our drugs and target those with a heart attack, for instance, who should pay less for a beta blocker -- the only way we're going to be able to do this is working with a high-tech company who can help us get there. And so we work with a company who can take the data from all of our health plans and bump it up against knowledge to identify gaps in care and identify those who need essential care.

So we work with ActiveHealth Management. They collect, and this kind of depicts what they do. They collect claims data, pharmacy data, lab values in many cases. They put it into a CareEngine. They have about 2,000 matrices where they identify ways to improve care.

Now when ActiveHealth started, they used to report these gaps to providers. Some of the providers would report back hey, I know this patient needs a beta blocker but I can't get them back in the office. I can't get them to do what I need them to do. And so what we started to do was send the same messages to our members, to the patients. And

when I say we, it's ActiveHealth. ActiveHealth works in conjunction with most of our health plans.

And so we allowed them to send these messages to our members and built a couple of programs around the member messaging to make sure that if members had questions that they could be supported. And so we did this through a program called Informed Care Management and health advocates and health coaches. All of this is beginning to make a difference.

So we've got the high-tech company and we introduced the value-based formulary. Again, one of the things that our nurses -- nurses were hearing from our members the same thing their physicians were hearing from our members' physicians is they can't afford -- affordability is one of the reasons why our folks are not compliant with drugs.

So we did offer copay reductions for certain classes of drugs, mainly related to diabetes, heart disease, and asthma. And we chose those diseases: one, we took a look at our population, we took a look at our expenditures, and those are our most costly conditions that we can affect. And there is medical literature out there that tells you if

folks become more compliant with the drugs in the classes listed here, it will mitigate cost increases because hopefully you're going to prevent some adverse things from happening.

So what we did is we made generic drugs free. We made them free because they were only $5 to begin with. Again, go back to our plan design, they're the least expensive drugs. Those were the ones we were trying to incent. So we made generic drugs free, and we had a 50 percent brand reduction.

You know, we don't really know what the right numbers should be yet and that's one of the things that we're trying to study. But at least it's our first step into incenting the right drugs.

And then ActiveHealth identifies the members. They look at those members who are currently taking the drugs and communicate the new program to them because we want them to stay compliant. And also identify those numbers who are not taking the drugs so we can begin to first inform them that these drugs are now more affordable. ActiveHealth also informs the physicians. And hopefully, we can incent them to become more compliant.

Our goals for this program are to improve compliance, improve quality of care, decrease adverse events, decrease hopefully health care cost increases -- I should add that word -- for both members and employers, and improve satisfaction.

You know, when we think about value-based formularies, I can tell you also another reason why we started with drugs is it was doable. We worked not only with ActiveHealth but also Express Scripts, who was our pharmacy benefits manager, who completely bought into this and enabled it.

One of other things is we think about our population. If we're going to incent something, we have to make sure that they get the incentive at the point of service. If they can't afford the drug, they're not going to be able to pay full price and then submit a claim to get half of it back. They have to get the incentive at the point of service.

So again, starting on the drug side enabled us to do this.

And so we implemented this. And then we were able to study the effects, working with the University of

Michigan. The study design is a pre/post control group. We used another employee who also used ActiveHealth, all of the same programs that we did with the exception of the value-based formulary. And what we did is we wanted to model what happened with the five clinical categories and then analyze patient specific data.

Basically, what we wanted to look at were the financial and clinical outcomes of the value-based formulary. What happened? And what we want to see is decrease in adverse events and a decrease in the health care trend.

The first step in doing our analysis is to ensure that it was implemented properly, but also we want to compare the differential change in outcome between Marriott and the control group, and again look at the adherence rates before the intervention and after the intervention, look at those who were currently non-adherent, what happened, and those who were currently adherent, did they remain adherent?

So the initial findings showed that members' out-of-pocket costs for brand-name targeted drugs decreased by 27 percent whereas the control group members' costs went up about 4 percent. Members out-of-pocket costs for targeted

generic drugs felt about 65 percent while the control group members' costs fell by only won percent. So step one showed that we implemented it correctly.

We also did the financial outcomes, which Mike is going to present. I can tell you in year one, just looking at the preliminary results, we lost money which actually isn't a surprise. It did take a while to get it implemented properly, working with Express Scripts and ActiveHealth. But also we have an employee population that once we have a message, and the message is hey, these drugs are now cheaper, they're more affordable, we need you to go back and consider taking them, it takes several years to get that message out.

Also it didn't look at productivity savings, didn't look at disability savings.

So in year two Aetna actually, one of our health plans, it's about 40 percent of the folks who had this value-based formulary, looked at our 2006 data. It's starting now to show a savings, which is good. We're just digging into the numbers so we do need to take a look at that.

But the other thing we have to consider, when we

put this value-based formulary in place and we listed the five classes of drugs, we made those drugs available to everybody unless there was a reason that we did not want to incent that drug. So ActiveHealth could weed out those folks who are on a drug that might be for diabetes but because of lab tests that came in, we don't want to incident Glucophage or something like that. So that was our first step.

Our next step is to take a look at all right, for those who are on a beta blocker who have had a heart attack, we want them to stay on the beta blocker. Maybe we'll make those drugs free. We want to add further incentives. So that's our next step for this year and into 2008.

The good news, actually Kaiser has put this in place for us, which we were very happy about. And they're doing it as a pilot. And I think that was brave of them. We're fully funded with Kaiser so they're taking the risk on that. But the good news is others are beginning to see the need for value-based formularies.

What's next for value-based formularies for us, we just implemented a smoking cessation program where we made some of the drugs for those programs free, as well as the

counseling. We made office visits for preventive care free, another area -- once we studied our data, we saw our HEDIS data just was abysmal. It didn't even reached the national averages.

So again, we can at least take out the financial barriers that prevent folks from getting their preventive care and we're beginning to look at cultural barriers and the other barriers, as well.

But I have to say that this isn't as easy as you think. We did this for all of our self-insured plans. And actually for 2008 even most of our fully insured plans are doing this. You can put zero dollar copay on the ID card but physicians are not used to this. So either they don't understand not to take a copay when the patient goes into the office, or they mistakenly code it with a diagnosis and it doesn't get paid free for the member.

So again, this is all a journey. It's a lot of communication. We can do the communication with our members. We're looking with our health plans to do the communications with the physicians.

What we wanted to do in 2008 but decided to do some pilots to see how it works is for those folks that are

diabetics, that have a heart condition, that have asthma, when they go to get their preventive care, when they go to get their glucose tested, the other exams that they need, we'd like to make those office visits free, too. Again, we want to incent that care.

Administratively we haven't figured that out yet. That's our next step, is really to figure out the administration.

We also implemented a personal health record. We did it through ActiveHealth again. They have all of our data. One of the reasons we want to do this is they can collect all of the data from the claims data, from lab, from x-rays, from pharmacy. And for those members that have Informed Care Management or use a health advocate, they can collect data from members that they normally wouldn't get. Do you smoke? What is your family history? Mark talked about the importance of that. What are your over-the-counter drugs that you're taking? And put that in the CareEngine, as well. But we want more of that data. So personal health record, where we have everybody complete it, will get us more data.

That's easy to implement. Now we have to get

people to use it. So we've got quite a few challenges.

But I would say we are convinced that using evidence-based medicine to identify those who need essential care and then putting a plan design in place to incent that essential care is really our next step and an important piece of our strategy.

That's what I've got and then Mike is going to talk about the results of some of the studies.

DR. CHERNEW: I can say hello and it's wonderful to be here, thanks for having me, while the slides are coming up.

The slides have fewer typos in them than the handouts so I'll mention them as we go along.

This is a topic we've been involved in for a long time and I'm thrilled to be able to come here and talk with you about it. It's a little awkward because some of you may know I'm a proponent of value-based insurance design, and I really am, and I'm a big fan of everything that Jill has done. I think she's shown leadership in a whole range of ways.

I was asked to be a bit of a skeptic, which as an economist is easy. So I'm going to be a little skeptical

and hopefully we'll have some more skeptical questions as I go through.

One of the things that I want to say when people talk about value-based insurance design is exactly what "it" is, exactly what value-based insurance design matters in your conclusions. So I want to draw your attention to two particular design distinctions.

The first one is what I call service-specific programs. You may have heard what Pitney Bowes did or what Jill described at Marriott. I consider those service-specific interventions because they basically focused on particular services, in their case chronic disease medications, and lowered the copays for those services for all of the people who may be using those services without distinction.

That's a different design than what happened at say the University of Michigan, or as Mark described at Aetna. At the University of Michigan, they focused on only patients with diabetes. So at the University of Michigan you got a lower copay for your diabetes medications and your depression meds and your blood pressure medications, but only if you had diabetes. Some Mark and I might have been

employed at the same place and we might pay different copays for the same meds, based on our clinical conditions. So it's more of a targeted program that Mark spoke of.

The second distinction I want to talk about is people often talk about the value-based insurance design program as only lowering copays. In fact, that's what Marriott did and what most of the other firms have done, they just lowered copays. But in fact, conceptually you could have a value-based insurance design program where you try and hit any financial program you want. But instead of doing it with one level set of co-pays by spreading them -- this is the sign for spreading them -- by spreading them to encourage the things you want to encourage and discourage the things you don't. Again, you'll ask me how can I distinguish that, and that will be 12 o'clock and we'll run for our planes.

But that also is a value-based insurance design program. And that flexibility allows you to hit financial targets a lot easier than if you just say I want to hit those financial targets by lowering copays. So I think it's important to realize the distinction between those different types of services.

The questions I want to talk about, what are the barriers to VBID implementation? What are the economic effects of value-based insurance design? And how can value-based insurance design be implemented in Medicare?

Most of what I talk about and most of what's been talked about hasn't been Medicare-specific. I do want to say a little something about how these ideas, if not the details of the programs, can be implemented in Medicare. I think that's very important. And I do think there's a broad analogy.

So some barriers to value-based insurance design implementation. The first one is implementation. That tends not to be a problem in these programs that are service-specific. It's easy to lower copays for certain chronic disease medications. And you could lower copays for certain other types of services if you didn't want to make a distinction by disease. It's harder, as Jill mentioned, particularly for non-pharmaceutical interventions when you want to make some distinction by disease. And there are some companies that are working to do that. Marriott and the myriad of vendors that they work with, I think, are pretty much at the forefront of that.

There are legal barriers. A lot of time when you talk about folks, they worry, if you want to do this, stay within your HSA, there's a question. Can I lower copays for this and for that? And my sense of this -- I'm not a lawyer -- is that the law is unclear in a range of ways. There's concerns about discrimination. There's concerns about the tax rules for HSAs. But a lot of folks have done this and at least through some legal departments they've deemed that these type of things are implementable and you've seen them implemented. That doesn't mean that the law couldn't be clearer to encourage this more.

Then one of the big questions you hear is what's called beneficiary acceptance, particularly in the targeted programs. But the idea is if I lower somebody's copays because they have asthma or diabetes, someone else who doesn't have those diseases is still paying the higher copays. They might be upset. And you worry about the equity of encouraging better treatment for some diseases than others.

I will tell you at the University of Michigan the experience was not oh, you lowered copays for these other people, you jerks. The experience was much more, through

almost every e-mail, you're wonderful, you've really helped us out, we think you're great, thank you, thank you, thank you. I think there's not a lot of people trying to get diabetes so they can get lower copays.

So I admit that this is potentially a problem but none of the people I've known -- and you can speak with Jill -- who have done these types of programs, have reported a lot of negative response to what other people were getting. But again, some of these programs are novel. So I say so far, so good.

The economic effects. Will it save money? I don't like that question. I'm going to say something about it. A better question is how do we finance health? What we're trying to do through VBID and a whole range of things is to make people healthier. The question becomes how do we pay for that in one-way or another?

One way to pay for that, of course, is through offsets, which I'm going to talk about. But there's other ways. Even if VBID costs money, I would argue that doesn't mean we should charge people more for their chronic disease medications. We should find a way to make sure that people are taking things that we deem are essential.

Now if they're not essential or not appropriate, that's a separate question. But the question should not be will this program save money? That shouldn't be the hurdle. It's not the hurdle when you set someone's broken arm or a whole range of other things. The question should be how do we finance the health care benefits that we want to give to people? I think that's a crucial distinction.

And that leads us to my third question, which I like even better, which is how do we enhance value? How do we make the health care system more efficient in providing benefit for the amount of money that we spend?

So I like this slide because it's soothing. It's dolphins and tuna. But the basic idea behind saving money in these cases is there are some people that would have taken their medications anyway and other people that wouldn't have. When you lower copays, typically if you lower copays for everybody, the benefit from that is to identify the people you want to target. In the fishing analogy, the tuna, the people who you want to catch.

But the problem is you often end up lowering copays for people that would have taken the medications anyway. So you're not getting any incentive effect for

those people. And so if you knew, if everyone had on their forehead, sort of tattooed, I'm not going to take my medication unless you lower my copay to $5, you could go around and have a benefit design. And they walked in, they'd show their forehead, they get...

But that doesn't work so well. And so the challenge in this program is how to separate that out. And that's what's going to drive the economics of the program.

The perspective is key. And there's going to be a typo on the slide that you have, but it's right on the screen.

The one perspective is the aggregate perspective, which the key point about that is -- and I'm going to use Jill because she's so nice to be here. She's not quite the audience, but for my example.

When Jill's company, Marriott, lowers copays for their workers, for people that would have taken the medication anyway there is a shift in spending. The $5 that would have been spent by the employee that's been reduced is now picked up by Jill. In the aggregate perspective, that nets to zero. The $5 was spent. It's just a question of who.

In a payer perspective -- and this is below and this is the part that's wrong on the handout but right on the slide -- that's a cost to Jill. Jill paid five more dollars. Someone else got the $5. And that makes the aggregate perspective cheaper. The employer perspective is more expensive. The aggregate perspective is appropriate for cost-effective analysis. It's what economists tend to look at societally. And they deal with the distributional issues separately.

And in the aggregate perspective, the only real cost is the cost of the extra medications that are being used if it's a formulary as opposed to some other service, as opposed to the shift.

So the results from the literature -- and I say literature/press. There's a lot of press on this point. As an academic, I have to be skeptical of the press because otherwise what would I do? Pitney Bowes, for example, they report a 6 percent decrease in overall diabetes costs and savings exceeding $1 million. They report savings even in their Rx spend, in some presentations I've seen, from this type of intervention.

The city of Ashville had a comprehensive

intervention where they targeted diabetes. It was run through the pharmacists so it was more than just copay reductions. But they reported also a reduction in annual per participant total cost for diabetes of a per person cost of over $1,000, which is nontrivial.

I don't want to go through a big discussion of evaluation here. But I will say if you read those and we had a discussion over cantaloupe or whatever else you can eat over there, I might be skeptical of some of those things. There's a stronger controlled study done by Amitabh Chandra and Jon Gruber look at what happened when public employees in California were charged increased copays. So that's not VBID lower copays, that's increasing copays, but there might be a symmetry.

They found the medical offset was 20 percent overall. That means for every extra dollar you would charge to employees -- save because employees are paying more -- 20 percent was extra medical costs. In the VBID context, that would mean every dollar you spent in giving employees a break, you would get 20 cents back because medical costs would go down by 20 cents. In the highest spenders, the most targeted group, you got a 50 percent offset.

The key thing is there's no doubt, that I'm going to present some numbers. I think it's not quite -- because everything is refutable -- but it's close to irrefutable that if you lower copays, people buy more stuff. And if you lower copays on good stuff, they buy more good stuff.

The question is because that stuff is good, the evidence would suggest and we find, you get health benefits. This is just a numbers issue. It's just an actuarial question. How big are those health benefits relative to the amount that you had to spend? What was the baseline risk and how much did you reduce that?

So here's some results from a study we've done where a VBID initiative increased adherence about three percentage points. The way I really should have phrased that is non-adherence went down by about 10 percent. So copays were lowered by 50 percent and non-adherence went down by about 10 percent. If your adherence is 100 percent in the beginning, you're not going to save a lot of money by lowering copays to folks because you don't have that much room.

The way to think about this, think about that number of tuna in the sea and how many of those people you

can reel in by lowering copays. We found about 10 percent by a reduction. And that actually is in a line with the rest of the literature on the responses to copays.

And I think prevented about six adverse events. So six people didn't have heart attacks, which is really good, particularly if you're one of those six people.

And the question becomes can the non-drug savings, the savings in terms of those adverse events, offset that? So this is where I'm going to ring my hands and be sort of dismal economisty and break out into a sweat.

The actuarial analysis and the econometric analysis suggest pretty clearly that the answer, even in the short term, was yes, you could save money. The problem was there were huge standard errors around the estimates. There was a range of issues with the nature of the control group and what the trends were. What I can say is the firm that implemented this clearly had better experience than any trend analysis would have suggested they had. Whether that's completely attributable to the intervention is what I worry a lot about and stay up at night thinking about.

So we did what I call some plausibility analysis to see well, knowing what we know clinically and knowing

what we know about the adherence effects, how much money could you have expected to save based on working that through? The answer is going to be it's plausible -- I'll show you some numbers in a second -- that the overall cost from the aggregate perspective was a wash. It's plausible.

It's unlikely, in my opinion, that the payer themselves in the first year saved money.

So to give you some numbers, the increased drug spend was about $2.51 overall for people in the study. That's not for the whole plan, $2.51. That's just for people who were eligible for the lower copays. They spent about $2.50 more per member per month.

the payer spent $7.73. So that's over $5 more. The reason, of course, is the $2.50 is just the extra drugs. The $7.73, that's the extra drugs plus the extra amount that the employer was paying for the drugs that would have been bought anyway.

So then the question was how much money was saved on less medical spend? Now remember these numbers are almost all accruing to the employer because the copays for the workers were small for like the hospitalizations and these other big ticket things.

So if you believe that this extra people, if you believe a given person, when they take their medication versus not, if they're non-drug spend goes down by 17 percent, if that's the magnitude that you believe the savings is, you would get a wash from the aggregate perspective. And I will tell you that from the literature that's in the range of plausibility. You can find literature for people with chronic diseases and you might say oh, you're not actually crazy and you could talk to a group as distinguished as yourselves and say that with a straight face.

For the payer to have saved money in the short run you need to have non-drug spending go down by about 50 percent for those three extra people that took their meds. And that's a lot for the literature to really justify. And so that's where I think the numbers are.

Now I should say there's a few things about the analysis that's important. We didn't include any productivity gains in here. So those numbers, 17 percent of 48 -- that assumes that there's no productivity value. And I think the productivity value is important. I can't measure it so it doesn't get on my main slide. It gets on

my little three bullet point slide.

But the productivity things matter. There's no disability savings associated in our numbers. There's also, in any of our societal costs, there's no social security implications. So no one's gone through to figure out what it costs or saves Social Security if people are healthier. And that's a complicated question that I really don't want to get into. But if you manage chronic disease better, I should say that's a good thing. I feel very strongly that's a good thing. But the fiscal ramifications extend more broadly than our analysis has attempted to do. And I'm not going to make any policy conclusions about that except to say again, as strongly as I can, we really do want people to take their chronic disease medications. And the idea of charging them more for it is probably not a good thing. The idea of charging them less for it probably is a good thing. And it's just we have to figure out how we're going to deal with that.

The drivers of performance of these types of programs depend on a few things. How many patients respond? I told you what our numbers were. They're pretty consistent with the literature.

What's the initial compliance? If there's low initial compliance, that's going to make it look a lot better because it's lot more tunas and a lot fewer dolphins.

How effective are the service? It works a lot better if the services that they're taking are very good at reducing the risks of adverse events?

What are the costs of those adverse events? If they're very expensive, it's going to save you a lot more money than if those adverse events are cheap.

And then again, the key is often going to be can you target patients? Targeting high risk noncompliant patients is going to give you a lot better financial program than targeting everybody.

There was a study, I'm sure you're familiar with, by Allison Rosen, a colleague of ours, in 2005 that talked about giving medications for free for people with diabetes in Medicare. And she said that could pay for itself. What makes that work? The baseline risk is what makes that work.

Medicare is a wonderful place to do this conceptually because you have beneficiaries that are at risk of adverse events that are higher than some of the leading folks that have a bunch of working age people. Right?

They're not going to see as good a return as the Medicare program would because the risk in the Medicare program, the amount of money on the table that you can save is so much higher.

Let me give you my quick summary. Unless properly targeted, copay reduction only VBID program -- just lowering copays -- will typically not save money for the payer. Whether they save money overall, maybe. But they're not going to save money for the payer.

So if the question was could you save money by lowering copays, for most employers from their perspective there's not enough money on the table to save money by lowering copays unless you target it well.

That said, and I should stand up or turn around or get a cheer or something. Even so, that still might be a good thing to lower copays. Aggregate costs are going to rise a lot less. Maybe they will going to be negative. But you're going to see the profile from the aggregate perspective is going to be a lot better. And more importantly, health improves.

So the question becomes how do we finance it? One way is you could raise copays for other services, services

you think aren't important. And of course, if there's a lot of service you don't know the evidence about, you don't have to raise copays all that much because you're spreading it potentially across a big set of services.

In Michigan, I think it was like a dime for all things that weren't advantage you would have to raise copays to offset because you're targeting and so it's just how the math worked.

You could raise premiums. Maybe people would pay for better health.

You could lower wages, which is how economists thing. I'm not telling you to lower wages. Do I have to leave now?

But economists think better health gets paid for by workers that have lower wages. And of course, if they're willing to do that, that's a good thing. I'm not arguing for lower wages.

And then, of course, the one that I have to put on here because I'm the skeptic is, of course, you could decide societally we want to actually pay for more health by raising taxes or some other distributional mechanism.

The key point behind value-based insurance design

that I really need to stress is in order to manage the system the way in which I think we want the system managed, we need to be more clinically sophisticated. In a range of ways, pay-for-performance, disease management, we have become much more politically sophisticated. That's a really good thing.

In the area of what we charge patients, we haven't historically been clinically sophisticated at all. And the idea behind value-based insurance design is to extend that same notion of clinical sophistication that goes behind pay for performance, that goes behind disease management to the incentives that patients face.

And the interesting thing is many of those other programs, in pay for performance, for example, involve services the completion of which require not only the providers to recommend them but the patients to do them.

And so I can't emphasize enough, I believe, the necessity of thinking about the synergy between what's going on on the payment side and the patient side. And that's really the crux behind value-based insurance design.

My last slide is just going to have a few things to do with Medicare. And I'm a little insecure saying this

in front of this group but in the Medicare health support program -- I maybe shouldn't say can't use financial incentives. But the Medicare health support programs are limited in the way in which they use financial incentives. They could have a nurse -- my understanding is they could have a nurse sit outside your door and every morning ask you what medications you've taken. But if they were going to lower your copays $5 they would run -- or maybe $5 wouldn't make any difference. But if they were to lower your copay substantially, there would be some issues about the legality of doing that. So there's an asymmetry in how they're allowed to incent people to do things, which I think is at least useful to think about.

Of course, you can do a lot of these things in the special needs plans or in Medicare Advantage programs generally where you could set formularies in different ways. We haven't seen a ton of that, although I'm hoping we will see more.

There's issues related to adverse selection and other things that go on that I think are important to think through. But I think that when one thinks about the ideal benefit design for patients in a Part D plan or even outside

of a Part D plan, you really would want to make sure that you don't disincent people from taking the medications that you know and the clinical evidence is strong is really very good for them and may provide -- the money you spend on that, some portion of that money -- maybe all of it -- will come back to you in the end.

That requires some bit of finagling in certain settings but I do think for Medicare it's an important way to make the program a little more clinically oriented, which is what I would like to see happen.

Thank you.

MR. HACKBARTH: Thank you. Let me just do a little meeting management here first. We're running a bit long. We're scheduled to be finished at 12 o'clock and I know people have airplanes to catch and the like.

What I'd like to do is to extend to 12:15, which will allow us maybe 20 minutes or so for some discussion and then 10 minutes for a comment period. So if people can hang in for that extra 15 minutes, I'd appreciate it. If not, I understand.

Let me begin with a question about Medicare and how this applies to Medicare. In Medicare, we've got a

design now where we have the drug benefit provided through independent private insurers. And then for most beneficiaries still the rest of the insurance coverage provided through traditional Medicare.

Does that division inhibit this because you've got different pockets? And for example, Humana, of they change and adopt this for their drug program, savings may accrue somewhere else in terms of lower disease, chronic disease costs.

Help me just think through that issue. And John, you probably have something to say on this as well.

DR. CHERNEW: Yes.

MR. BERTKO: This one seems to be complicated. so in Mike's example, and Mark, I think, using the diabetes one, nobody's going to take insulin and various things who doesn't need it. So that one might be doable.

When you get to anything like the statins or some of the others where there could be off label use, you can do it within a SNP. But can you do it in a regular PDP, a prescription drug only plan? That would seem to be difficult. I don't really know the answer to that.

But how do you prohibit people who might be given

a prescription for this who don't fall into the targeting criteria?

And I completely agree with Mike about how narrow and specific the targeting needs to be in order to be cost-effective.

DR. CHERNEW: But your question, though, was the incentives. So the incentives to do this in an MA plan or a SNP are a lot greater than the incentives to do this in a straight PDP, for the exact reasons you said, implementation aside.

DR. FENDRICK: But I think briefly, from the clinical standpoint, it's proven to be extraordinarily difficult, even for those champion plans and companies, to get down to this fine granular level of targeting. Which again, to my very first point, is not driven by maximizing health outcomes, but in terms of getting cost-effectiveness, as you say, John.

I still think that while I'm sure we're going to talk a lot about targeting, is this generalized concept that almost every American now, on a given class of a formulary pays the same amount of out-of-pocket independent of what the condition is. I think most people are happy to

acknowledge in every stakeholder group that we probably, whether it be for primary or secondary prevention, using a statin should probably be lower than a non-sedating antihistamine.

So people say I can't get to that level of information technology to find the heart attack patients. I would argue strongly that should not preclude the discussion of just doing some kinder, simpler VBID interventions that will get to that same price point that Mike had mentioned.

DR. MILSTEIN: In modeling impact of value-based insurance design, the analyses that you described are what I refer to as sort of static analyses, opportunities on a one-time basis to reduce spending, improve health, or some combination thereof. Any comments or any attempt at -- admittedly highly speculative modeling -- on what might happen, how it might affect I'll call it the drug development financing pipeline if Medicare began tilting toward drugs that were more cost-effective?

DR. CHERNEW: That's a harder question than the hard question I thought you were going to ask. The hard question I thought you were going to ask was over time won't this get better, which Jill alluded to? Which I think it's

plausible. In fact, we saw some of that. But one has to go through exactly what the numbers are to decide what you think about that.

I think that the economics would suggest that that would be true, but empirical evidence that would suggest that that would be true is really difficult to come by. You certainly would like that to be true to make sure that you would want your innovation in areas that provided the best health and were the most productive in that regard.

MR. BERTKO: A somewhat related question and it's two parts. The first is in today's environment, it looked like you guys talked about maybe five possible conditions to which this might apply. And I'm just going to ask about how many total conditions you think?

And then secondly, do you see that comparative effectiveness offers a way to work on a greater number of conditions? Would this be one of the things we could use it for?

DR. FENDRICK: As a person who performs this type of research, obviously the self-serving statement. This is a full employment act for me and I want to make sure that's clear.

I think that what this does is say an awful lot about the fact that how much more research we need about what is not only the better intervention from the clinical side but the better intervention from the financial side.

We are all fully supportive of the efforts happening inside the Beltway and elsewhere, state level and plan level, in terms of increasing the amount of reality-based effectiveness trials in the community. But as we have been asked to comment by the Institute of Medicine, is that comparative effectiveness research is merely just a tool to say what the data are on the clinical side. And most of you know more than me that the politics are not, in fact, to show what's better or what's not but ultimately how it shifts from the quality improvement to the cost containment side.

The point about this turns to my very early point is that in those very early areas of medicine where we have Grade A evidence that it's clearly the right thing to do -- beta-blockers after heart attacks and glucose control and any other thing -- we've shown that the evidence enough, even if it's perfect, we've done poorly in that situation. So obviously the more evidence the better.

But we argue very, very strongly that the system has to be able to reflect that evidence to align incentives, as Mike said, across the board. I think the disease management copay example is the best one to show that the silos still aren't talking together. And the quicker we get them to do so the better off we'll be.

DR. CHERNEW: Are you going to answer the number of diseases this would apply to?

DR. FENDRICK: I've told people for a very long time that the sad part from the clinical side and the good part from the economic side is that the areas that we have, John, in terms of that we would strongly recommend copay relief in terms of not only returning health but ROI is in fact, 10. You've mentioned many of them. Most of them are in the pharmaceutical areas.

And thankfully, on the non-pharma areas Medicare, whether they've done it intentionally or not, have really aimed to improve coverage and reduce out-of-pocket expenditures for the beneficiaries in the health maintenance exam, in the cancer screening opportunities that you provide.

But as Jill said, it's easier on the pharma side.

If we really were to make an investment into diagnostic testing and procedures, I think once the infrastructure is in place somewhere that was at least presented in recent legislation, we'll be able to get larger population discussions, as well as returns on investment in the short term.

What I want to say, unfortunately which is going to come up, is we can all go down the list, depending on how far, to the 10 or 12 or 15 things that we consider good. And Mike knows, when we started 10 years ago, I was unwavering on my 10 things. And I've been convinced, given the cultural context of various regions and plans and employers that it doesn't matter to me anymore what you consider to be value. Let's just encourage those things.

There always is that question of what would you discourage? I think for this group we want to be known as the team that led to a strong scientific argument to remove barriers to get good things to the right people. I think the much, much harder part, which is largely driven by the fiscal part and not the economic side, is to decide what are those things that we should discourage?

What I've seen nationally is trying to discourage

the use of high value branded drugs as opposed to low value inexpensive drugs really does strongly draw attention to the fact that we care much more about cost than we do about quality.

MR. DURENBERGER: Just by way of quick background, I got here by starting out in 1973 in Minneapolis-St. Paul with a lot of major companies which were doing both health management and prospectively health care management. Doctors at Honeywell, doctors at General Mills, things like that and so forth.

So this isn't a new phenomenon but it got killed and now it's being brought back, or so it seems to me. I just think I'm just noticing in the last couple of years -- and Jill, you're a great example of it, as are others of your colleagues -- that this whole movement needs to be strongly supported on the research side, as I think she has indicated.

My question is probably in two parts, and this is sort of like why are we doing this at MedPAC?

I also come from a community which most recently has a great big managed care plan which bought Golden Rule and bought Definity and claimed that somehow or other it was

improving value in health care. But its former CEO was probably the first guy that talked to me about what you just talked about today. McGuire believed that despite all the things that at that time employers wanted, what the country really needed was a basic benefit which would describe in value-based terms with subsidy alternatives depending on who can afford it and so forth. But he's the first person who made the argument to me that this is an important thing to do.

But my question is from your experiences, particularly as we sit here as MedPAC with sort of a basic benefit that we're trying to pass off some of that benefit structure to Medicare Advantage plans without telling them what we really expect from them other than go sell more product, how important is it to do the work of defining a basic benefit along the lines that you've talked about as soon as possible rather than allowing 1,000 flowers to bloom and everybody comes up with their favorite this, that and the other thing?

Is this not a really very, very important part of getting health care costs under control, beginning down a line of private side/public side, using the current tax

subsidies and so forth, to develop a better understanding in people in this country about what is health and how do you management it? And whose role is what? And how do you reward it? And what is health care? And how do you reward those most appropriate clinically beneficial therapies?

Do any of you have a response on that?

DR. CHERNEW: I don't know why I get to respond. I think that people have pushed us to define one value-based insurance design plan that we can go around and say this is the plan, here's what it would be, do this. We've been very resistance to do that because Mark won't do it and he's the doctor.

But also, in part, because there seems to be different views on a range of things. I think that it is not so important now to have one particular plan structure that everyone would have to offer unless you're concerned about adverse selection issues like in Medigap markets with the A through J. So that's an important question that hasn't been studied very well in this.

I will say from our experiences -- very, very limited -- you don't see very many people switching employers because oh, this employer wanted -- because they

have a little bit less on what their diabetes meds are. But that's not to say when people are choosing health plans, we've done some preliminary analysis, I'm sure you've seen, on the Part D plans that people aren't very aware of what drugs they take and what the benefit structures are.

And so I think the challenge is going to be how well the risk adjustment is working. If you were going to apply this to Medicare that becomes crucial. And then how you might want to try and standardize. Because I would worry in some plans, particularly on the plans where they're on the hook for medical costs, that if you offered really good chronic disease management programs you would get a lot of people that had chronic disease. And I think that's just a shame, right, because you don't want to be in a situation that discourages that.

And maybe standardization would help. In the private sector, I think that would be an impediment because people would have different opinions and they would not necessarily --

MR. HACKBARTH: Let me follow up on that. Given your response to my question, that the incentives under the Part D program aren't quite right because of the different

pockets. It may be that the only way that you're going to get it in Part D is to mandate it as part of the benefit design and do it earlier rather than later.

DR. CHERNEW: So for a Part D plan where it's just a drug cost because they're not taking on other costs necessarily, you still would have an adverse selection problem because you'd have more people taking those drugs. But you would have to worry about the selection and mandating certain types of services would matter.

The problem you always run into, and I wish I knew clinically more, is what has been so useful is people that have moved incrementally. So maybe it applies to 10 areas, maybe 15. You've seen it done in like five. And you don't want the doing it in five to preclude the other areas. So you want some flexibility.

Although I do think there's some ideas -- diabetes would be one -- where I think the world would be a better place if there were certain standardized rules in those particular disease areas.

In fact, and this is an economist not a physician speaking so I could let Mark comment. I do think there's some areas where these types of things are amenable where

you could implement it in a really somewhat feasible way. And I think focusing on those areas instead of waiting for the perfect design is useful. And we have, Michigan and a lot of other places, has focused on areas like diabetes because you can identify people with diabetes easier. Even John mentioned this. There's some real advantages to that.

Although as Mark mentioned, Aetna is doing some -- cardiovascular disease is really a big area. Some time and resources to understanding what type of benefits are important for people with cardiovascular disease really could help people. The level of standardization is more of a political question in some ways.

MS. BERGER: One of the things that, to answer your question, we think a lot about this. And we think possibly that if we were going to plan the perfect plan design that it would actually be a little different for everybody. It would depend on their diseases. It would depend on their stage in life. So that really further complicates it. But we actually think that's an important thing to do.

DR. FENDRICK: Just a quick comment to the Senator's point about cost control. I think that as sitting

on the Medicare Coverage Advisory Committee, where we're not allowed to talk about cost and talk only about quality, so I came here because I know you talk about cost and I hope you're allowed to talk about quality. So it's a really important idea that at the highest level of what's happening, even in this agency, that as you say, Glenn, the pockets may not be talking to one another.

For economists to say well, the way to get costs under control is to prevent the idea of health enhancing, cost improving technologies, which is 99.9 percent of the things I could do. Economists could say that that actually means like how politically palatable would it be to shut down the NIH and all other privately funded research because we have this insatiable appetite for improved health.

I think the purpose of VBID is to come to MedPAC to say current systems of cost-sharing are hurting people and our estimate are killing more people than this whole safety issue which has caught Americans' attention.

And while we are never going to suggest that all things should be free for all people, that we've invested billions in this country to determine what helps and what doesn't help individuals in the Medicare sector. And as

Mike told me 15 years ago, and it took me 14 years to understand, that it's all about aligning incentives.

As long as we continue to pay doctors to go to the plate, as opposed to hit singles, doubles, and home runs, you're never going to have the situation where you're going to have this ultimate -- for me the holy grail of where I am getting paid when I'm actually doing the things that my training has told me that I should be doing and not being paid as handsomely for those things that don't work or don't help people and might actually harm people in the long run.

MS. HANSEN: I have one question and it's related to something, Jill, you brought up and the population of your associates. You said that you're beginning to tackle the whole issue of your diverse populations, since you do have oftentimes many fro a lower socioeconomic group and their racial components. And to relate it back to Medicare, I think it's Jack and his team at NASI that did the whole Medicare disparities, that there still is that.

So could you describe some of the efforts being made right now to deal this whole model vis-à-vis some different populations for this impact?

MS. BERGER: When we think about the VBID model

and we think about our different cultures, the one place where we're beginning to tackle it is communication. Actually, a couple of places, communications and then understanding the difference in the ethnic group. We're working with Kaiser pretty closely on this, as well as Aetna because they're spending a lot of time thinking about this.

We actually first thought we could begin to target materials to some of our cultures, our African-American culture, Hispanic culture, Asian American cultures. But it's actually hard for us to really make sure that if we target somebody that it's correct.

So we're looking to our health plans to help us do this. We are putting together materials that we're hoping will resonate with various groups.

We're also going a lot more local than we ever have before. So we're learning about our various cultures in Orlando, for instance, where we have a big Haitian Creole population. This is a population that I'm not sure a lot of folks truly understand. We do know that the closer we bring access the better and we're working with some provider groups that are coming into the property and working with our different cultures.

So a lot of it is communication. And it's teaching our different ethnic groups how certain diseases may affect them differently. And that's some of the work that we're doing with Kaiser.

So we're just scratching the surface. There's so much more that needs to be done that we're trying to learn about.

DR. CHERNEW: I would just add, in other research that we've done in terms of income, so it's a different split, lower income people are much more sensitive to higher copays. In economics that's what you would expect. In some things, that might not bother you as much as in other things. But if we're concerned about disparities and you want to worry about health effects, it's really important to make sure that certain subgroups of people don't pay a lot for certain types of medications. Maybe a lot of medications but there are some that you could really point to, these are really high value medications. And at a minimum you want to make sure that you're not charging low income people who have had coronary events a lot of money for their statins.

DR. STUART: I know we're pushing the time limits

so I'll be very, very brief.

I want to thank you for coming and I hope you come back because I think this is really important for Medicare. But I think there are some real challenges that the Commission is going to need to deal with.

You indicated that standalone PDPs have less of an incentive to put these into place than the MA-PDs. I would suggest that they have no financial incentive to do so.

In fact, they couldn't do it anyway because they don't have the medical claims that would be necessary to do the targeting. They'd have to use the drugs to target the disease, which kind of gets around one of the problems. So that's a problem for us.

The second problem is a bette noir that I've had for a long time, which is we get no information. CMS does not get any claims information or event level information from MA plans. And so even though they were the ones that would have the greatest incentive to employ these value-based insurance designs, we're not going to know it on the basis of what we get from the plans. And I think that's a real problem.

And then lastly, ironically, risk adjustment can

work against us in this regard because if you're successful in reducing complications from disease through these mechanisms what that's going to do is it's going to reduce the risk score. So the revenue that the plan gets from doing these things is going to go down.

So we're not very aligned with our incentives, I think, in terms of being able to bring this off. And I'd like to suggest that the Commission spend some time in figuring this out and have this as the agenda item in the future.

DR. KANE: I guess Bruce helped clarify my question. At what locus between Medigap and Part B and Part D, where do you put the responsibility for designing copays?

But I was wondering to what extent at least information could help us, if there could be something like do the drug plans even know compliance? The PDPs, do they have a sense of the compliance? And could they be reporting on compliance and possibly eventually be held at risk over time for the Part A/B complications that occur if compliance is not improved? Could there be some kind of a linkage between the A/B experience of -- I don't know but I'm just trying to think about how you use information, at least.

DR. STUART: It depends on how you define compliance because of its compliance with the drug for a particular disease then the answer is the PDPs won't know about it unless the drug is used only for that diseases.

DR. KANE: Maybe John can clarify that.

MR. BERTKO: In certain very limited categories, and let's take diabetes, you'd know what the compliance is for those drugs. You're right on a wider scale, though.

DR. KANE: You can pick certain conditions that you wanted them to report on compliance. And if those rates were not good, you'd hold them accountable for some Part A/B expenditures. I don't know, it seems like that's the only level you could do it though. You'd really have to really know ahead of time.

It's worth talking about, I agree.

DR. CROSSON: I just want to thank the panel because I think this is a very important movement, notion, potential change not just for the Medicare program but across the country. It's one, as Jill has mentioned, that we've been interested in.

Having said that, it is a good deal easier, as I think each of you have pointed out at some point in the

presentation, to figure out what barriers to drop, what copayments to lower, what copayments to make disappear, and where improvements can accrue than it is to figure out the other side of the financial equation, which is what not to pay for, what barriers to put in place, et cetera.

The case of the 26-year-old woman who's concerned about colorectal cancer and has no family history, that's kind of an obvious one. But the fact is that more broadly it's a good deal more complicated than that.

So we've been doing some modeling here to try to figure out what sort of interventions of that kind could, in fact, balance the finances of this. I'm talking about, on the plus side, dropping the barriers completely to the management of chronic disease including no copayments for office visits, drugs, et cetera. What would it take to do that?

One of the things we've focused on, and this is all just modeling, we haven't actually done it yet, is the notion of shared decisionmaking. That's the other piece of consumerism, if you will, that has some value to it.

At least on a preliminary basis, it looks to us that if we actually took some of the products and notions

that Dr. Wennberg developed over time and expanded those and targeted some of the high-cost discretionary procedures, leaving the ultimate decision up to the patient and the physician but invested in that, that we might in fact recoup the costs of the barrier dropping, if you will.

And I just wonder -- and sort of as a first step, I just wonder whether that has had thought of, looked at, or modeled at all, outside of what we've done?

DR. CHERNEW: Thought of, most certainly. I don't know an organization that implemented a program like that, so I don't think it has been studied in great detail. As Mark mentioned early on, we've been hesitant for a range of reasons to say this particular service should be charged more.

I think one thing to think through is all of this is, at least in the commercial sector, done in the backdrop of rising cost-sharing that people are facing. Something is going to be done. Something is being done on cost-sharing. So the question is at the margin how are you adjusting things?

I don't think you're going to find one service and say oh, we're going to pay for better chronic disease

management by charging everybody for some procedure that we think is overused. But I think in the context of generally rising cost-sharing, you could work out a program to hit your financial targets.

There are consulting firms that would tell us you tell us your financial target and we'll give you that financial target with a more clinically sensitive copay structure. I just haven't seen the --

DR. CROSSON: And we like to save money on consultant costs.

DR. CHERNEW: And in the leadership of your plan, they're very clear in chronic disease management programs. So the real question is what happens to the whole mass of stuff that's outside of that without actually targeting any particular part of that mass.

MS. BERGER: We've actually modeled this a little bit. I'm sure it's very simplistic. Do you know why we haven't done it yet -- although I know we'll be there for 2009 -- is trying to figure out how we communicate it to the members. Everything we've talked about we're trying to figure out how to communicate it.

One thing I'm convinced about, but I could be

wrong. I'm convinced that our folks just don't know what the drugs cost and they're either pleasantly surprised when they go to the pharmacy or not. And so we're trying to do a better job communicating that. Because we have that three tiered plan design that Mark presented. And then on top of that the VBID.

But that's what we're trying to figure out, is the communication piece.

DR. FENDRICK: Jay, you as a clinician, understand that the real problem with the creating barriers side is that second point about the clinical heterogeneity. Most of the things that all of us would argue would be low value services, there is almost always a situation where patients clearly benefit.

And until you create that information technology and comparative effectiveness research to basically say I believe that back pain surgery is probably clinically indicated about 15 percent of the time. And if you just put high copays for back surgery we get in the whole dolphin/tuna situation.

But because we're getting close to the end, and you mentioned shared decisionmaking, comparative

effectiveness research, information technology, I think I have to say, given that this is the only opportunity I'll get to present to the Commission, that there is a profound belief that comparative effectiveness research and information technology, in and of themselves, are going to be important mechanisms to health care cost containment. And it is my personal opinion, doing this for 20 years, that given A, experiences that we've shown with new medical interventions; and B, our unwillingness to disadopt things unless we have something better and more expensive on the critical arena, that unless benefit design is literally there the day the research comes out and the information technology is set up that because of the underuse problem none of our simulations suggest that you'll get any cost savings at all.

That in fact, because of the underuse problem of these things that we like and we find to be important, that any advantages you get in terms of this proposed, we're going to stop doing the bad things, will be completely overwhelmed by doing more of the health producing but cost increasing interventions.

MR. HACKBARTH: Bob, you get the last word.

DR. REISCHAUER: This is really a comment. I was a little surprised by, I think both Mike and Jill mentioned, that there was fairly widespread beneficiary acceptance of moving in this direction. I wonder whether, as this goes forward and matures, that will be the case or whether it's transferable into Medicare.

One dimension where you might expect some resistance to develop is privacy. The more granular you get, the more Marriott or a plan or something knows about your condition, your behavior, et cetera, et cetera -- and it might be that people are positive about people caring about them but we have some subset of the population that seems to resist or think that this is not good.

The other area is we're talking about targeted interventions here. And maybe for the University of Michigan population or Marriott, where most people are healthy most of the time and they don't want diabetes and they probably think -- they haven't listened to Mark yet and they think well, there is an advantage, if we can treat diabetes more effectively it's going to lower our insurance costs overall and this is good. So there will be a benefit for the non-targeted person.

That's not really true in Medicare where everybody has something and there's going to be this well, why did you do it for them when my little area doesn't cover as many people, there aren't as many people, but it's equally expensive. And then of course, there are all the interest group that will say yes, this is effective and this is important, you have to do that. And so suddenly the dike breaks.

MR. HACKBARTH: Due to the inevitable time limit, we're going to have to just let that stand on its own merit, which is substantial.

So thank you very much. This was a very interesting and helpful discussion. We really appreciate your spending the time with us.

We're going to have a very brief public comment period. I apologize for our running late and ask those who make public comments to understand if Commissioners need to leave to catch airplanes. The airline industry has not agreed to hold its planes for MedPAC, at least not yet.

So if you have a comment to make, please keep it very brief, no more than a minute or two.

I would remind everybody that staff goes to great

lengths to reach out and get information from people who are interested in these issues. That is the single most effective channel to communicate with the Commission. And please don't consider the public comment period as your opportunity. It really is not.

Having said that, if there any public comment, now is the time.

MS. ARMSTRONG: Thank you.

Thank you, Chairman Hackbarth, Dr. Reischauer and Dr. Miller and MedPAC Commissioners. My name is Lois Armstrong and I'm the President of the National Alliance for Hospice Access.

First of all, we do want to thank MedPAC for meeting with us and for reaching out to us and listening to our analysis and perspectives regarding the cap. We look forward to being helpful in any way that we can.

I'm going to take up just a couple minutes of your time because I want to put a face on this problem. I recognize that you're sitting in Washington and looking at it from far away. I don't know what we hospice providers look like to you when we hit the cap, but I want you to see that I am such a provider.

Let me tell you about our alliance. It's a growing grassroots organization of hospices. Our members are either family-owned or community-based not-for-profits. We have over 130 providers in 20 states. And we are serving 9,000 patients every day. Our members are independents. In other words, they do not have access to public markets, venture capital, or private equity.

In my real life, I have managed hospice programs for 20 years. I've managed large community-based not-for-profits. I've managed for-profit programs.

Today my family, along with another, owns a hospice that serves Northeastern Oklahoma and we are being required to pay back a great deal of money to Medicare for the year 2005, regardless of the eligibility of our patients or their right to have the services that we provided to them.

As we have reviewed before, in 1998 Congress gave eligible beneficiaries the right to have as much hospice service as they needed to do as long as they remained medically eligible with a medical prognosis of six months or less if the disease followed a normal course.

In summary, Congress expanded the benefit in 1998

and now guarantees medically eligible beneficiaries unlimited days of care but simply neglected to ensure that providers would be paid.

NAHA estimates regarding the cap are somewhat larger than MedPAC's. We base these on published material by Palmetto GBA and also Medicare's own cost reports. Our estimates say that these cap repayments have grown from under $5 million in three states in 1999 to approximately $200 million in over 25 states in 2005. They've been roughly doubling every year.

Independent hospices like the ones in our coalition don't have the money to repay. We spent it two years ago providing hospice services to Medicare beneficiaries who were eligible to receive these services. These hospices are being driven into an economic crisis, yet their only fault was serving all of the eligible beneficiaries in their community.

In summary, the cap is not limited to a few states. At least 25 states have cap issues in 2005 and these data are two years old. Our members come from West Virginia and Los Angeles and Idaho and Minnesota. Our hospices serve the rural, the poor, and urban ethnic

communities. This cap is a systemic problem because we are admitting patients under criteria that Medicare asked its fiscal intermediaries to develop for each of the non-cancer diagnoses.

But the cap hits all of us, whatever our state, at average lengths of stay well under 180 days.

Duke University recently --

MR. HACKBARTH: Thank you very much.

MS. ARMSTRONG: I'm going to take one more second.

MR. HACKBARTH: People have time constraints.

MS. ARMSTRONG: Chairman Hackbarth, everything we know about end-of-life care tells us that quality and cost benefit.

Thank you.

[Whereupon, at 12:24 p.m., the meeting was adjourned.]