

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
MITRA BEHROOZI
JOHN M. BERTKO
KAREN R. BORMAN, M.D.
SHEILA P. BURKE
RONALD D. CASTELLANOS, M.D.
FRANCIS J. CROSSON, M.D.
NANCY-ANN DePARLE
DAVID F. DURENBERGER
JENNIE CHIN HANSEN
DOUGLAS HOLTZ-EAKIN, Ph.D.
NANCY KANE, D.B.A.
ARNOLD MILSTEIN, M.D.
RALPH W. MULLER
WILLIAM J. SCANLON, Ph.D.
NICHOLAS J. WOLTER, M.D.

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

2 MR. HACKBARTH: I apologize for the late start.

3 Our first topic today is our mandated report on
4 pay for performance for home health. Sharon, when you're
5 ready.

6 MS. CHENG: Good morning. Today's session is
7 going to be our final installment, as it were, on the work
8 that we have done toward this mandated report in pieces.
9 We've worked in small pieces up to this point.

10 This is probably going to be the greatest level of
11 detail on the home health part of the mandate, and the next
12 iteration that you are going to see of this work as it comes
13 back to you to look at will be pulling back in focus,
14 putting all of these pieces together, and also drawing out
15 general principles. So this is about as tight as it's going
16 to get. After this, we're going to back up and we're going
17 to take a broader focus at addressing this mandated report.

18 At the last meeting some of the commissioners had
19 concerns about home health as a setting, about the data from
20 this setting, and the measures that we had. We are going to
21 stress in this report that the Commission has stated that
22 the measure set that we have is a starter set. We've been

1 characterizing it as such. It's an important principle to
2 us that P4P as a system will evolve, not just here but in
3 all the systems. This isn't a set piece that will change
4 and respond to the environment.

5 In this particular setting then, you could imagine
6 a measure set that would evolve to include process measures
7 that relate to some of the outcomes that can measure. We
8 could look at a structural measure like accreditation in
9 this setting if that would be interesting. We could
10 consider patient experience also as an important measure for
11 this setting.

12 These measure sets are a starter set and they're
13 going to evolve over time.

14 That said, we narrowed this down to about five
15 pivotal decisions that in designing any pay for performance
16 system you would have to address. The first question is
17 where does the money come from? How do you fund that reward
18 pool? The second then is how do you measure your providers?
19 The third is once you've measured those providers, how do
20 you set a benchmark? How do you determine their comparative
21 performance? Then how do you balance awards for those who
22 have attained high level of quality with those who might not

1 have attained those upper levels but they're making
2 substantial improvements over time? And then finally, when
3 you start writing checks, how do you calculate those
4 rewards? And how does this system work on the
5 implementation side of it? So let's go through each of
6 these questions in turn.

7 The first question is how would you fund the
8 reward pool? The Commission has stated in previous work, as
9 a principle for pay for performance, that we'd like to see
10 this system be budget neutral. It doesn't add, it doesn't
11 subtract money from the pool. Its goal is to realign the
12 incentives within the system and to make the system more
13 responsive to our desire to get better value for our
14 purchasing.

15 When we look at the private sector pools when they
16 start funding a system like this there are quite a few
17 examples. The range is broad. It goes from 2 percent to a
18 15 percent pool. Researchers from Harvard, from the Agency
19 for health care Research and Quality, the folks at Leapfrog
20 have done comprehensive surveys and there isn't a right
21 level for the pool.

22 One of the things that we're going to use as a

1 tool to get us through considering these decisions is a
2 model. This is just a model for illustrative purposes.
3 This is definitely a tool for us to use so we can talk about
4 the principles and the decisions. So I'm kind of just
5 putting it out there.

6 For the purposes of our model, we considered a 5
7 percent withhold. That means that for the period of
8 performance there would be 5 percent of the base payment
9 that would be held back by the program throughout the year
10 from all of the providers in the system. That revenue would
11 be at risk. The risk of losing revenue again reinforces the
12 idea that what we're after here, an important part of pay
13 for performance, is changing the incentives of the payment
14 system. We'd like a system that pays more for the best
15 quality and pays a little less for quality that's low.

16 It also might serve as a motivation for part of
17 the distribution of performers that's difficult to get to.
18 What we're talking about here are the ones who are perhaps
19 on the lower middle end of the distribution. They perceive
20 themselves to be unlikely to win that attainment award.
21 They might perceive themselves to be unlikely to show a lot
22 of improvement. But they might be motivated to improve

1 their quality during our period of performance to avoid a
2 penalty.

3 So that's part of our concept of trying to move
4 the whole distribution to the right, not just to get at a
5 tail.

6 Of course, on the other hand, a system that puts
7 revenue at risk is not going to be as appealing to the
8 providers that participate in the system. One study that
9 looked at different incentive designs found that there might
10 be a higher reaction by gaming to a system that included
11 penalties, that people responded that they would be more
12 likely to consider gaming a system like that.

13 In home health, if we considered a 5 percent
14 withhold, in this sector for Medicare that generates \$625
15 million for a total pool. So you can do some quick math if
16 you were thinking of a smaller withhold or a larger withhold
17 about what the total pool looks like. The median agency in
18 Medicare had about \$1 million in Medicare revenue. So the
19 meeting withhold at the agency level would be about \$50,000
20 for that period of performance.

21 Again, we have another principle to guide us when
22 we're thinking about right levels here, and that's payment

1 adequacy. We want to make sure that if we're contemplating
2 a withhold that we always have enough money in the system so
3 that providers have the capability to provide access to care
4 for beneficiaries.

5 Our second question then is how do we measure the
6 attainment of high levels of quality? We have a principle
7 to guide us here again. We stated that the measures should
8 be well accepted by providers and the research community.
9 To the extent possible, they shouldn't be a substantial new
10 data burden to either the people that have to collect them
11 or the people that have to analyze them, CMS or the
12 providers. We should be trying to get at an aspect of
13 quality that we believe is under the provider's control.
14 This means this is something that they can have a direct
15 influence on. And also it means that we're measuring
16 something where there's room for improvement.

17 Finally, where it's appropriate, we want to make
18 sure that these measures are adequately risk-adjusted. We
19 want to make fair comparisons from provider to provider and
20 we want to make sure that we don't develop an access problem
21 for patients that might be a little bit more difficult to
22 get those higher outcomes for.

1 So as an illustration of this second decision, we
2 considered a measurement that has 20 indicators of the
3 patient's level of function. We have two potentially
4 avoidable adverse events. The way we put these measures
5 together is that we take the average score on a scale from
6 zero to two of the patient's functional improvement
7 stabilization.

8 So after we've taken that average, let's say it's
9 1.8, then we would look to see whether that patient had
10 experienced any adverse events during their home care stay.
11 These are potentially avoidable adverse events, so the ones
12 we were looking at was an unplanned hospitalization or the
13 use of an ER that followed diabetes going out of control,
14 injury from a fall at home, a wound that had a substantial
15 infection, or hospital or ER use due to an improper
16 medication, a dose or an interaction.

17 So if any one of those four potentially avoidable
18 adverse events occur, then we subtract one point from that
19 average. So we started off, with this hypothetical patient,
20 with a 1.8 but they went to the hospital because their
21 diabetes went out of control. So that score goes down to
22 0.8. That assigns higher weight then to the adverse events

1 than to our functional outcomes.

2 One of the reasons that we considered this as a
3 design was another idea that's been important in our
4 discussions is that we want to make sure that we are looking
5 across settings when we can. So this is a measure that lets
6 us look at the impact of home health on the use of
7 hospitalization and the use of the ER.

8 It also starts to get at the efficient use of
9 resources. To the extent that we can appropriately care for
10 people in the home and prevent these potentially avoidable
11 adverse events, then we're going to be using our hospital
12 and our ER resources more efficiently because we're going to
13 be avoiding harm to the beneficiary and something that
14 didn't have to happen anyway.

15 To compare patients across agencies what we've
16 done for our model is to group patients by their primary
17 home health diagnosis. So in our model what we're doing is
18 we're just looking at patients who have therapy, OT or rehab
19 after care as their primary reason for being in home health.
20 You can look at other primary diagnoses, CHF, COPD,
21 pneumonia or other things and compare like patients to like
22 patients across agencies using this system.

1 Finally, again for the purposes of our model, we
2 only measured an agency's Medicare patients. Now many of
3 these agencies are going to have Medicaid patients, they're
4 going to have private pay patients. They're doing other
5 lines of business. But we thought that by looking just at
6 their Medicare patients we would be consistent again with
7 our goal, our idea that what we're after here is aligning
8 Medicare payments and we'd certainly be open to the idea
9 that this would be a place where this system could evolve.
10 It there was an opportunity for a partnership with a local
11 quality initiative or something else that we could do, then
12 we could certainly contemplate partnering with that and
13 collaborating with that.

14 So our third pivotal decision then is how do you
15 set the threshold for a reward and, in our system, for a
16 penalty? Again, the Commission stated as a principle that
17 P4P should be budget neutral at the end of the year. So to
18 guarantee budget neutrality the program can hardwire one
19 threshold before we've measured anything that's going on.
20 We can either set the score that we are going to reward, we
21 could predetermine the number of winners. We could say
22 we're going to reward the top 10 percent of agencies. Or we

1 could determine the size of the reward.

2 But you can only do one of those beforehand to
3 make sure that you don't spend out too much money because
4 you have too many winners, or you don't spend out all of
5 your money because you have too few.

6 So we were trying to think of which one are these
7 are we going to use, again for our illustrative model. We
8 looked at another Commission principle and that's that P4P,
9 to the extent possible, should measure something that's
10 under the provider's control. Well we hope, the philosophy
11 of this system, is that providers can have a substantial
12 impact on their quality score. It seems that providers
13 would have less of an ability to affect the number of other
14 winners or the size of other winners. And so picking the
15 threshold as a score seemed to align with this principle.

16 We also acknowledge, when we contemplated the
17 score as a threshold, whenever you're going to measure a
18 provider's quality what you're doing is you're making the
19 best estimate that you can of the true underlying quality of
20 that provider. Anytime you make an estimate you're going to
21 get some measurement noise. That noise is not going to be
22 under the provider's control. A substantial source of

1 noise, for example, is if you have a small sample. That's
2 not something that we're trying to solve here.

3 So by choosing the score and then by looking at
4 that score and the confidence of that score as an estimate,
5 then we're trying to get at something that we feel the
6 provider can control and take out some of the things that
7 seem extraneous to the things that they can control.

8 So in our model then we set a benchmark score.
9 That's the threshold we decided to hardwire, before the
10 period of performance. And we decided that we were only
11 going to reward or penalize statistically significant
12 differences from our benchmark. So high scores, large
13 samples and consistency increase our certainty that what
14 we're getting it is a good estimation of the true underlying
15 quality of the agency and we're getting less of the effect
16 of noise.

17 It also acknowledges, hopefully, in this
18 distribution that most of our agencies are probably average.
19 And so we're trying to identify the ones that are
20 exceptionally good or the ones for a penalty that are
21 exceptionally low quality.

22 The fourth decision is how to balance awards for

1 improvement and attainment. Again, we're going back to our
2 principles on this one. We've stated that a P4P system
3 should include both attainment and improvement awards.
4 Again, this is consistent with our idea of moving the whole
5 curve to the right. We want to make sure that we're
6 acknowledging those agencies that have attained a really
7 high level of quality, but we want to get at people who
8 maybe are near the middle or near the top of the middle and
9 we want to give them an incentive to do even better, to try
10 to move that whole distribution to the right.

11 There are two large P4P projects out there in the
12 environment already, the California Physician System and CMS
13 Hospital System. They're both contemplating adding
14 improvement awards to their system, which currently both of
15 those run on attainment awards. That's an important part of
16 our design.

17 So as an illustration then of how you could
18 balance these two things together, we would test whether the
19 year two performance was statistically significantly higher
20 than year one. This is again the same kind of concept that
21 we used when we were comparing agencies to the threshold.
22 What we want to do is have a system that has a little less

1 of a tendency to reward noise and more of a tendency to
2 reward what we think is a good estimate of a real
3 improvement.

4 One of the upshots of this design is that it
5 could end up rewarding a pretty small amount of improvement
6 but that tests out to be statistically significant. So one
7 of the things you could contemplate as a little tweak to
8 this basic model would be not only this test of statistical
9 significance, but you might also set a minimum amount of
10 improvement. You wouldn't reward something under 5 percent
11 or 4 percent or 10 percent, also.

12 So this gives us basically what we can contemplate
13 as a matrix of possibilities. So in our system you can have
14 three levels of attainment. You could be below our
15 benchmark, you could be statistically similar to our
16 benchmark, or you could be above it. When we look back from
17 our period of performance to our previous year of
18 measurement, you could either have shown improvement over
19 that time or you could be not improving. And so this would
20 be the opportunities for reward and penalty.

21 For example, if you were below our standard for
22 performance and you were not showing improvement, then you

1 would be in our penalty pool. If you were average but you
2 had shown an improvement, we could contemplate a reward that
3 we would set to be half the size of the full reward. And
4 then, if you were above our benchmark, you had attained that
5 high level, then you would be eligible for a full reward.

6 So there are a couple of moving pieces here. What
7 I'd like to do now in the next couple of minutes is look at
8 a graphical representation to see how this would play out on
9 an agency level.

10 What we've got, and this was in your mailing
11 materials, we walked through with six agencies on this.
12 These are based on our real dataset. These are six genuine
13 agencies from our dataset. So what we can do is we can look
14 at the national average score. We've measured that ahead of
15 time to set our benchmark.

16 Then we look at the year two score. That's our
17 period of performance. That's where we're focusing on, is
18 year two. But we also look back to year one to see how
19 they've changed over time.

20 So agency one, in this example, in both years
21 their score was substantially below the national average and
22 they weren't showing any improvement. So let's look at all

1 our agencies and we'll see how this plays out for six
2 agencies in our system.

3 So you have agency one, two and three. What we're
4 showing you is our point estimate and the confidence
5 interval around those. In each of those three cases, the
6 point estimate and the confidence interval around them are
7 below our national benchmark. So those three agencies would
8 be in the penalty pool.

9 The fourth agency has a point that's above our
10 initial benchmark, but the confidence interval includes the
11 national benchmark. So we would say statistically that's
12 indistinguishable from the mean. So we would call that
13 agency average. And then agencies five and six are both
14 entirely above the national average, so they would be in our
15 reward group.

16 Remember this is part of our matrix. Agency three
17 is below the national score, but they showed significant
18 improvement from year one to year two. So the effect of our
19 model would be to lift that group of the penalty group and
20 into the no change group. They're not eligible for a reward
21 for improvement because they're still below the benchmark,
22 but we lift them out of that penalty group.

1 That's how it plays out when you look at the whole
2 system. The last step is how do you actually start moving
3 money around? How do you calculate the rewards and the
4 penalties?

5 To maintain budget neutrality then, we would
6 suggest that the entire pool that we developed from that
7 withhold would be spent, and no more than that pool would be
8 spent. So average agencies would receive a refund at the
9 end of the period of performance that was equal to the
10 amount that was withheld from them. And then agencies with
11 high attainment or improvement would receive a refund and
12 then, on top of that, would receive a reward that was in
13 proportion to their total Medicare revenue.

14 Here's kind of a complicated scorecard, and again
15 this is just from our model so this is just one way of
16 putting together, as we've talked about, a long series of
17 decisions. But if you put it together in some of the steps
18 that we've taken, we were able to measure the performance of
19 7,217 agencies. That's most of the 8,000 agencies that
20 participate in Medicare and our measurement year.

21 You can see that we would assign them some to the
22 penalty group, some in the no change, and then others in the

1 improvement and attainment. Each would have a different net
2 financial impact. So the penalty group, at the end of the
3 year, would have a negative 5 percent because their withhold
4 would not be returned at the end. The no change group would
5 have a zero percent net financial impact. Their withhold
6 would be returned. And the improvement award is half the
7 size of the attainment award.

8 The total impact of the system of the sector would
9 be zero because we're spending out an amount that's equal to
10 the amount that we withheld from the agencies that are in
11 the penalty group.

12 As we've talked through this, one of the things
13 that we've stressed is trying to get our estimate right,
14 trying to make sure that we're matching an estimate of
15 quality to an agency's true quality. That's going to have
16 the effect of being able to assign any reward or a penalty
17 to small agencies less frequently just because of their small
18 sample size. We also contemplated two strategies to
19 increase the small agency inclusion in the active ends of
20 this system.

21 One way would be to allow voluntary quality
22 associations. So small agencies could come together for the

1 purposes of measurement and have their patients pooled as if
2 they were one larger agency. They could participate in the
3 system.

4 Another way that we use consistently through our
5 model, actually, was to pool data across two years. You get
6 a lot more strength that way, and it also had the
7 statistical properties of being more stable so you're not
8 measuring shocks to the system like a change in ownership or
9 other small things that have a little bit more of an impact
10 on a one-year measure. We also have enough data in the
11 system that we can use two years pooled to look at our
12 agencies.

13 So our next steps are going to be to kind of take
14 this on the road. We need to get input from you. We'd also
15 like to talk to some measurement experts, some people that
16 have worked on quality pay for performance systems and talk
17 to the stakeholders in the system.

18 And then what we're going to try to do is
19 integrate these pieces. So again this is sort of our lowest
20 level of detail. So the next time we're going to come back,
21 we're going to pull back. We're going to pull these pieces
22 together. We're going to look at the theory of incentives,

1 the basis and the principles for pay for performance that
2 apply across settings, some ideas about developing measures
3 that we learned in developing this one and talk about P4P
4 design.

5 So with that, I'd like to get your input on the
6 plan.

7 MR. HACKBARTH: Nice job, Sharon. Questions?
8 Comments?

9 DR. MILSTEIN: Very clear and helpful way of
10 organizing our thinking about this.

11 My comment, specifically, was a suggestion with
12 respect to the high end. Right now, under the current
13 concept, there would be no differentiation between an
14 organization that was in the top tier and was not improving
15 and an organization that was in the top tier and was
16 improving.

17 It seems to me if our vision for what we want from
18 our health care system is a more rapid rate of evolution and
19 discovering better ways of taking care of people, we might
20 be well served to create a little bit more reward for those
21 that were in the top tier and improving through innovating
22 and discovering better ways of caring for people, in this

1 case in the home.

2 So I would want us to at least consider that
3 higher reward for top tier organizations that were
4 essentially breaking through and defining new benchmark
5 performance.

6 MS. HANSEN: My comment also is that I thought the
7 chapter was just really very clear and certainly made great
8 sense. I appreciated the cross-setting approach because I
9 think as we continue to move on this issue of looking, in
10 some ways, the episode this is kind of implicit in that part
11 of it. And the risk adjusting, I think, is absolutely
12 important.

13 It's pointed out here that over time hopefully
14 that the other populations, especially the dual eligibles --
15 and I know that that's definitely down the roadside. But I
16 think so often that that complexity of population does merit
17 that inclusion, since there's already data available in the
18 OASIS database.

19 And then finally, the last one is looking at the
20 different areas to look at. Therapy seemed like a really
21 good functional way to look at this first cut. But when we
22 start looking at the other ways to look at the data, I bring

1 this up kind of on a consistent basis, but just thinking as
2 the population has comorbidities just how to take that
3 comorbidity factor into play. And I don't have, by any
4 stretch, any science on this. But rather than taking the
5 singular diagnosis, so many people do have that comorbid
6 issue that continually needs that kind of rigor of the lift
7 of how to address that.

8 DR. KANE: I actually wanted to go a little
9 further than the comorbidities and say that I'm a little
10 concerned about socioeconomic differences that might not be
11 captured. If you're in a low-income house and you have
12 really poor housing set up, you might be more likely to
13 fall. Or if you have nobody at home with you, you are more
14 likely to have problems. So I just felt that the clinical
15 groupings alone probably weren't a fair way to capture
16 everything about why somebody might have problems.

17 Also, I didn't understand therapy being a clinical
18 group. It's a treatment, not a diagnosis. I wasn't quite
19 sure how that popped out as a clinical grouping as opposed
20 to a treatment grouping. Certainly stroke patients often
21 need therapy and I wasn't sure how they came out separately
22 from therapy. So I guess I wasn't -- there must be some

1 rationale behind there but I didn't understand that.

2 The last thing, and I think for me was probably
3 the most concern -- I don't know how you get around it
4 unless you deweight it -- but the fact that the quality
5 indices are measured, the functional improvements, are
6 measured by the caregiver.

7 And that, as you explained to me, Sharon, is part
8 of their care plan now. That's something you think about
9 how am I going to get from A to B. But if it starts to be
10 the reason that you paid or not, or a bonus or not, it's
11 very subject to manipulation.

12 Whereas the bad things that could happen, like the
13 hospital admission or the infection, those are all
14 documentable separately. But these progressions on the care
15 index are done by the caregiver. I don't know how you would
16 audit that for consistency across agencies or even over time
17 and within one agency as things started to heat up on the
18 pay for performance measure.

19 So I guess those are my three things, the
20 socioeconomic adjustment, therapy as a diagnosis, and then
21 how do you adjust for these caregiver designations of
22 quality improvement?

1 MS. CHENG: The socioeconomic has been something
2 that as we've worked up to this point consistently have come
3 up. It's a tough question because it's not tremendously
4 appealing to develop a system that has, as an explicit
5 statement, we are going to have a lower standard of quality
6 if you serve patients in a lower SES.

7 And so trying to make sure that we adequately
8 account for things that are outside of the provider's
9 control and that we acknowledge that effort put into a
10 difficult patient has been achieved, absolutely that's part
11 of the system. But we also want to make sure that we don't
12 accidentally set up lower standards. And so that's
13 something that we'll keep thinking about and maybe we can
14 have some discussions as we come back to you with how to
15 account for socioeconomic in a system like this.

16 It's a tough question.

17 MR. BERTKO: Just a couple of questions that might
18 be in your follow-up stuff. Going to a different version of
19 actionable, it struck me to ask about how quickly this would
20 be reported. Because would the first group of penalty
21 people literally fall into a two-year penalty because they
22 might not know the answer until mid to late in the first

1 year? And what would be the reaction there? Would there be
2 consultants and such?

3 I don't know if you've talked about that at all?

4 MS. CHENG: We have. We don't have a real solid
5 answer because we're using data that currently flows through
6 the system, and all incredible credit to CMS on setting up
7 this system. Right now agencies can get reports on their
8 OBQI scores, which are the kinds of things that are going
9 into our system. They can get those, I think quarterly. So
10 CMS does really try to get this information back to
11 agencies, not real-time but fairly quickly.

12 The level of complexity then is how much would
13 that cycle change if they would go from computing the OBQIs,
14 as they do now, to contemplating this measure that we've
15 talked about. We've gotten a little bit of a reaction from
16 them that this seems more complicated to them and might be
17 slower. We can keep following up with that and see what
18 kind of cycle would this information be able to flow on.

19 MR. BERTKO: A slightly related question which
20 you'll just have to remind me is the penalty group here
21 which would say get minus 5 percent, and this is kind of how
22 do you set the threshold. If the 5 percent was taken out,

1 would they still be at least at break even status on
2 average?

3 MS. CHENG: Break even now?

4 MR. BERTKO: In terms of cash flows, let's just
5 say, to keep this as simple as possible. Margins. Would
6 current margin less than 5 percent still be zero or above?

7 MS. CHENG: We can look at the margins of the
8 agencies that are in our penalty group as it's currently
9 constituted. The aggregate average margin for this sector
10 is 16 percent.

11 MR. BERTKO: So it seems like yes.

12 MS. CHENG: But we could get at what the penalty
13 group looks like specifically.

14 DR. REISCHAUER: I thought this was a really
15 interesting presentation, and it brings to the fore the
16 complexities one encounters trying to design a pay for
17 performance system like this.

18 I think we would all feel that you get the most
19 bang for your buck or the most responsive reaction from
20 providers if the providers know if I can achieve X, I will
21 get Y dollars. And I might have read this wrong, but it
22 strikes me one can't do that with this system at all. In

1 fact, you've provided some examples here. But there is no
2 behavioral response. And it's conceivable that if you put a
3 system like this in place, you would get the British
4 response to their pay for performance system, where
5 everybody was above average. And so, in fact, there was no
6 penalty at all. There was no money to hand out. Or the
7 amount of money to hand out was infinitesimal.

8 I'm not saying I have a solution to this because
9 if you change that aspect of it and guarantee a certain
10 amount of money, then you lose some of the other advantages
11 of this approach. But I think we should bring out sort of
12 the complexities that can arise from a system like this.

13 You also sometimes create incentives that you
14 wonder are they really the right ones. There's another
15 chapter in here which I had the same reaction to, which is
16 so let's say you aren't very good and you don't think you
17 have much of a capacity to improve. Does that create an
18 incentive to be small because your standard error is much
19 larger? And while there might be efficiencies from larger
20 scale organizations, what you build in over a long period of
21 time is an incentive not to taking advantage of those
22 because you might get dinged on this.

1 Or we've been through some discussions here about
2 what is a home health agency? Is it a little outfit? Or is
3 it 15 little outfits that are all together? I imagine that
4 there is some corporate and organizational flexibility here
5 where they can design themselves in such a way as to, in a
6 sense, play off their standard error given their performance
7 possibilities.

8 So those are just some of the complexities that
9 arise.

10 But just to show you that I read this thing
11 carefully, I think, I think there's a typo on page 13 where
12 the pooled score data does not fall within -- for agency
13 three -- between the first year or the second year score for
14 agency three.

15 MS. CHENG: I'll chase that down.

16 DR. SCANLON: I feel less qualified to comment
17 since I didn't catch that, Bob.

18 I wanted to step back a little bit and talk about
19 the principles of pay for performance. I think that we
20 should be thinking in terms of two business cases, one from
21 the purchaser's perspective. And this reinforces what Arnie
22 said, which is how do we get the most from our payments?

1 And that involves potentially both rewarding or creating
2 bigger rewards for people that have achieved attainment and
3 are improving. But it also goes to the issue of how we
4 balance improvement rewards versus attainment rewards.

5 I think one of our equity instincts is to say we
6 want to always reward the people that are at the top the
7 most.

8 From a purchaser's perspective, that may not be
9 the optimal thing to do because you're really concerned
10 about what do you achieve in the aggregate. That's the
11 principle we should be pursuing, is the business case from
12 us as a purchaser.

13 There's a second business case that's involved,
14 which is how we're going to get the provider to respond.
15 You have to look at it from the provider's perspective. To
16 me, we don't focus enough on what's the cost of achievement
17 because it's not necessarily zero. People are not
18 performing badly because they are just too lazy to do
19 something different or they're too ignorant of it and we
20 just have to point it out to them, immediately they're going
21 to respond. They may have to make investments in order to
22 improve their performance. And the issue is are they going

1 to make those kinds of investments.

2 I think it's particularly important in the area of
3 home health when we look at the distribution of margins. We
4 look at the average margin, we look at the distribution.
5 There's a question of whether people at the upper end of the
6 distribution of margins, whether the penalty is going to
7 matter to them. If I'm going to lose 5 percent and reduce
8 my margin from 35 to 30, am I going to make a 10 percent
9 investment in order to avoid the 5 percent penalty? It's
10 not going to be sufficient.

11 One of the things that we really need to be
12 concerned about is the underlying payment system we have
13 here and grafting the pay for performance on top of that
14 because it's the underlying payment system and the pay for
15 performance mechanism that the provider is going to consider
16 in terms of their business cases and now they want respond
17 with respect to what we're hoping to achieve.

18 Let me make a couple of comments about where I
19 think we are in terms of the specifics of a pay for
20 performance system. I agree with Nancy and Jennie in terms
21 of the need for -- we really have to have incredibly good
22 risk adjustment here. It's got to involve -- you've pointed

1 out the problems with the CMS risk adjusters. We need to
2 improve on that and go a lot further.

3 I think it's maybe sort of misleading to talk
4 about socioeconomic status as a thing we want to risk adjust
5 for it. We're really trying to potentially adjust for
6 informal care availability or informal supports. You could
7 be very wealthy and have very poor informal care support.

8 We're not saying that poor people should get
9 lesser care. We're saying that people whose circumstances
10 are such, we may need to take that into account, that they
11 lack the informal care.

12 In terms of measurement, while it's again sort of
13 intuitively appealing to say we'd like to pay for
14 improvements in terms of functioning, for this service I
15 think we have to ask is that always the goal? It may be
16 that it's incredibly good care that keeps somebody
17 stabilized and even better care than for someone who
18 improves. And so the idea that we would give two points for
19 improvement and only one point for stabilization may not be
20 the right metric.

21 The same thing is true with respect to
22 deterioration. There are various paths for deterioration

1 and people could be deteriorating but getting very good
2 care. And so the question is do we know enough to be able
3 to come up with a metric that's zero, one, two? I think
4 potentially we don't, that we really need to be considering
5 how complex this service is. It's not something that's all
6 focused on people that have the potential to get better and
7 are going to get better with the right kinds of services.

8 That's it.

9 MR. MULLER: My comments are along those lines,
10 too. We have evidence in, for example the last 10 to 15
11 years in public reporting, of cardiac cases that case
12 selection sometimes gets driven by high report. We had that
13 in specialty hospitals, where case selection had a lot of
14 effect on margins. I think we have that in nursing homes.
15 I would argue that, like Bill implicitly does, that a lot of
16 the reasons for the different margins in home care and home
17 health really have to do with case selection.

18 So I think the extent to which we have a reward
19 system where the easier way to get the reward is case
20 selection rather than better management of care, I think we
21 have to be concerned about that, again with Bill.

22 In 5 percent, which is a bigger number than we've

1 discussed in other provider groupings in terms of putting
2 into the pot, it may not matter as much to people making 60
3 percent on whole. But obviously if you think about 5
4 percent in another category, where the margins aren't 60 but
5 maybe one or two or three or minus one or two or three, if
6 we have a reward system with where easier way of getting
7 there is to pick your cases.

8 I would go back to something that Carol Rafael
9 used to point out to us all the time when she talked to us
10 about this. There's very little margins in home care when
11 you take incredibly complex patients. And there's big
12 margins to be made when you take ones that are less
13 difficult. In fact, we know from our previous work that by
14 having gone more towards episode payments, you do have some
15 tendency to go for the ones that are a little easier to take
16 care of than when you've had per treatment kind of payment
17 system.

18 So I, too, share the comments that were made
19 earlier that I thought this was a very well principled look
20 at how one thinks about a pay for performance system. But
21 as long as we keep having an underlying system where there
22 are great rewards for case selection, we may not want to

1 exacerbate that.

2 So I would you say we just need to say that a lot
3 in terms of what we say here, that let's reward performance
4 rather than case selection.

5 MR. HACKBARTH: Let me just ask about that. I
6 agree with the basic point. We've got significant problems
7 in the base payment system in home health. And from an
8 incentive standpoint, I would agree that if you can make a
9 30 percent margin providing poor quality, you're probably
10 not going to be all that concerned with a 5 percent penalty
11 and going down to 25 percent.

12 DR. REISCHAUER: Remember, this is year after year
13 after year. So your example of the investment of 10 percent
14 really has to be looked at over a 10-year period because the
15 investment doesn't necessarily have to be repeated every
16 year.

17 DR. SCANLON: It's not clear. We're not talking
18 about an investment in capital. We're talking about --
19 well, or labor. I mean, this is an issue, if you look at
20 the distribution of margins, it's very correlated with the
21 distribution of visits. So you're going to have to continue
22 to provide more visits year after year. So you might not

1 get back. If it's going to reduce you from a 30 percent
2 margin to a 20, and you can only get five back, you might
3 only get that five back year after year.

4 MR. HACKBARTH: From my perspective, if we were to
5 have a hierarchy of home health payment issues, clearly
6 improving the base payment system would be number one on the
7 list, if you have to choose.

8 The question then arises well, does it make sense
9 to work on these concurrently, as opposed to sequentially?
10 In other words, do we have to not do pay for performance for
11 home health until we have a better base payment system? Or
12 can we try to move forward on both fronts concurrently?

13 And that's less clear to me.

14 An argument that Sharon has made to us before is
15 that when you have a payment system like home health it's
16 sort of squishy and you don't know exactly what you're
17 buying. In fact, pay for performance could be a useful
18 complement if you can define objective things that you want
19 to get. It can sort of help buttress what is an underlying
20 weak payment system and direct some of the money towards
21 things that you want.

22 That brings me to the concern that Nancy raised

1 about some of these functional status improvement measures
2 being squishy. They're not an entirely objective assessment
3 by people on the scene. You add payment rewards for higher
4 numbers, I'm willing to be you're going to get higher
5 numbers, even if the patients don't change.

6 But there are some measures that you've proposed
7 that are more objective. Some of them raise questions about
8 a risk adjustment. But I think that we may be able to work
9 through some of those issues, get some objective measures
10 that reward better performance, and do that concurrent with
11 improvement of the base payment system.

12 I don't see it necessarily as sequential, oh, you
13 can't do anything on pay for performance until you resolve
14 the base payment system. There's a question at the end of
15 that.

16 But as a policymaker, that's what you have to
17 think through. None of these things is perfect, but can you
18 move forward on multiple fronts at once?

19 MS. BURKE: I was going to simply reflect back, in
20 the context of your question, to Bob's point that he made in
21 passing. And that is one of the difficulties here is that
22 we're not dealing with the things that occur in a building.

1 One of the difficulties here is the definition of what is,
2 in fact, home health? What is, in fact, a home health
3 agency? That's an issue that we raised in our previous
4 conversation, that it can be a very small thing that cobbles
5 together a variety of things rather than a broad array of
6 things that we would, in fact, in the normal course, define
7 as an appropriate home care agency with a variety of
8 services.

9 So I don't disagree at all with what you're
10 suggesting, Glenn, that one doesn't preclude the other and
11 that is a conversation occurring on both. But I think there
12 is a more fundamental challenge, which is the one Bob
13 raises, which is what, in fact, is it that we think we are
14 purchasing?

15 I do think that there is a value in looking at the
16 more objective. Because I think Nancy's exactly right,
17 there are a huge number of these things that could very
18 quickly become very subjective and will, in fact, reflect
19 either a decision on which cases you take, will reflect how
20 one defines whether improvement has been made.

21 But all of that falls back to this fundamental
22 question which is what is it? We have always had

1 difficulty, frankly, with things that don't occur in
2 buildings because they're much more hard to define when you
3 don't clearly articulate exactly what constitutes a home
4 health agency and a home health benefit.

5 But I don't disagree at all that you ought to be
6 able to at both but go to the objective to make progress,
7 have that conversation. But I think we will be bedeviled
8 continually by this fundamental question.

9 DR. HOLTZ-EAKIN: I think, having listened to all
10 this, it's important to remember one thing. There are lots
11 of dimensions here. There's the accuracy of the
12 measurement. There's the scope of the entity that's going
13 to provide the service that can be an influence. There's
14 the level of the performance. There's improvement in
15 performance.

16 And you've got one thing, which is the dollars
17 you're handing out which you think are going to somehow get
18 these all right simultaneously. That's a mistake. You have
19 lots of other instruments available to affect some of these
20 other things. You can report the scores and people know
21 whether they're doing poorly or not. We talked about that
22 in other context. You can provide transparency so that when

1 people are signing up they know something.

2 So let's not get fooled into thinking that the
3 dollars that go out each year are the things that will get
4 all of these stars to align. There are more ways to do it
5 than one.

6 MR. DURENBERGER: My question has been asked
7 several times and it largely goes around the issue of what
8 are we purchasing? And what will it take to get it? And
9 then reflecting that the answer to the second one will
10 differ depending on size and a whole lot of other factors.
11 So I would just reinforce the comments around those two
12 sides of this because this applies them to a lot of the
13 other things that we contemplate doing under pay for
14 performance.

15 But if I may, I want to ask Bill one question
16 because I didn't understand exactly what you meant by using
17 the word equity when you were talking about from a
18 purchaser's standpoint. How should a purchaser be thinking
19 about equity?

20 DR. SCANLON: I'm not sure how they should be
21 thinking about equity. But I do think that maybe it's our
22 instincts that what's equitable is do we reward the best?

1 That they get rewarded for doing something that's better?

2 The reality is that if you're really trying to
3 improve the average product that you're getting or the
4 overall product that you're getting, maybe rewarding the
5 weakest is your best strategy. That's what I was getting
6 at. You're rewarding the improvement.

7 It runs against our instincts. The cynical side
8 would be to say the top performers are going to be top
9 performers anyway, and they're willing to do this for the
10 money we're giving them. How often do you go off and buy
11 something and say no, you're not asking enough for that, let
12 me give you some more? It's not the thing we do normally as
13 purchasers.

14 But I think, when we talk about pay for
15 performance with respect to Medicare, and Medicare is this
16 huge program and we should be concerned about equity, we
17 often think about it that we need to reward the best. But
18 from the overall program perspective I think, in terms of
19 getting the most for our dollar, we need to be worried about
20 how can we move -- as Sharon talks about -- moving the
21 distribution to the right. Maybe we don't change the tail,
22 we move the left-hand side of the distribution.

1 DR. REISCHAUER: This issue that you raised in
2 your initial comment was one who struggled with on our
3 Institute of Medicine panel, and there were many who said
4 well, you have to reward the best. That's the American way.
5 It's not right for somebody who is mediocre but improving to
6 get more than the best.

7 My argument in that arena was if you set the
8 system up with thresholds, achievement thresholds, as Sharon
9 suggested, that you have to improve at least X percent to
10 get an improvement award, this is all very temporary. You
11 can only get them for two or three years without becoming
12 the best or one of the better ones. And so we should view
13 this as a transitional kind of situation.

14 I couldn't agree with you more, from the
15 standpoint of Medicare as a purchaser what you are
16 interested in doing is lifting all boats, particularly the
17 boats that are lowest in the water right now.

18 MR. HACKBARTH: It was one of the things that I
19 really appreciated about Sharon's work is her effort at
20 balancing this improvement and attainment thing. I think
21 maybe we can continue to tweak that some more, but clearly
22 she's worked hard at that.

1 MS. BEHROOZI: Actually, I thought I had two
2 comments but I think they've kind of merged in my mind
3 listening to everyone speak.

4 Sharon, your work is great and really well self-
5 contained. I'm tempted not to mess with it at all.

6 But as you say at the beginning that on the
7 horizon there are other factors that probably ought to be
8 incorporated. Listening to the conversation, it seems to me
9 that process measures really ought to come in sooner rather
10 than later. I think that would address Nancy's point about,
11 I would call an auditability. You can actually measure
12 whether somebody has got whatever, patient education going
13 on, or worker education going on, or high worker turnover,
14 all of those factors that would be measurable and would
15 contribute to quality.

16 And it would also soften the blow, as you were
17 saying, that improvement for those that are below mean but
18 are improving, it would soften the blow of the penalty while
19 certainly process measures being in place not only would
20 soften the blow but actually provide a financial means maybe
21 to help them get to the point of improvement if they thought
22 they had to improve, if they had to show improvement before

1 they would either not suffer a penalty or be eligible for a
2 reward. You know, throw up there hands and say how am I
3 ever going to manage this? Especially of they're faced with
4 challenges that are somewhat more out of their control like
5 socioeconomic conditions or whatever.

6 It had struck me as I was reading the paper, when
7 you were talking about the improvement and attainment reward
8 columns being separate, but the penalty end, they overlap.
9 They are contiguous, the not improving and below mean. You
10 have to achieve both of those in order to suffer the
11 penalty.

12 Well, to support Arnie's point and what I think
13 people have been talking about, it seems that then
14 symmetrically or whatever you should also have to be
15 improving and above mean to get the full reward or the
16 higher reward. And then if you're in that other box now,
17 that says full reward which is above mean but not improving,
18 if that's below the full reward, then that leaves more money
19 available to put into the improvement pot, whether it's for
20 the below mean or at mean or above mean, who are improving.

21 I guess in response a little bit to Doug's point
22 that it's not all about the money, that is one case in which

1 it is about the money because you want people to have the
2 money to be able to continue to make the investments. I
3 don't know if it's 10 percent, but especially in process
4 measures it might not be quite so expensive to put the
5 measures in place that will eventually lead to the
6 improvement.

7 DR. KANE: I just wanted to follow up on Doug's
8 comment that there's more than payment here. And I wonder
9 if there's a way to get a sense of the characteristics of
10 those who fall into the penalty box now and see if there are
11 process measures or measurable characteristics that
12 differentiate them from those who hit improvement and
13 attainment, or even case studies? Just some way to find
14 what it is here that creates the differences that might not
15 be accounted for by a clinical group or the things that
16 we've got in the model now.

17 DR. MILLER: Just for at least Sarah and I and
18 Sharon to track through some of this, and to give you a
19 sense of how we'll deal with all this, as you know it's a
20 mandated report. We'll be back in April to talk about it in
21 its entirety.

22 Just a couple of things here. I'm going to

1 simplify this but don't think that we weren't listening.

2 There's three or four comments that need to be
3 dealt with in a sense that let's just say at the front end
4 of this report to kind of set the tone and say what the
5 report does and doesn't do. To acknowledge again, as we
6 have repeatedly, that it's very hard to define what this
7 benefit is and what we're actually purchasing, which make
8 this a challenge.

9 Secondly, walk through some of the issues with the
10 measures, how robust the measures we are talking about here
11 and the potential need for other kinds of measures, more
12 outcome, more process, or some of the -- I'm not quite sure
13 how to refer to it -- the circumstance of the beneficiary,
14 and to have a robust discussion of that.

15 And then to acknowledge the payment system issues,
16 the underlying payment system, and that those things need to
17 be thought through and potentially thought of either
18 simultaneously or to at least be aware that they need to be
19 addressed.

20 To emphasize that there are other ways to get the
21 facilities to do things than just moving money around, make
22 that point.

1 And then to emphasize repeatedly throughout the
2 report that we're talking about an illustration here. This
3 is not us saying this is the particular way to do it.

4 The one thing I think I left out of that quick
5 summary is there is this kind of discussion of rewarding
6 attainment and improvement, the transitional nature of it,
7 and how one thinks about those concepts.

8 I think if we can address that in the front end of
9 this report to set the tone, I think we can capture, at
10 least at some level, most of the comments that we've gone
11 through here.

12 DR. SCANLON: I guess the issue is whether an
13 illustration is taken as a recommendation. I think there
14 needs to be some vigilance so that it's not. I think we
15 have recent experience with a very good report that talks
16 about pros and counts of different options. I think that at
17 every step of our illustration there are pros and cons and
18 that choices are not necessarily clear in most cases, or any
19 case, in terms of what you want to do.

20 I think that's the kind of tone that we should be
21 striving for. Because otherwise I think it becomes, this is
22 the MedPAC model for pay for performance. And I don't think

1 we're there.

2 MS. HANSEN: The one question I have, Mark, and I
3 know it's a twofold component. One is measuring the
4 improvement of the organization, the entity. And then what
5 happens to the individual.

6 I guess my only request to see how it could be
7 highlighted that sometimes people will -- I just don't want
8 the agencies to not take these complicated cases that
9 sometimes don't improve a whole lot, which go back to a
10 comment that Bill, you made, that I just don't want, again,
11 to avoid bad cases. And some cases will not necessarily
12 make these huge improvements.

13 So it's, on the one hand, very individualistic to
14 the patient. But it does -- you want to have a school of
15 gifted kids because you'll do well and move ahead. But what
16 about these messy tough cases?

17 I just want to make sure that that is highlighted
18 and protected.

19 MR. HACKBARTH: Okay, thank you, Sharon. Very
20 good job.

21 Let's move on to our next topic, which is hospital
22 readmissions, and Anne and Craig will do that.

1 MS. MUTTI: This presentation discusses a policy
2 option to reduce Medicare payment for potentially avoidable
3 readmissions. We presented this idea, as well as one on
4 bundling Part A and B payment for inpatient stays at the
5 last meeting.

6 Today we are focusing on readmissions only because
7 of staff and time constraints. We plan to come back in the
8 summer and fall and continue our work on this area and hope
9 to generate more discussion next fall on that particular
10 issue.

11 Our intent at the moment is to include an initial
12 discussion of readmission payment policy and options in the
13 June report. We would plan, again, to come back to you with
14 further analysis in the summer and fall and give the
15 Commission a chance to consider this issue further in time
16 for the March report of next year.

17 Currently Medicare pays for readmissions that do
18 not occur on the same day as discharge at the full DRG
19 amount. This policy creates no incentive for providers to
20 invest in the type of care that prevents costly
21 readmissions. So a change to consider is to pay less for
22 readmissions that may be potentially avoidable.

1 Pursuing this option provides an opportunity to
2 address several of the major deficiencies in Medicare fee-
3 for-service payment policy. First, it encourages providers
4 to invest in patient care after discharge, creating a sorely
5 lacking incentive for providers to coordinate care across
6 settings.

7 Second, by holding one or more providers
8 accountable for the collaborative performance of a team of
9 providers, this policy would encourage providers to
10 collaborate with one another.

11 Third, it would link payment to quality of care
12 and to patient-centered care.

13 In a sense, it is a step toward broadening the
14 bundle of services Medicare pays for. With DRGs, Medicare
15 introduced an effective incentive to control the volume of
16 hospital services during the stay. This option takes on the
17 next challenge, how do we better align incentives for the
18 volume of care once the stay has ended.

19 At the same time, it builds on an interest in
20 having base payment rates reward better quality. In the
21 DRA, Congress required that Medicare reduce payment for
22 potentially avoidable complications that arise during the

1 hospitalization. More recently it required GAO to analyze
2 how frequently and how much Medicare pays for never events,
3 for which some have advocated that Medicare should not pay.

4 MR. LISK: I'm going to start of here showing you
5 hospital readmission rates, which we define as the percent
6 of cases discharged alive from the hospital that are
7 readmitted within a specified time frame and they're not
8 transfers. Here we show seven, 15 and 30-day readmission
9 rates.

10 As you can see, the number of hospitalizations
11 that result in readmissions is significant. In 2004, 6.2
12 percent of hospitalizations among beneficiaries resulted in
13 a readmission within seven days, and 17.6 percent of
14 hospitalizations resulted in a readmission within 30 days.

15 Readmission rates also vary by condition. The 30-
16 day readmission rate for people with end stage renal
17 disease, for example, is 31.6 percent.

18 Medicare spending on readmissions is substantial,
19 \$5 billion for cases readmitted within seven days, \$15
20 billion for cases within 30 days.

21 In 2004, the average payment for readmission
22 amounted to about \$8,200, about the same as for an initial

1 admission.

2 This is what we currently spend on readmissions.
3 The spending and readmission rates for what we might
4 consider potentially avoidable readmissions would be less.
5 We are working to identify potentially avoidable
6 readmissions and will share this information with you in the
7 future.

8 MS. MUTTI: Research suggests that hospitals and
9 physicians can reduce the number of readmissions, often by
10 improving the quality of care. AHRQ has found that by
11 providing better safer care, hospitals can reduce the
12 incidents of adverse patient safety events during
13 hospitalization.

14 These adverse events, which include anesthesia
15 complications, pulmonary embolisms, infections due to
16 medical care, and hemorrhages, all can increase the chance
17 that the patient will need to be readmitted. A study
18 looking at California non-Medicare data found that the
19 likelihood of readmission doubled, from 14 percent to 28
20 percent, if there was an adverse patient safety event in the
21 initial hospitalization.

22 Second, by adopting best practice guidelines into

1 clinical care, providers can avoid complications that occur
2 after discharge. For example, appropriate use of blood
3 donors can reduce the risk of blood costs after discharge,
4 early extubation can reduce post-discharge complications, as
5 can better monitoring of medications at discharge. In fact,
6 one study found that two-thirds of adverse events after
7 discharge are due to medication errors.

8 Third, better communication at discharge is needed
9 and is possible. Providers are able to reduce the
10 likelihood of discharge if they fully and clearly explain
11 how patient should care for themselves, how to take their
12 medications, and what systems to look for. Nurse visits to
13 at-risk elderly patients before and after discharge can also
14 make a significant difference. A study in two Philadelphia
15 hospitals found that such an approach reduced readmission
16 rates 45 percent over the 24 weeks of the study.

17 Fourth, hospitals and physicians need to review
18 their practice patterns. Some of the variation in
19 readmission rates may reflect provider preferences. For
20 example, some physicians may prefer to admit certain types
21 of patients even though most of their peers successfully
22 treat those patients on an outpatient basis. Some hospitals

1 may encourage early discharges when an extra day would have
2 prevented the need for readmission. A reevaluation of some
3 of these preferences may be warranted.

4 How systems' own actions validate the ability of
5 these types of strategies to reduce costly readmissions.
6 Many of the participants in CMS's physician group practice
7 demonstration, who are at risk for the cost and quality of
8 certain types of patients, see the opportunity to save money
9 and improve quality by reducing readmissions. Indeed, they
10 have employed just the kinds of strategies I've mentioned
11 above. For example, one group was able to reduce
12 readmission rates by simply arranging for follow-up
13 outpatient appointments at the time of discharge.

14 How might payment policy encourage provider
15 investment in processes of care that reduce the incidents of
16 avoidable readmissions? Again, our focus is on making a
17 change in payment rates. We offer one approach here,
18 although certainly there are a number of ways you could do
19 it. In fact, when we all sit down together we keep thinking
20 of new ways you could do it. So we're just going to offer
21 you an illustration. There are many ways to tweak this.

22 For example, the policy could focus on hospitals

1 with relatively high rates of potentially avoidable
2 readmissions and reduce payment only for their readmissions.
3 Top performers, that is those with relatively low risk-
4 adjusted readmission rates, would not be penalized. This
5 approach recognizes that some rate of readmission is to be
6 expected. Even with the best care, some readmissions are
7 going to occur, even those that are potentially preventable.

8 The focus, therefore, is on those with excessive
9 readmission rates relative to their peers. To identify
10 those with excessive rates, Medicare could first calculate
11 each hospital's risk-adjusted readmission rate based on
12 their prior year's performance and then select a benchmark
13 readmission rate, perhaps based on the performances of those
14 in the top performing quartile.

15 For the subsequent year, Medicare would reduce
16 payment for each related readmission for only those
17 hospitals with readmissions higher than the benchmark, as I
18 mentioned earlier. Eligibility for the penalty could be
19 reevaluated each year. The incentive to reduce readmissions
20 is therefore twofold: first, by avoiding a readmission you
21 get full payment for the services delivered. Second, if by
22 avoiding readmissions you bring down your rate to be in the

1 range of the top performers, you would not be subject to the
2 penalty in the following year.

3 This approach combines several attractive
4 features. It does not penalize hospitals with lower rates
5 of readmissions. The penalty can be applied as claims are
6 paid, rather than assessed at the end of the year which may
7 have a greater operational impact and create fewer cash flow
8 problems. And it can be designed to reduce Medicare
9 spending.

10 It does have the disadvantage of making the
11 penalty in a given year dependent on performance in a
12 previous year. We've toyed around with ideas of fixing
13 that, but that could be another discussion.

14 So for those hospitals that have high enough
15 readmission rates to qualify for the penalty, the next two
16 slides explain how payment could be reduced for the
17 potentially avoidable readmissions. This approach is
18 designed to accommodate instances where the readmission is
19 to a different hospital than the hospital with the initial
20 stay. And this, from some preliminary analysis, is not that
21 uncommon.

22 For this reason, the payment reduction applies to

1 the initial admission but is contingent on the occurrence of
2 the readmission. So let me walk you through a couple of
3 diagrams in an attempt to make that clear.

4 Under scenario A here the red and green bar
5 reflects an initial hospital stay for the beneficiary, both
6 the duration of the stay and the payment for the stay. The
7 sum of the red and green is the DRG case payment for the
8 hospital.

9 The red part of the bar is what with hospital
10 would be paid as soon as Medicare receives the claim. The
11 green portion is the withhold. The withhold is returned to
12 the hospital if Medicare determines there was no potentially
13 avoidable readmission within a specified time period. And
14 for this example, we're using 20 days.

15 Because in this scenario the patient is not
16 readmitted in the 20 days after discharge the withhold,
17 which is the green part of the bar, is returned to the
18 hospital.

19 In scenario B, again we have the same red/green
20 line reflecting the initial hospitalization. The green
21 portion of the first bar is the withhold amount. In this
22 example, Medicare will see through claim review that the

1 beneficiary was readmitted about seven days after discharge
2 from the initial stay, and that's reflected by the yellow bar
3 there. In this case, according to some set of decision
4 rules, some clinical software that can be used, it was
5 considered to be a potentially avoidable readmission. The
6 readmission may be to the same hospital but it could also be
7 to a different hospital.

8 Because this related readmission occurred within
9 the 20-day window, Medicare would keep the withhold from the
10 initial hospitalization.

11 The readmission is paid in full because it could
12 be to a hospital that had not previously been involved with
13 that patient's care. And in this way the withhold on the
14 initial stay keeps the penalty on the hospital that had the
15 greatest ability to prevent the readmission.

16 Applying a parallel incentive for physicians to
17 avoid readmission should also be considered. It has the
18 advantage of encouraging hospitals and physicians to
19 collaborate in the effort to reduce unnecessarily high
20 readmission rates. If either provider is not engaged in
21 improving performance, improvement is obviously far more
22 difficult.

1 One way to hold physicians accountable is to apply
2 a withhold to physician claims for services delivered in a
3 hospital that is subject to the penalty, that is those
4 hospitals with the relatively high readmission rates. For
5 surgical admissions, the withhold could apply to services
6 delivered by the primary surgeon. For medical discharges,
7 perhaps the withholds could apply to all E&M visits or other
8 physician visits pertaining to discharge during the
9 hospitalization.

10 As with the hospital, the withhold could be
11 returned to the physician if no readmission occurs during
12 the designated time period.

13 Among other design considerations are the need to
14 define what potentially avoidable readmissions are.
15 Software is being developed by at least one vendor and is
16 expected to be available this summer. Providers and health
17 plans have also developed their own clinical logic that
18 incorporates those decision rules as to what's related and
19 preventable.

20 Another issue is to consider that risk adjustment
21 based on severity of illness may not fully account for all
22 factors that influence the need for readmission. For

1 example, some people may lack the informal caregiver support
2 needed to avoid falls or medication errors that necessitate
3 readmission rates. If a hospital sees a disproportionate
4 number of these patients, its performance may look worse
5 than its peers and it may be motivated to avoid caring for
6 those patients.

7 One response to the situation is to adjust the
8 expected readmission rate by relevant factors, such as
9 education level or home support to the extent that they are
10 measurable. On the other hand, if you don't make such an
11 adjustment you keep the pressure on the hospitals to affect
12 the rate. And research has suggested that they can, indeed,
13 affect the rate.

14 Another related issue concerns the potential for
15 noncompliant patients to be unevenly distributed across
16 providers. One response is to allow hospitals and
17 physicians to indicate if a patient was noncompliant upon
18 discharge or readmission. Readmissions for those patients
19 would not be counted in the provider's overall rate.

20 To temper the incentive to declare a high
21 proportion of patients as noncompliant, Medicare could
22 publicly report the number of patients who are exempt from

1 the rate for each facility and require those providers who
2 had excessive rates of noncompliant patients to have
3 remediation plans in place, demonstrating how the provider
4 planned to reduce the incidence of noncompliance, or at
5 least was trying to.

6 This approach creates a large administrative
7 investment, however, and may inappropriately reduce the
8 provider's motivation to take the necessary steps to avert
9 readmissions. For example, the line between a patient's
10 noncompliance and a provider's ability to clearly convey
11 discharge instructions is not always clear.

12 Our planned next steps on this issue are to
13 further explore current readmissions patterns. For example,
14 have their rates increased over time? What portion of all
15 readmissions may be considered potentially preventable?
16 What portion of readmissions are admitted to a hospital
17 different than the one that had the initial admission? And
18 what's the variation in readmission rates across hospitals?

19 We'd also like to further consider the design
20 issues. How should chains of readmissions be handled? How
21 should or could this be paired with a case management fee or
22 some other positive reward for the investment in the systems

1 of care needed to reduce readmission rates? How do we avoid
2 a time lag in establishing eligibility for the penalty?

3 So we have a lot of work that we plan to do. We
4 look forward to your comments and reactions to our
5 presentation.

6 MS. DePARLE: I continue to think this is very
7 exciting work, and you've made more progress since the last
8 time we talked about it and it gets even more exciting.

9 One question I have is going back to your slide
10 about the percentages -- I think it was like number two or
11 three, percent readmitted.

12 I was surprised at how much data we really have on
13 this. You're saying that right now, by hospital, Medicare
14 could say the percentage of patients readmitted to a
15 particular hospital and it would be lagged only by one year;
16 is that right? We could say how many were readmitted last
17 year?

18 MR. LISK: We could, in terms of the data that's
19 complete claims files, we could do 2005 now. When we
20 started this analysis we had 2004 data available, and we
21 could do 2005 now. So there is some lag.

22 In real time, conceivably you could do something

1 that is closer to real-time as claims come into CMS and not
2 wait for the full year claims files, too.

3 MS. DePARLE: Because I'm not sure you'd even need
4 that, not that it's necessary to...

5 MR. LISK: But for what we use, we use the real
6 claims files for the completed year, so that's what we have.
7 But theoretically you could do something a little bit
8 quicker.

9 MS. DePARLE: You referenced the studies New York
10 has done and, I guess, New Jersey. What do they do? Do
11 they use this data and therefore use a full 18 month lag?
12 Or do they do something that's more immediate?

13 MS. MUTTI: The New Jersey study was just at one
14 year in time. It wasn't trying to implement anything on a
15 real-time basis. So I think they just had whatever year
16 that they had recently available. And New York, I would
17 have to check and get back to you on that.

18 MS. DePARLE: Bill and I were chatting about how
19 this, we believe, at least I believe, these percentages of
20 readmissions there has to be a strong linkage between this
21 and the care that people are receiving post-admission, our
22 discussion right before this about home health and the

1 quality of home health care, for example, post-discharge,
2 post-admission.

3 So is there a way to link up those percentages
4 with what people were getting? So of the people who were
5 readmitted in 30 days, the 17.6 percent, were they getting
6 home health and SNF and by what percentages?

7 MR. LISK: If you go to your paper, actually,
8 table two has the readmission rates by discharge
9 destination. So that shows you differences by discharge
10 destination.

11 What you'll see, and you can look at this at both
12 and seven-day and 30-day rates. Let's say for home health,
13 for instance, if you look at the seven-day readmission rate,
14 it's actually a little bit lower than people who are
15 discharged home without home health. But as you get up to a
16 15-day or 30-day readmission rate, it actually gets to be a
17 little bit higher than the people who are discharged home
18 without any post-acute care, for instance. Meaning that the
19 home health care may have initially forestalled the
20 readmission but eventually it was going to still occur, is
21 one possibly.

22 But it could be also differences in the risk of

1 the patients, as well. So you have that here, as well,
2 again with let's say the people who are going to skilled
3 nursing facilities you should see higher 30-day readmission
4 rates for those patients. then it could be some of the
5 clinical aspects of those patients.

6 It could also be some of what happened in the
7 hospital and why the ended up going to a SNF and why the end
8 up needing to be readmitted later on, too.

9 MS. BURKE: Could it also be availability of beds?
10 To where Nancy is going, inevitably one of the issues that
11 always arises is the availability. The discharge planners
12 will tell you our preference would of been X but there were
13 no beds available. There were a number of things, as well
14 as the condition, that is literally what was available in
15 terms of the post-discharge. I don't know how easily you
16 pick that up.

17 MS. DePARLE: They tell us that but then the
18 aggregate data seems to indicate there is no shortage of
19 these things. But I think you're right, on any one case you
20 might find that.

21 And then I wondered, is it possible to match up
22 the readmissions with a physician? Because a physician has

1 to be part of that. So is it the same physician who's doing
2 the readmission?

3 Because your last point was about are there ways
4 to create some incentives for case management or chronic
5 care management or something? I think you were talking more
6 about the hospital, but one wonders is it the same
7 physician? Or have they somehow gotten to a different
8 physician or a specialist who then is admitting them? So is
9 it possible to link that up with the data?

10 MS. MUTTI: I don't know if this fully answers
11 your question. In the example that we gave, we suggested
12 maybe you could identify those hospitals that had higher
13 than expected readmission rates. And for every patient that
14 was admitted to that hospital, you could hold the physicians
15 accountable for their readmission, also. So every claim
16 will say what hospital the physician service was delivered
17 at, so you would have that leverage.

18 MS. DePARLE: So you mean the original physician
19 who admitted them the first time?

20 MS. MUTTI: We were suggesting that you could be a
21 little bit more selective on that since it may not just be
22 the admitting physician that had the total control over the

1 patient. But that in surgical cases it would be probably
2 fairly safe to say that the primary surgeon had control. On
3 medical cases that physicians that are delivering the E&M
4 visits probably had more control than say a consulting
5 physician. And we would be trying to get at those
6 physicians that had the most influence over the possibility
7 of a readmission.

8 MS. DePARLE: It does seem to me that's a big key
9 to this and I'm not sure how you do it fairly. But it seems
10 like that's a big key to understanding what's going on here.

11 DR. REISCHAUER: I'm on the other side of this. I
12 think we can get too complex awful fast. You want the
13 hospital accountable and it can deal with the physicians
14 that you don't want to be, in a sense, penalizing let's say
15 the sloppy physician in the bad hospital but not in the
16 hospital where all of the colleagues are performing well.
17 And you're getting to the small Ns here. There's just all
18 sorts of complexities, I think, that you'd run into. I
19 think is a case where you really want to make sure you know
20 how to walk before you begin to trot.

21 MS. HANSEN: Actually, Nancy-Ann did cover several
22 of the areas. And I guess I'm still on the other side of

1 you on this because I think I'm coming from the
2 beneficiaries' side, is that if the endpoint for a Medicare
3 beneficiary is to get the best care and have the best
4 outcome, the ability to follow that continuity of -- you
5 know, it's implicit care coordination to make sure that upon
6 discharge, whether the physician writes the order to go to
7 an available skilled bed or by default maybe not to a home
8 health agency, there is a point of continuity and handoff
9 there that makes a big difference sometimes in whether or
10 not care will come back to a hospitalization with the risk
11 adjusting for the complexity.

12 So I know that it's a question of being too
13 detailed but it's almost a case scenario to really play out
14 to see if there's a way to take a look at that so that the
15 endpoint is minimizing avoidable hospitalizations.

16 DR. MILSTEIN: I think this is directionally very
17 well aligned with the vision of almost every report and
18 chapter of reports that we've written in the last couple of
19 years. And I think, as you begin to drill into this, all of
20 the usual cautions associated with the more performance-
21 sensitive payment system would apply. You can just take
22 almost everything we said in our discussion and it would

1 apply here.

2 That said, my intuition is there's a lot of
3 opportunity to improve beneficiary quality of life and
4 eliminate wasted spending in the segment of care between
5 leaving a hospital and the next 30, 60 or 90 days.

6 I think most beneficiaries who I have a chance to
7 talk to, to this day, don't really feel that there's someone
8 watching out for them during that period. They sort of feel
9 they're largely on their own.

10 My intuition would be that yes, some of the 16.8
11 percent readmissions within 30 days are not avoidable. But
12 I've been very impressed with what's been accomplished over
13 the last year when clinicians have really taken a hard look
14 at things that were supposedly unavoidable and gone after
15 them tooth and nail. I'm referring to, for example, the
16 state of Michigan with respect to the central line
17 infections that were just accepted as something that had to
18 happened in American health care. There are quite a few
19 hospitals in Michigan where it's been driven down to zero
20 just because somebody said for the first time let's focus
21 and let's not assume that these are inevitable.

22 I think a very substantial fraction of the 16.8

1 percent of readmission in 30 days, my intuition would be,
2 would fall within that. So I think it's a really wonderful
3 target.

4 In some ways, given our acknowledgment in the SGR
5 report of how difficult it might be to achieve all of our
6 vision right away, particularly in a way that would deliver
7 results in the near-term, I wonder if we might conceptualize
8 this as sort of a bridge toward this bigger vision. And
9 should some of the solutions that we thought about in the
10 SGR discussion be relevant here, such as should we allow, in
11 addition to having a penalty provision, which certainly we
12 need, should there also be an opportunity for a win by a
13 hospital, in alliance with its physicians, forming at least
14 an accountable care organization for the 90-day period post-
15 hospitalization and there being a two-way opportunity not
16 just to be penalized but also to win. Understanding it's
17 far short of the vision that we would hope for, which would
18 be accountability for a lot more things for a longer period
19 of time. But is this a potential opportunity for an initial
20 bridge or baby step?

21 MR. HACKBARTH: Arnie articulated better than I
22 could some points that I agree with. But a key question, an

1 empirical question, is what percentage of these readmissions
2 are potentially avoidable? Could you just talk a little bit
3 about your plans to try to get a grip on what the size of
4 the opportunity is?

5 MS. MUTTI: Sure.

6 There's a range of different rules that you could
7 use. Some have decided just to use the initial admission
8 and readmission counts as potentially preventable if it
9 were all in the same MDC or the same organ problem.

10 The software that's being developed is a little
11 bit more comprehensive than that, and it represents work
12 over the course of the two-year period where they had a
13 clinical panel reviewing specifically this type of initial
14 readmission, this readmission, is it potentially preventable
15 or not? And judgment being used here.

16 We are talking about trying to use that software
17 with our data to give us a ballpark of what one approach
18 could come out as determining what percentage of claims
19 are...

20 MR. HACKBARTH: Has anybody ever looked at or made
21 a comparison of a system like Jay's where the incentives are
22 right and properly aligned with performance and institutions

1 where the incentives are not properly aligned? Has that
2 sort of comparison ever been done?

3 MS. MUTTI: We did speak to a medical director
4 recently of a commercial health plan that had looked at
5 California data and had done readmission rates by hospitals.
6 I wonder if that might not be able to be teased out of
7 that.

8 MS. HANSEN: I certainly would like to offer once
9 more the national PACE data that goes across the country,
10 since we have all of the incentives aligned plus the home
11 factor considered. And whether the home assessment is done,
12 the medications are there, the transportation is there, and
13 if there was an infection it would be our responsibility.
14 They do have that kind of data available nationally.

15 MR. MULLER: I think we all have to pay homage to
16 the Goddess or God of continuity of care, but I think we're
17 stepping into something here that's very much more
18 complicated than this chapter indicates. The notion that of
19 the these things are avoidable, I think, is way overstated.
20 I think some are, obviously things like never events, if
21 people have to come back in for retained foreign objects, I
22 think we can all agree on that.

1 But asking hospitals to be responsible for what
2 happens for 30 days afterwards, you're really going to have
3 to put in a major cost structure to do that. And whether
4 one wants to do that or not, and whether the best place to
5 put that is in the hospitals, is another kind of policy
6 matter.

7 But by and large, most of our cost structures are
8 not geared towards that right now. They are geared somewhat
9 towards discharge but not necessarily the management of care
10 for the next 30 days.

11 As the table indicates, two-thirds of the patients
12 go home. So if everybody's going to go home care and you
13 can monitor it, it would be one thing. But many of them go
14 home. And all of the kind of comments that were made
15 earlier around the home care dialogue here, in terms of the
16 differences in patient's homes, environment, and so forth,
17 come into this consideration here.

18 Whether one wants to have -- if one had a major
19 penalty for readmissions, then you have to start thinking to
20 yourself how much assurance does a hospital want that people
21 will never be readmitted? Do you keep patients an extra two
22 days to make sure they never get readmitted, in terms of --

1 and therefore further exacerbating capacity problems in many
2 of the urban hospitals which are running much fuller
3 capacity.

4 We also work in a world, as we know from our
5 January chapter, where hospitals on the average are making
6 minus 2 percent or minus 3 percent on Medicare. So I think
7 to add this capacity and to really monitor care and evaluate
8 it for 30 days afterwards, my conjecture is that this would
9 be an enormous increase in resources to be about to monitor
10 that and so forth.

11 For example, just in my hospital alone in the last
12 year we added 50 people just to help on discharge planning,
13 mostly because we were so busy and we needed some help on
14 that. Even simple things like saying let's get all the
15 appointments made for the patient. Almost all patients now
16 need some kind of physician appointment afterwards. That
17 takes 10 or 20 people to do that, when you think about that,
18 because it's not just making one call. You have to
19 triangulate back and forth between what the family can do,
20 what the physician can do, transportation, et cetera and so
21 forth. Those are not easy steps. It just tells you how
22 complicated this is.

1 I'd be more cautious about thinking there's a lot
2 of easy findings here. I think -- I mean easy findings in
3 terms of money. I think certainly on never events, I think
4 most everybody can agree on that, that there should be some
5 kind of penalty for that. And whether if there's an
6 inappropriate management of things like surgical wounds or
7 hospital-acquired pneumonia, one can think of some kind of
8 penalties for that.

9 But an awful lot of what we're looking at here
10 really requires a bigger commitment of resources. I think
11 I'll build on one of the things that Arnie's said. This
12 should not just be a penalty. This should be -- whether
13 it's budget neutral or not -- there should be some kind of
14 thinking about how many resources we want to put into this.

15 My sense is if we want a policy objective of
16 better care for patients after discharge, whether we're
17 willing to pay for that in some kind of modification system,
18 I would say unlike Arnie's example of the kind of gains to
19 be made in hospital where there's much more control, for
20 example better management of central line placement. But I
21 think the management of patients post-hospitalization,
22 you're really asking hospitals to engage in something

1 they're not as geared up to do right now.

2 Again, whether one wants that to be done inside
3 the hospital setting or some other kind of accountable care
4 organization. You might say it's home care, but not all of
5 these people go to home care. Whether all these people have
6 primary care physicians, probably not.

7 So I could give you a whole list of things in
8 terms of just even whether -- many of the patient that get
9 readmitted come back to the emergency room. Whether they go
10 to the same hospital as they were originally in because in
11 an emergency by and large ambulances take you to the closest
12 hospital and maybe not where you were treated and so forth.

13 So I could give you a whole list of things without
14 going too far. My main point is this is an enormous
15 difference in the cost structure. We may want to add this
16 to the cost structure of hospitals but we may not. I would
17 not assume that just the savings of avoiding some
18 readmissions are going to pay for the difference in the cost
19 structure.

20 MR. HACKBARTH: So what I hear you saying, Ralph,
21 is that as opposed to looking at adjustments in the hospital
22 payment policy, a better path from your perspective is to

1 look towards better integration and coordination of the
2 post-acute care experience and setting up an infrastructure,
3 whether it's housed in hospitals or someplace else, to
4 better manage that as a way of affecting the readmission
5 process, as opposed to trying to accomplish the goal through
6 tweaking the hospital payment.

7 MR. MULLER: Yes, and also I would say -- I don't
8 know whether the previous commissioners mentioned this --
9 the real-time problem here is considerable in terms of --
10 there's always some blatant ones that shouldn't be
11 readmissions. But knowing within 20 days whether something
12 has been inappropriately readmission or not is very hard to
13 figure out and would require all kinds of processes for
14 evaluation, audit, appeal and so forth. Which may take 60,
15 90, 120, 180 days to adjudicate.

16 So in many ways, if one takes off the payment for
17 the readmission automatically, the notion that within 20
18 days we would figure out whether that's appropriate or not,
19 I think is just not a realistic estimate. So it would take
20 a long time.

21 So again, you'd have major squabbles in terms of
22 what's an appropriate denial for a readmission and what is

1 not. I just don't see how this can be done very much in
2 real time.

3 This is one in which I normally try not to get
4 defensive about these things. I think it's so much more
5 complicated than what we know right now. And I think almost
6 everybody likes to think that readmissions are avoidable. I
7 think most of them are not avoidable.

8 In fact, we have a payment system that, in fact,
9 incents by having payments on a case payment does, at some
10 level -- we're not going to the 95 percent confidence
11 interval on when somebody should be discharged. We're
12 making some judgments on average.

13 So obviously when you make some judgments on
14 average as to when people should be discharged, to then say
15 100 percent of those should not have been discharged until
16 everything appropriate was done would also have enormously
17 to the underlying resources you would put in the payment
18 system.

19 Whether, as a matter of public policy, you would
20 want to put so many resources into a hospital system until
21 you could reassure yourself that nobody ever got discharged
22 until there was -- only about a 5 percent chance they would

1 come back, just strikes me as also not a wise -- because a
2 lot of people just get better on t heir own afterwards.

3 So therefore, whether you'd want to put those
4 resources in to make sure that almost 95 percent of those
5 people could be assuredly said would have no risk of
6 readmission, is probably also I think a big waste of
7 resources.

8 DR. CROSSON: I actually have a point to make but
9 I'll start out with my regular point, just so everybody is
10 clear that I'll always make the same point. And that is
11 that actually accountable care organizations appropriately
12 paid to manage quality and resource use is the answer.

13 But on this specific question, actually as I
14 looked at this and have listened to the discussion, I think
15 this path is going to take us down one of the most
16 complicated paths that we've ever taken. I'm not really
17 convinced that trying to improve care through rewarding or
18 penalizing readmissions is a sensible way to go for a lot of
19 the reasons that have been stated.

20 There's the issue of risk adjustment. There's the
21 question that we haven't even grappled yet with, which is
22 how are we going to determine what's really preventable and

1 what's not preventable? And how individualistic, as Jennie
2 said, to a patient is that really?

3 And then the whole issue of the post-hospital
4 environment and what hospitals can or cannot do about that
5 in the absence of some sort of integrated system.

6 I completely agree with Arnie here that there is
7 something, though, to be gained here for patients. But the
8 question is whether the lever is the readmission or whether
9 the lever really isn't the fact that the science now,
10 through Don Berwick and others, about what should go on and
11 what shouldn't go on in the hospital and the relationship
12 between that and adverse events and readmissions is getting
13 better by the year.

14 And whether or not, if we were to simply deal with
15 the hospital and physician payment for hospitalizations
16 around the presence or absence of those events or processes
17 or in some cases bad outcomes like a catheter-associated
18 infection or whether, in fact, the patient had adequate
19 protection for post-surgical blood clots or not. Whether or
20 not going directly -- it's sort of like Mitra said earlier,
21 this almost screams for process measures -- as opposed to
22 trying to get into a system so complex and so subjective

1 that we'll essentially get lost and, as Ralph said, we'll
2 add a lot of cost.

3 I think we're getting -- you know, process
4 measures are not as good as outcome measures. But when the
5 process measures very closely correlate with the outcome
6 that you want, sometimes they are the right direction.

7 So I'm just wondering whether in the end this
8 particular approach is going to be fruitful.

9 DR. KANE: The thought that came to mind here is
10 end-of-life care and what proportion of readmissions are
11 related to somebody dying within three or four months?
12 Again, that might be related to what Jay is saying, that
13 there's a process here around end-of-life care that maybe we
14 need to identify. I don't know how many readmissions are
15 related to end of life care, but I'm guessing there is some
16 substantial proportion that are.

17 Just hearing about relatives, parents dying, going
18 to the hospital on multiple times on their way down the
19 tubes -- that's probably not the right way to say it -- but
20 whether there can't be some -- I mean, that might be one of
21 the kind of processes that we could identify and say do you
22 have an appropriate way to intervene with families and

1 transition them into hospice or family counseling or some
2 other way to avoid the need to keep hospitalizing people.

3 The first step is how many of these are end-of-
4 life readmissions related to somebody in the last six months
5 of life? And then, if that's true, what might there be in
6 place, what kind of processes might there be in place to
7 think about avoiding the admission and transitioning into
8 hospice care?

9 DR. CASTELLANOS: I'd like to talk from a
10 physician viewpoint. I agree, I think going down this road
11 is going to be a bumpy, bumpy road. But I think we can
12 learn a lot. I think there's no question that the physician
13 community, in my opinion, can do a better job. And my
14 opinion, I think the hospitals can do a better job.

15 I think what we need to learn from this is a lot
16 of things. One is we need to look at it from a disease
17 specific viewpoint. As Arnie mentioned, I think there's
18 been a significant benefit from the central line
19 improvements.

20 And we need to look at the top four or five
21 disease processes that cause this readmission and then
22 answer the question why is that doing? And more important,

1 what can we do similar to what was done with the central
2 line to improve this? We're not going to cut it down to
3 zero, but I think we can improve it.

4 As Ralph mentioned, it's very difficult to hold
5 the hospital responsible for the care that the patient gets
6 outside of that facility. And quite honestly, it's
7 difficult to hold a physician responsible, especially when
8 that patient gets transferred to a skilled nursing facility
9 or a long-term care facility where that physician doesn't go
10 and has no rights to dictate the care or help with the care.
11 A lot of my patients go into a nursing home and I don't go
12 to nursing homes. It's physically impossible to do that.
13 So the care they get there, I have no responsibility for
14 and, unfortunately, no direction.

15 The noncompliant patient, it's a difficult
16 problem. I can tell you that 90 percent of my problems are
17 caused by 5 or 6 percent of my patients. So how do I handle
18 it? I don't see those patients. I ask them, I think we
19 have a problem. I think you need to see another doctor.
20 It's the easiest way to handle that. But it's not the best
21 thing for the patient.

22 The other thing is the disease processes that I'm

1 dealing with. You can look, there are doctor and there are
2 doctors, and there are hospitals and there are hospitals.
3 What's happening in the community hospitals is that the high
4 percentage of complication procedures are being -- excuse my
5 language -- turfed to the tertiary center. I think Karen
6 should talk on that.

7 Just because the hospital has a lot of
8 complications or readmissions from say a very high surgical
9 procedure and you see it not in a local hospital doesn't
10 mean the tertiary hospital is doing a bad job. It means
11 those patients are sick and those disease processes are
12 difficult to deal with.

13 I think, in summary, I would like to say I think
14 we can learn a lot by going down this path but I think the
15 path is going to be very bumpy.

16 DR. WOLTER: Just to underscore a couple of things
17 that have already been said, I think it would be useful if
18 we could pull the data sort of by the disease state. If
19 there's any a concentration of readmissions that would be
20 interesting to see. End-of-life care.

21 And then I was going to mention that in the group
22 practice demo, several of the organizations are focusing,

1 for example, on congestive heart failure admissions. Ralph,
2 I think we believe actually there can be a significant
3 reduction of readmissions related to something like
4 congestive heart failure.

5 And that might be an interesting tack on this
6 approach to start with one DRG or cluster of DRGs like
7 congestive heart failure, rather than all readmission rates.
8 Because we could maybe learn a little bit more about some of
9 the issues we'd get into if we went to sort of all
10 readmission rates.

11 It would really be nice to do it in the context of
12 bundling that DRG, I think, because then you'd really start
13 creating the incentives for people to work together.

14 But I do think there are probably a lot of devils
15 in the details of trying to do this broadly right out of the
16 gate.

17 And then also, to underscore something Jay said,
18 there's probably a lot to gain in terms of reduction of
19 readmission rates through things like medication
20 reconciliation, reducing post-op infection rates. And
21 that's kind of go where the money is, so to speak, would be
22 really important to keep incenting hospitals to work on that

1 because they have more ability to influence those things.

2 So just a few thoughts.

3 DR. BORMAN: I have a question for you about table
4 two in the mailing materials. The distribution of
5 readmissions by discharge destination, and you've got that
6 very nice share of the cases and share of 30-day
7 readmissions.

8 My attention was kind of piqued by trying to look
9 at this on a percentage change basis. Just as a down and
10 dirty calculation, if you look at skilled nursing facility,
11 their share is 16 percent, their share of 30-day readmits is
12 20. That's a 25 percent increase relative to their share.

13 If you look at the next line, inpatient rehab
14 facility, their share is not quite 4 percent, their 30-day
15 readmission is 33 percent. They probably have the biggest
16 relative drop of the whole group.

17 I wonder, as you try to drill down here, whether
18 those two groupings might, in fact, have some overlapping
19 diagnoses that might go to some of those, that might offer
20 you some of what we're talking about here in terms of not
21 just globally going out after disease categories. But right
22 here you may have identified where the biggest variations

1 are and yet may have some overlapping diagnoses. That might
2 be a bigger payoff for the analytic time maybe to focus on
3 those.

4 Just a thought, and there's probably some
5 statistics here that this plain Jane general surgeon doesn't
6 understand. But that did strike me.

7 In terms of a couple of things that have been
8 said, I would absolutely support there is a facet here of
9 patient accountability that's very difficult. It is a very
10 fine line what a patient should be expected to be
11 accountable for and what they are accountable for. But I
12 think we cannot simply dismiss that, and we have to
13 acknowledge that's an ongoing consideration. I have
14 multiple examples that come to mind if anybody wants to talk
15 to me privately that are rather hair-raising.

16 In terms of never events, I would just comment, I
17 think we can all easily agree that never events are
18 something that yes, we ought to be able to do with that and
19 so forth. I would point out there's kind of a nice study
20 that the ACS did relative to looking at closed claims over a
21 recent two-year period, 2004 to 2006. It was an extremely
22 small percentage of things that actually came to litigation.

1 So you would think it might amplify that group.
2 It was a tiny percentage of the whole closed claims. And it
3 was about 500 closed claims analyzed over two years. So I
4 think we can all jump on the never events bandwagon and
5 that's wonderful. It's a great place, something maybe we
6 could do right off the bat, sort of like the outlier things
7 we talked about in terms of the SGR. But I think we also
8 have to realize that maybe the game will be relatively small
9 on the surgical side of that, at least.

10 Then with regards to the point that Ron brought
11 up, obviously we keep coming back to this issue of where's
12 the robustness of our risk adjustment capability? And that
13 will be a huge factor here. Even if one subtracts out
14 academic centers, there are certainly in communities
15 organizations that are clearly getting more complex patients
16 than oftentimes are the kinds of things that Jay represents
17 or Nick represents as places that are more capable to deal
18 with sort of the patient that demands multidisciplinary
19 care. It just begs for robust risk adjustment.

20 The last thing I would just like to mention is
21 trying to think about this in terms of hospital and
22 physician accountability and just remind ourselves that this

1 is one of those places where hospitals and physicians are
2 fairly disparate. And that there is the opportunity for
3 hospital payment pretty cleanly for the readmission. And
4 for a surgeon, at least, when you're talking about a 90-day
5 global procedure, unless you return the patient to the
6 operating room you really don't get anything for that care.

7 And so within that context we are already not
8 paying at least the provider for those events. And we
9 should remember that and just be careful of having such a
10 broad slash that we sort of double cut folks that are
11 already facing or have a reporting mechanism and a penalty
12 mechanism, using some of the terminology that we've had
13 today.

14 For example, there's an easy identifier in the CMS
15 system with regards to the dash 78 modifier, which is a
16 return to the operating room, which you do get paid for.
17 But it's discounted when it's done as a complication of the
18 primary care.

19 So again surgeons in major globals already are
20 being penalized for these events. So I would just caution
21 on taking too broad a swipe at things here and recognizing
22 that this is the place where physicians and hospitals

1 differ, and there are significant differences within the
2 physician community related to things that are already
3 bundled versus things that are not.

4 MS. BEHROOZI: Thanks, Jay, for trotting out my
5 little red wagon, because I was going to try to hold back.
6 But I really think that it's difficult to discuss this
7 untethered from process measures because hospitals are
8 already required now to report on process measures? Isn't
9 that true? Under penalty of withhold? Some process
10 measures.

11 So it's not like it doesn't exist all at yet.
12 It's not like something that has to be built from scratch.
13 And it's an effort that, I think, MedPAC ought to encourage
14 be expanded.

15 And then not only will you get to some of those
16 things that create the conditions for hospital readmission,
17 but higher acuity of those people -- not necessarily the
18 same people -- but people before they are released from the
19 hospital, before they are discharged and admission for one
20 thing becomes a discharge for another.

21 It's not just about -- it's often not about what
22 the surgeons do or with the discharge planners do. It's

1 about whether people in the hospital are washing their
2 hands. Those are the kinds of things that you might not be
3 able to measure in the outcome of the patient, in
4 particular, but that's really the kind of program that
5 hospitals can report on.

6 MR. HACKBARTH: Okay, thank you very much for the
7 thought-provoking discussion.

8 Next is our final session before lunch, and that
9 is the 21st century Medicare beneficiary.

10 DR. ZABINSKI: Over the coming decades the
11 population of Medicare beneficiaries is expected to change
12 in some important ways. One change is the well-known
13 increase in the number of beneficiaries as the baby boom
14 generation becomes eligible for Medicare beginning in 2011.

15 A second change that has not been as widely
16 studied is that the profile of beneficiaries'
17 characteristics is likely to change in the coming decades.
18 These changes will affect program spending and
19 beneficiaries' needs and their preferences for health care.

20 Today I will discuss our analysis of the changing
21 profile of beneficiaries' characteristics. I want to
22 emphasize though that this is our first crack at this

1 analysis and we would really like to encourage input from
2 the commissioners on adding your thoughts on the
3 characteristic changes that you view as important but that
4 we've overlooked so far.

5 The purpose of this study is twofold. First, to
6 start out by identifying changes in beneficiaries'
7 characteristics that are likely to be the most important to
8 the Medicare program. Then we want to move on to identify
9 possible changes to Medicare so that the program could
10 better serve beneficiaries in the future.

11 The method of our analysis was first to convene a
12 panel of experts who have a variety of backgrounds and
13 represent a variety of organizations. Then we supplemented
14 the information from the panel by reviewing the literature.
15 With this method, we identified first eight important
16 changes to beneficiaries' characteristics that are likely to
17 affect the Medicare program, and I will discuss those
18 changes over the next few slides. Then after that I will
19 present five possible changes to the Medicare program so
20 that it could better serve future beneficiaries.

21 A first change in beneficiaries' characteristics
22 is an increased prevalence of being treated for several

1 chronic conditions. For example, the proportion of
2 beneficiaries treated for five or more chronic conditions
3 increased from 31 percent in 1987 to 76 percent in 2002.
4 The reasons underlying this change in the prevalence of
5 chronic conditions are basically four. There's an increase
6 in the obesity rate among the elderly; there's been advances
7 in the technology for diagnosing chronic conditions; there's
8 been advances in technologies for treating chronic
9 conditions; and there's been some changes in disease
10 definitions so that more beneficiaries are identified as
11 having a chronic condition.

12 This increase in the prevalence of chronic
13 conditions has some important implications for Medicare.
14 First, it suggests the possible need for more care
15 coordination where care coordination has been identified as
16 being vital for effectively caring for beneficiaries who
17 have several chronic conditions. Also, you want effective
18 targeting of beneficiaries who will receive care
19 coordination. In particular, you want to target those who
20 would benefit the most and avoid those who would benefit
21 only a little. This would help make care coordination more
22 cost-effective.

1 A second key change in beneficiaries'
2 characteristics is a decline in the proportion of
3 beneficiaries who are disabled as measured by the presence
4 of limitations in activities of daily living, or ADLs. For
5 example, the number of limitations in ADLs per beneficiary
6 declined from 0.68 in 1992 to 0.61 in the year 2000.
7 However, this decline in disabilities has not appeared to
8 have decreased the cost pressure on Medicare. That's
9 occurred because the cost of those who are not disabled,
10 that is beneficiaries who do not have any limitations in
11 ADLs has risen in relation to those who are disabled. What
12 this reflects is an increase in being treated for chronic
13 conditions among those who are considered to be relatively
14 healthy. It also suggests that the cost pressures from
15 disabilities has declined over the last couple decades while
16 cost pressures from chronic conditions have increased.

17 However, a recent study suggests that this decline
18 in disabilities that we've seen may not continue well into
19 the future. In particular, a cohort of baby boomers
20 reported more difficulties in activities such as walking,
21 climbing stairs, getting out of chairs, and kneeling or
22 crouching than an older cohort that is in its first few

1 years of Medicare participation.

2 A third key change in beneficiaries'
3 characteristics is that obesity rates have increased among
4 the elderly and are likely to stay high in the coming
5 decades. Obese beneficiaries are important because they're
6 more likely to have conditions such as diabetes, heart
7 disease, hypertension, and osteoarthritis. Also, they could
8 have a greater need for dialysis.

9 The obese beneficiaries also have a relatively
10 high annual cost and, surprisingly, several studies have
11 shown that their life expectancy is not any shorter once
12 they reach age 70. Consequently, obese beneficiaries tend
13 to have very high cumulative cost to the Medicare program.

14 A fourth possible change in beneficiaries'
15 characteristics is a decline in the proportion of the
16 prevalence of employer-sponsored insurance, or ESI, to
17 supplement traditional Medicare. For example, the
18 percentage of beneficiaries who have ESI declined from 28
19 percent in 1999 to 25.5 percent in 2002. But this change is
20 just the tip the iceberg. The decline is likely to
21 accelerate because fewer employers have indicated that they
22 will not cover future retirees.

1 For example, among large firms providing
2 subsidized benefits for future retirees, 8 percent have
3 decided to drop that coverage for future retirees in 2004
4 and 12 percent decided to do so in 2005. Also, the Employee
5 Benefit Research Institute said these changes may not have a
6 noticeable effect on the trends in insurance coverage until
7 at least a few years after the baby boom generation begins
8 to retire.

9 An issue in regard to this decline in the
10 prevalence of ESI is that alternatives to ESI are likely to
11 be viewed as inferior. For example, one alternative to ESI
12 is Medigap coverage, but Medigap typically requires
13 beneficiaries to have higher premium contributions for
14 coverage that is often less comprehensive than ESI.

15 Another alternative to ESI is simply to go with
16 traditional Medicare without any supplemental coverage.
17 This option carries greater risk of catastrophic loss
18 because Medicare does not limit beneficiaries' out-of-pocket
19 liabilities.

20 A fifth change that we identified in
21 beneficiaries' characteristics is a change in their racial
22 and ethnic profile. In particular, the proportion of

1 beneficiaries who are of Hispanic origin is likely to
2 increase. For example, right now we know that 6 percent of
3 the 65 and older population is Hispanic but 14 percent of
4 the entire U.S. population is Hispanic. This change in the
5 racial and ethnic profile could present language issues for
6 the program providers and for beneficiaries.

7 Also, Hispanic beneficiaries have some important
8 clinical differences from the overall Medicare population in
9 that they're more likely to be obese, diabetic or have
10 limitations in three or more activities of daily living.
11 They're also less likely to have cancer. Therefore,
12 Hispanic beneficiaries may have different health care needs
13 from the overall Medicare beneficiary population.

14 One interesting change that the expert panel
15 discussed at length is that adult children may become a less
16 reliable source of custodial care for their parents who are
17 Medicare beneficiaries. The panel indicated that adult
18 children often provide custodial care to their parents but
19 they may become a less reliable source because people are
20 having fewer children and adult children are starting to
21 live greater distances from their parents. So in the future
22 beneficiaries may have to rely more on paid sources of

1 custodial care than their children and these paid sources
2 are generally not covered by Medicare so they can be quite
3 costly to beneficiaries.

4 A seventh change in beneficiaries' characteristics
5 is that future beneficiaries are likely to have more formal
6 education than current beneficiaries. In particular, more
7 beneficiaries will have college degrees and fewer will lack
8 a high school diploma. Our expert panel suggested that this
9 change in the education profile will result in beneficiaries
10 becoming more involved in their health care decisions. For
11 example, they may better understand their treatment options
12 and they also may be more willing to ask questions of their
13 providers.

14 In addition, future beneficiaries, being more
15 indicated educated, may be more willing and adept at using
16 information technology such as personal health records.

17 A final change in beneficiaries' characteristics
18 discussed by the expert panel concerns income issues.
19 First, income among the elderly has grown much more slowly
20 than their health care costs. For example, during the 1993
21 to 2003 period annual real growth in income among the
22 elderly was 1.3 percent. In contrast, annual real growth in

1 the Part B premium over the same time frame was about twice
2 as high at 2.5 percent.

3 Also, the distribution of income among the elderly
4 appears to be becoming less even, which mirrors the rest of
5 the U.S. population. This may exacerbate differences in
6 access to care between rich and poor beneficiaries which
7 ultimately may lead to perceptions of inequity.

8 So after identifying changes in beneficiary
9 characteristics that are likely to be important to the
10 Medicare program, we moved on to identify possible changes
11 to Medicare so that the program can better serve future
12 beneficiaries. This part of our work relied on two sources.
13 First, the expert panel. And secondly, previous work by
14 MedPAC. In the end, we found that there was a lot of
15 overlap between these two sources.

16 One change in the Medicare program that could
17 result in better service to future beneficiaries in
18 facilitation of care coordination. Care coordination has
19 been identified as being especially beneficial to those who
20 have several chronic conditions. This is important in light
21 of the increase in the prevalence of chronic conditions that
22 I discussed earlier. However, in past research the

1 Commission has indicated that the structure of traditional
2 Medicare can make care coordination difficult.

3 So in the same previous work, the Commission also
4 identified four keys to facilitating care coordination in
5 traditional Medicare. First is the need for care managers,
6 who are typically nurses, to act as the focal point for
7 patients and their providers. Secondly, you need
8 information systems that help identify patients who would
9 benefit the most from care coordination, and this can help
10 make care coordination more cost effective.

11 Third, you need incentives for physicians to be
12 part of the care coordination team. And then finally, you
13 need to find ways to get patients engaged in their treatment
14 programs.

15 So in the June 2006 report the Commission
16 discussed two models of care coordination that bring these
17 four points together into a care coordination program. One
18 of these models is similar to a pilot project and the other
19 is similar to a demonstration project that CMS has launched
20 in Medicare and are still ongoing.

21 A second possible change in Medicare is expanding
22 the use of health care information technology. The benefits

1 of IT are that it can help improve quality, efficiency and
2 care coordination. Recent analyses show that IT has been
3 diffusing in the health care sector but its use is still not
4 widespread. So in a previous report, the Commission
5 considered several options for encouraging the use of IT.
6 And in the end, the Commission recommended use of quality
7 measures that are supported by IT in P4P initiatives.

8 A third possible change in Medicare is to use
9 comparative effectiveness analyses. Comparative
10 effectiveness allows one to compare the relative value of
11 different services. It can help providers and beneficiaries
12 make decisions about the most effective treatments for each
13 health care dollar, which can help improve safety and
14 quality.

15 In a session after lunch, Nancy Ray will lead a
16 discussion of how comparative effectiveness analyses can be
17 produced for use in the Medicare program and other parts of
18 the health care sector.

19 A fourth possible change which was discussed at
20 length by the expert panel is to promote lifestyle changes
21 such as improving diet and exercise to help reduce obesity
22 rates. Some programs like this already do exist, such as a

1 Silver Sneakers.

2 The panel stressed that these promotions should
3 include the population that is nearing Medicare eligibility
4 as well as actual Medicare beneficiaries because it is
5 easier for younger people to make the necessary lifestyle
6 changes. A point that I want to add to the panel's thoughts
7 is that these programs do not have to be run through
8 Medicare.

9 A fifth and final possible change that we
10 identified is to restructure the benefits and cost sharing
11 in traditional Medicare. To start, though, I want to
12 acknowledge that Medicare is widely considered to have been
13 quite successful in improving access to care among the
14 elderly. However, the benefits and cost sharing in
15 traditional Medicare are also considered to be unusual for
16 an insurance plan.

17 For example, the deductible is higher for
18 inpatient care, which is usually considered quite
19 nondiscretionary, than it is for ambulatory care, which is
20 typically considered more discretionary. An insurance
21 theory says the opposition should be true and that
22 nondiscretionary services should have lower cost sharing.

1 A second unusual feature of Medicare is it does
2 not limit beneficiaries' financial obligations but most
3 insurance in the private sector does so.

4 Possible modifications to cost sharing in
5 traditional Medicare discussed by the expert panel include,
6 first, having a single deductible for Part A and Part B. In
7 addition, you may want no cost sharing beyond the deductible
8 for inpatient services, but some additional cost sharing for
9 most other more discretionary services. The idea is to have
10 cost sharing that encourages the desired behavior by
11 providers and beneficiaries.

12 And to allow this cost sharing to be effective,
13 you may want to limit the extent to which supplemental
14 insurance can cover that cost sharing.

15 A second possible change discussed by the expert
16 panel is to include a limit on beneficiaries' financial
17 obligations through a stop loss provision.

18 To conclude this discussion, we started by talking
19 about eight changes to the beneficiary characteristics that
20 could have substantial effects on the Medicare program in
21 the future. Then we went on to identify possible changes so
22 that Medicare could better serve beneficiaries in light of

1 those changes. The next step in this analysis include
2 getting the commissioner's thoughts on items that should be
3 added to the list of important changes to beneficiary
4 characteristics or added to the list of possible policy
5 changes. From there, we would update the analysis to
6 reflect your input.

7 Then over the little longer term, likely in 2008,
8 we would like to simulate the effects of important changes
9 to the beneficiaries' characteristics and changes to the
10 Medicare program so that the program can better serve
11 beneficiaries.

12 Now I turn things over to the Commission.

13 MS. BEHROOZI: This was really interesting, Dan.
14 Thank you. It's really comprehensive. And a lot of the
15 things that people think they know are happening, but it's
16 nice to see it all laid out here.

17 The one of particular interest to me is income
18 among the elderly has grown much more slowly than health
19 care costs and distribution of income appears to be less
20 even. I think it's really significant and that has big
21 implications for any recommendations with respect to cost
22 sharing changes.

1 It seems logical that if someone makes less money,
2 they can afford less of everything, including health care.
3 But I don't think there are yet a whole lot of studies to
4 support that. Just last month the Kaiser Family Foundation
5 I guess extracted some data from its employer health
6 benefits surveys and did a report on insurance premium cost
7 sharing and coverage take up, which showed very significant
8 differences in take-up of insurance coverage provided by
9 employers given different levels of cost sharing. There was
10 always a significant difference between higher wage workers
11 and lower wage workers, no matter what the cost sharing
12 level was of the premium.

13 So I think that that's the kind of thing,
14 particularly if the income disparity is going to continue to
15 grow, Medicare should pay close attention to that. We
16 should not be discouraging people from taking Part B. The
17 current difference between the premium for higher income and
18 lower income beneficiaries maybe needs to be adjusted even
19 so that it's lower for the lower income beneficiaries, not
20 just about bringing more money into the system but about
21 encouraging lower income people to get the coverage so that
22 they can access primary and preventive care and end up not

1 having more acute conditions that land them in the hospital
2 getting more expensive care.

3 And if there are ways to target copayments or
4 deductibles or other kinds of cost sharing in ways that
5 incent people to seek preventive care, I think that would
6 also be a good avenue to pursue.

7 MR. MULLER: I too, Dan, think this is a very good
8 chapter.

9 I have a question about how technology fits in and
10 but it's not obviously a characteristic of a beneficiary.
11 But as you think about the changes that are going on in
12 terms of personalized medicine, in terms of more targeted
13 therapies for neurodegenerative diseases, cancer, heart
14 disease and so forth, when you think about the advances in
15 imaging, when you think about the less invasive procedures
16 for surgery and so forth, this could really change the kind
17 of care that beneficiaries get.

18 So it's not a beneficiary characteristic but it
19 could markedly change the kind of utilization patterns of
20 beneficiaries and could also -- on the one hand, it could
21 bring beneficiaries into the utilization cohort or it could
22 take them out of that.

1 So I'm not sure how I would introduce this, but
2 since we know from our previous work that the biggest driver
3 of Medicare costs in general, in terms of the increment from
4 year-to-year, are changes in technology I just want to have
5 us think a little bit about how changes in technology that
6 are forthcoming are likely to change the utilization of care
7 by beneficiaries.

8 I do think, especially the movement toward what's
9 called personalized medicine, much more individualized it's
10 happened the most in the pharmaceutical area but it's going
11 to happen in other diagnostic areas as well.

12 So again, if you could just think a little bit
13 about how we would introduce that theme, because I do think
14 it changes the beneficiary cohort of people who are
15 utilizing services.

16 And especially a lot of the biologics and the
17 pharma area are quantum levels of difference in terms of
18 cost compared to what is right now. And we've also talked a
19 lot about a lot about what's the threshold for acceptance of
20 new therapeutics, again more developed in the drug area than
21 it is in other areas. So I think those things could really
22 change what I call the beneficiary cohort in terms of

1 utilization.

2 Again, I don't know exactly where to take it.
3 I'll try to develop my thoughts, but certainly -- since
4 you've done so well so far -- ask you to keep working on it.

5 DR. CROSSON: First, I just wanted to compliment
6 Mitra for her thoughts about how to construct a better
7 benefit structure that supports the care of the elderly with
8 less income. I thought of a name for it. I don't know
9 whether this would work or not. We could call it Medicare
10 Advantage, just for the heck of it.

11 [Laughter.]

12 DR. CROSSON: I actually had a more technical
13 question I wanted to ask Dan, and that is you mentioned
14 early on that the cost of care for patients with
15 disabilities has gone down while the cost of care for those
16 with multiple chronic conditions has gone up. The question
17 is has that changed over time, or do you know has that
18 changed over time the relative cost by age cohort within
19 Medicare or not?

20 DR. ZABINSKI: Are you saying has the costs of say
21 the 65 to 69 changed relative to like the 85 and older?

22 DR. CROSSON: Correct.

1 DR. ZABINSKI: I don't know. That's a good
2 question, though. I'm sure that's not difficult to find
3 out.

4 DR. REISCHAUER: People with disabilities in those
5 age groups? Is that what you're saying? Or just people?

6 DR. CROSSON: No, I was just mentioning that
7 earlier on we had data that said that overall the cost of
8 care for individuals identified as having disabilities has
9 gone down. The cost of care for those identified as having
10 multiple chronic conditions has gone up.

11 Part of the reason for that was described as the
12 ability to diagnose chronic conditions. Quite frankly, I
13 don't have any friends who don't have any chronic conditions
14 at this particular point in life. So I was just wondering
15 whether, in terms of -- I'm thinking of things like
16 artificial knees and hips and other things of that nature.
17 I wondered whether over time then that has changed the
18 relative proportion of money that is going to, say the 80 to
19 85 year old cohort compared with the 65 to 75 year old
20 cohort?

21 MR. HACKBARTH: Jay, on your first point, when
22 Mitra was talking about that, it's funny, I had a different

1 reaction. I got QMB and SLIMB when she mentioned specific
2 programs to support Medicare beneficiaries with low income.
3 Funny how different people think differently about these.

4 DR. CROSSON: That's what makes the Commission so
5 great.

6 DR. CASTELLANOS: With the conclusion, you asked
7 us for some possible suggestions that Medicare could do that
8 would serve the future beneficiary. There's no question
9 that we need to, and I think we are going to, deal with the
10 workforce problems and making sure there's access to care.

11 Another thing is we also know that the beneficiary
12 is changing but the provider is changing, also. The new
13 medical doctor profile of the person graduating -- and I
14 think we had a little taste of that this morning when Ralph
15 said the top 10 or 15 percent of the graduating class all
16 picked dermatology or radiology or some procedure that was
17 more important to their lifestyle.

18 I'm seeing it in my practice. We don't have a
19 large practice, we have a group of 10 people. I see it from
20 my age group all the way down to the young kid coming out.
21 There's just no question that the younger doctor has
22 different ideas of lifestyle. I don't think they want to

1 work as hard as Karen and I work.

2 I'm not saying they're not good doctors. I'm not
3 saying they're not dedicated. But they certainly have a
4 different profile of their lifestyle change.

5 The other thing we need to really strongly
6 emphasize, again as we discussed with the SGR, is these
7 educational programs in the medical school, teaching them
8 about what we talked about, care coordination in this group,
9 evidence-based medicine, cost-effectiveness. Again, we need
10 to do that at an early age in their formal training periods.

11 MR. BERTKO: A quick comment. Dan, a good report
12 and I'm going to follow Mitra and less to Jay on the cost
13 sharing aspects of it, particularly supplemental coverage.
14 There certainly is evidence -- that you've got one of
15 reports there in the text about having zero cost sharing
16 causing some amount of induced demand.

17 I would make the point that at least actuaries
18 have seen, even a minimal amount of cost sharing that goes
19 from zero cost sharing to something -- it doesn't have to be
20 huge -- actually reaps much of the benefit. That might be
21 used in the trade-off against the maximum out-of-pocket
22 protection of some sort. So just to continue support for

1 your looks at this as you move forward.

2 The second one is a little bit more technical, and
3 you talked about it on the last page, simulating some of
4 these things in the future. I don't know whether you've
5 thought about using agent-based models where you look at
6 seniors' preferences. I think your good comment that I
7 hadn't thought of earlier is the near seniors group, as
8 well. And the agent-based modeling, in my experience, has
9 done a little better job there than the microsimulation or
10 actuarial models.

11 DR. KANE: I enjoyed it and it made me think a
12 little bit about some of the changes that I think are
13 important, one of which is the change in the site of care
14 and, in particular, the housing environments of elders. A
15 couple things are going on.

16 One is I think, at least in our marketplace in
17 Boston, there's a lot less use of skilled nursing facilities
18 for long-term care and much more use of senior care,
19 assisted living, and independent living. And so there's
20 much more of this congregate kind of long-term housing
21 situations that aren't necessarily totally medical. They're
22 much more housing and independent living with some support.

1 But the benefit package doesn't necessarily follow
2 to these new sites of care. House calls is one of the
3 things. Sometimes you can do house calls in a congregate
4 facility whereas you wouldn't necessarily do it spread out
5 geographically.

6 So the programs that encourage preventive services
7 and care management in the home is a different kind of
8 picture of where some of this might happen.

9 Telemonitoring in the home. I think there is an
10 opportunity for a lot more home focused care that can be
11 done because people are living in congregate facilities that
12 have opportunities to put in infrastructure to take care of
13 people and keep them healthy longer. And how can Medicare
14 foster that? Does that result in better care than having
15 the traditional silo-based care?

16 Group visits would be another thing, nurse
17 practitioner teams. Medicare doesn't pay for this in that
18 way yet, and I'm just wondering if we need to think more
19 about the benefit of thinking about paying in different ways
20 that foster more independent living.

21 MS. HANSEN: Actually Dan, I certainly had a
22 chance to talk to you a few minutes before this and I really

1 appreciate the breadth of the report.

2 I'd like to build on one thing about describing
3 the age cohort aspect and really teasing out these age
4 categories coupled with comorbidities. Because I think one
5 of the big factors, I remember years ago looking for were
6 there any teased out data for the 85-plus population, which
7 is actually the fastest growing cohort of older people. And
8 that has a unique characteristic in that about 50 percent of
9 that cohort will experience dementia, which is one of the
10 more expensive aspects that isn't, by itself as a diagnosis,
11 teased out as a payment category but affects all the other
12 issues.

13 So I think the whole aspect of segmenting out the
14 age categories would be great.

15 I'd like to pick up on the economic factor, even
16 though this is about Medicare, is that certainly through our
17 data with AARP we realize that baby boom as a growth group
18 doesn't have very much in savings. On average, about 50
19 percent of the population has about \$35,000 net savings
20 right now. If that's the case, people are going to move
21 into a dual eligible population in greater numbers than
22 before. So we should start looking at that economic

1 modeling as to what's going to happen to the Medicare
2 program because this will be a growing population.

3 The whole area of obesity as a major area is, I
4 think, teased out with the impact of diabetes. I know Nancy
5 will cover later about ESRD. But ESRD, which is one of our
6 big cost programs under Medicare, will also be, I think, a
7 program that will be affected.

8 Two points, one related to the whole area of
9 diverse populations and disparities. Since, even in the
10 current Medicare program, it is shown I think from the
11 National Academy's reports that there are still access
12 disparities or health disparities even with having a
13 Medicare program. So that issue may get further compounded.

14 The final one has to do with the diversity. The
15 Hispanic population was identified as the largest cohort
16 group. But I wonder if we could do two things about that.
17 One is kind of do a mapping of just some of the changes in
18 the ethnic population changes in the country that are
19 projected. Because that will have a large effect not only
20 on the Hispanic population but a broader population.

21 With the Hispanic population even as the first
22 lift, that language access is quite different. One of the

1 features is not just the way people utilize it but there are
2 language elements that will make a difference as to how care
3 and if care is received.

4 Thank you.

5 DR. BORMAN: One thing, Dan, on page three, and
6 this was, I think, just a wonderful report. I think may be
7 one of the most important things, sort of think tank ideas,
8 that's going on in the background of the Commission. I just
9 think this is wonderful work.

10 On page three you talk about increased use of
11 cost-effectiveness analyses. I don't mean this as a
12 wordsmithing comment, I mean it as a philosophical comment.
13 If we're going to be thematically consistent, that should
14 perhaps be comparative effectiveness because I think maybe
15 we're starting to hear, particularly with your comments this
16 morning about the reception of the SGR report, that that
17 maybe is an area that we can more confidently go. As I
18 recall, we struggled to define cost-effectiveness at last
19 year's retreat. I think we ought to be thematically
20 consistent here, in just the philosophic implications of
21 that.

22 Relative to the data about obesity, I wonder --

1 and again, this is someone who's not primarily a giver of
2 chronic care. But I would hypothesize that obesity in this
3 is a harbinger of what we will see in other chronic
4 conditions. That is, as we've gotten better at care and
5 drugs and detection and surveillance, that we will allow
6 people with multiple chronic conditions or even isolated
7 ones -- hypertension or whatever -- to live longer. So I
8 don't know that this is so much an effect of a single
9 disease but the first effect that we will see, that you can
10 live quite long periods of time with these chronic
11 conditions.

12 So then you get into the issue of certainty we
13 want to be interested in the preventive care. But there's a
14 certain element of this that's genetic, that will get us
15 down to a finite rate limiting place beyond which we
16 probably cannot go unless we want to go to some perverse
17 incentive of breeding programs or something that gets pretty
18 crazy. As long as we can't pick take our parents.

19 As you model this through, that we're going to
20 allow people to live to very expensive acute diseases. The
21 potential implication there for end of life, I think, is
22 huge. As end-of-life was brought up earlier, I think that

1 that has real implications here.

2 That leads me to the thought that we know that
3 right now that the duals and end-of-life care are two areas
4 that are huge cost to the program. To the extent that we
5 can -- what data do we have about projecting that into the
6 future as opposed to trying to project for a whole
7 population that maybe we don't understand. Can we at least
8 project for the groups that we know cost us a lot now?

9 I think that links up, if I understood Jay
10 correctly, with the modeling for some younger cohort, not
11 just the near-Medicare group, but potentially if you look at
12 the 35 to 45 year old group now, our best bet about what
13 they're going to look like as they are in the near-senior
14 and senior group. It seems to me that that will have some
15 benefit.

16 Finally just a comment about what beneficiary
17 ideally serves the program financially versus societally or
18 clinically. If you think about it, the 65.6 year old who
19 dies of their lung cancer saves the program a huge amount of
20 money. And so maybe that leads to this perverse incentive
21 well, all this stuff we're doing to stop smoking -- it
22 becomes crazy.

1 The reason I bring that up is to make a point
2 about finding data and applying data. And the point, in
3 part, is kind of timely in that the recent article about
4 lung cancer screening -- and I don't want to get into the
5 clinical validity or not of that -- but if you set that
6 aside as a clinical piece, forget the implications about
7 that on the cost piece are fairly extensive. And we need to
8 be creative about learning to use clinical data for economic
9 projection use, as well. That may speak to the comparative
10 effectiveness discussion later.

11 DR. REISCHAUER: Comments on a couple of the
12 dimensions that you talked about. One was employer-
13 sponsored insurance and the decline of that.

14 I was wondering how far we go in ferreting out the
15 implications of this? The first order implication, of
16 course, is people won't have as generous a supplemental
17 package as they had before. Therefore, Medicare basic
18 service use will go down. In other words, it's a Medicare
19 cost saving.

20 The second order would be that the fraction of
21 folks in Medicare Advantage will probably go up, that being
22 an efficient alternative if one doesn't have ESI.

1 Third is the number of people going bare will
2 increase, therefore bankruptcies and dependence on Medicaid
3 will rise.

4 We can go down a set of these things and you sort
5 of stopped way, way up at the top on that. And I don't know
6 how far we want to pursue these.

7 MR. BERTKO: I would only add one more. The Part
8 D cost is higher in the stand-alone PDP than it is for the
9 subsidy going into what's called the RDS, the Retiree Drug
10 Subsidy.

11 DR. REISCHAUER: Then a bit on pulling out
12 Hispanics and talking about them. I am very uneasy, and
13 maybe our information base is a lot better than I think it
14 is, but the issue here, to me, is are we saying something
15 about genetics? Or are we saying something about income,
16 culture, and the environment people grow up in when we are
17 looking at their prevalence of disease or their use of
18 services versus other groups? Are we talking about
19 something that is shared by recent immigrants or Hispanics
20 as such?

21 I want to dig a little deeper in this before I
22 pull out Hispanics and say this is something that we should

1 focus on as important to Medicare in the future.

2 Finally, just a footnote on John's point and your
3 discussion of copayments and how some services are less
4 discretionary than others. We have the RAND study by
5 Goldman, which shows pretty convincingly that very small
6 changes in copayments or coinsurance for prescription drugs
7 gets huge changes in compliance with drug regimens that
8 could end up costing the system, in a sense, huge amounts of
9 money over the long run.

10 So we want to be very careful about how we
11 characterize these types of services.

12 DR. WOLTER: I wanted to comment, actually this
13 slide kind of hits the things I wanted to emphasize. I
14 heard Ken Thorpe speak recently and he's cited, Dan, in the
15 references you provided on chronic disease. He is of the
16 view that about 70 percent of increasing Medicare costs are
17 related to the increasing incidence of people with multiple
18 chronic conditions.

19 I don't know what database he's used to put that
20 together, but it really strikes me that there is some
21 urgency about how we shift some of the fragmentation in the
22 Medicare system, some of the current incentives, and start

1 emphasizing that in fairly short order we better have better
2 approaches to chronic disease management.

3 That, of course, would bring us back to the
4 discussions we have been having about accountable care
5 organizations, about caring for patients across sites, more
6 investment in secondary prevention. And we have many more
7 perverse incentives in place right now than we do have
8 positive incentives to deal with this particular problem,
9 whether it's physician self-referral or hospitals that do
10 joint ventures with physicians. And all of the investment,
11 really, is going into acute interventional care. And I feel
12 some urgency about that.

13 I think maybe this type of report, which is really
14 excellent, is another platform for us to talk about some of
15 the changes that need to happen in fairly short order if
16 we're going to be able to continue to afford to have the
17 Medicare program and to take care of this increasing
18 incidence of chronically ill people.

19 MS. BEHROOZI: Just briefly, I just want to make
20 it clear that people with incomes low enough to make their
21 decisions about whether to access health care based on
22 whether they can afford it, not based on whether they need

1 it, is not limited to the dual eligible population, not
2 limited to what I understand is the QMB/SLIMB population,
3 and that is something I think we need to bear in mind and
4 will get worse as we go forward.

5 MR. HACKBARTH: Okay. We'll now have a brief
6 public comment period before lunch.

7 MS. FRIED: My name is Leslie Fried. I'm here on
8 behalf of the Alzheimer's Association.

9 I just wanted to indicate that next week the
10 Alzheimer's Association is releasing a report called
11 Alzheimer's Facts and Figures, which will include updated
12 information on prevalence of Alzheimer's disease -- which
13 goes to the previous comments -- as well as some data that
14 we had Hopkins do, Jerry Anderson, et cetera, on the
15 significant increase in costs that people with dementia cost
16 the Medicare program because they have multiple chronic
17 condition.

18 It compares Medicare claims data of people with
19 Alzheimer's disease that have certain multiple chronic
20 conditions and those without dementia and have the same
21 conditions. It's really incredible, the significant cost to
22 the Medicare program.

1 So it's embargoed until next week but I will send
2 a copy of the report to Dan and to anyone else who's
3 interested because I think that it really spells out what
4 the crisis for the Medicare program, especially given the
5 boomer population and the increased prevalence.

6 MR. HACKBARTH: Thank you.

7 All right, we will adjourn for lunch and return at
8 1:15 p.m.

9 [Whereupon, at 12:25 p.m., the meeting was
10 recessed, to reconvene at 1:15 p.m. this same day.]

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1 of understanding which services work and their value.

2 So first let me define some terms. When I say
3 comparative effectiveness, I mean studies that compare the
4 relative benefits, risks and costs of a service to its
5 alternatives. By services I mean drugs, devices, diagnostic
6 procedures, surgical procedures, and even no care. In
7 comparative effectiveness studies, researchers can measure
8 outcomes such as mortality, patient satisfaction, quality of
9 life, symptom severity and costs.

10 I'd like to remind commissioners of our previous
11 work. We have discussed clinical and cost-effectiveness
12 analysis in our June 2005 and 2006 reports. We have not yet
13 made any recommendations about it. In June 2005 we laid the
14 groundwork, what it is, past history, and use by other
15 organizations. In June 2006, we looked at methodological
16 issues in conducting these studies and introduced some of
17 the issues about setting up the infrastructure to conduct
18 this type of research.

19 Comparative effectiveness can help fill in the gap
20 between what providers know and do not know. Increased
21 public and private spending does not seem to be producing
22 uniformly better outcomes. Providers and patients have

1 little information that shows what treatment works best and
2 for which population. Several recent examples that
3 demonstrate this, for example the older drug class that is
4 used to treat hypertension was subsequently found to work as
5 well as a new class of drugs.

6 Comparative information, along with information of
7 provider quality and cost, could promote greater
8 transparency and value in health care.

9 There is no one public or private entity whose
10 sole mission is to produce comparative effectiveness
11 research. Among federal entities, conducting this research
12 is fragmented. For example, and I'm just going to take you
13 through one but I'd be happy to take questions, AHRQ looks
14 at comparative clinical effectiveness under it's MMA
15 mandate. AHRQ also looks at clinical effectiveness, cost,
16 and cost-effectiveness in other work outside of its MMA
17 mandate.

18 Comparative effectiveness is under produced by the
19 private sector. Some researchers contend that it is a
20 public good. A public good has two important properties.
21 It is non-excludable and it is non-rival. Non-excludable
22 means that it is difficult to prevent any person from using

1 the service free of charge. Once comparative information is
2 publicly available it is difficult to stop other groups from
3 using the information free of charge. Non-rival means that
4 one person's use of the goods does not, in any way, detract
5 from any other person's ability to use the same good in the
6 same quantity. One group's use of the information does not
7 detract from the use by other groups.

8 So private groups have less of an incentive to
9 sponsor work. And when they do, some researchers have
10 raised concerns that some studies are biased and that
11 research with negative results is not always published.

12 Comparative effectiveness could be used by several
13 audiences. Providers and patients could become more
14 informed and value conscious. Private and public payers
15 could use information to make better payment decisions.
16 Josh is going to talk more about its potential uses.
17 Ultimately, it could improve quality and safety. It may not
18 necessarily reduce health care spending if it increases
19 demand for services that are recommended but are under
20 provided but it may improve the value of health care
21 spending.

22 If commissioners want to move forward on this

1 issue, our contribution may be to give more insight into
2 what an entity that produces comparative effectiveness would
3 look like and the paper describes some alternatives. Here
4 are five options. An entity could be contained within an
5 existing federal agency, for example AHRQ. Or a new
6 executive branch agency could be created within, for
7 example, the Department of Health and Human Services.

8 Alternatively, a new independent agency that is
9 not within any one department could be created. For
10 example, like the SEC or the FTC or the FCC.

11 Another alternative is a public-private
12 partnership. Your briefing materials outlines three
13 different kinds of public-private partnerships that some
14 researchers have looked into. These public-private entities
15 can accept some private funding.

16 The one that some researchers have talked about is
17 called a Federally Funded Research and Development Center or
18 an FFRDC. FFRDCs are private not-for-profit organization
19 and they are operated by universities and corporations but
20 they are directly linked to a federal agency. For example,
21 the National Cancer Institute in Frederick is an FFRDC and
22 it is sponsored by NIH and it's administered by Science

1 Applications International Corporation and some other
2 organizations. FFRDCs typically help their mother federal
3 agency with scientific research and analysis.

4 The fifth option is to create one or more private-
5 sector entities. Your briefing goes through some of the
6 advantages and disadvantages of each of these five options.
7 Some stakeholders want an entity that is close to or within
8 the government, while others are concerned about too much
9 government involvement. Some suggest that creating a
10 commission along with the entity will provide for more
11 objectivity.

12 The type of entity and its funding will affect the
13 entity's level of independence from, on the one hand, the
14 federal government and, on the other hand, the private
15 sector. So you see how these are overlapping issues.

16 The paper also goes into options for financing a
17 center, voluntary or mandatory, public versus private. One
18 option is year-by-year federal appropriations. Another
19 option is mandatory federal funding from either the general
20 revenue or a trust fund derived from, for example, user
21 fees. On the one hand, an entity would have more
22 independence if it did not have to go through the annual

1 appropriations process. On the other hand, mandatory
2 funding might make it less accountable to those who fund it.

3 This slide lists some of the other issues to
4 consider if an entity were to be built. Peter will talk
5 more about some of these, for example to ensure transparency
6 of the process and that stakeholders understand how
7 information is being produced.

8 Before handing the presentation to Josh, again
9 commissioners, we are looking for your input. If you want
10 to move forward, our contribution may be to give insight
11 into the entity, the structure and its financing. We would
12 like to get your input. If enough consensus exists to move
13 forward with establishing an entity, we can discuss a draft
14 recommendation to articulate the principle.

15 At this point, I would again like to just briefly
16 introduce Peter Neumann and Josh Cohen. They are with the
17 Center for the Evaluation of Value and Risk at the New
18 England Medical Center. Both Peter and Josh have spent
19 many, many years thinking about how to and the role of
20 analyses that consider a service's value by weighing its
21 benefits, risks, and costs.

22 Josh.

1 DR. COHEN: Thank you, Nancy.

2 I will be describing two case studies conducted
3 for MedPAC by Tufts New England Medical Center illustrating
4 the use of comparative effectiveness analysis.

5 The first case study investigated the use of
6 erythropoietin or EPO to treat anemia and dialysis patients.
7 The second case study investigated the use of screening to
8 identify diabetes in asymptomatic individuals.

9 Turning first to the EPO case study, determining
10 the appropriate treatment level for EPO involves balancing a
11 series of often competing considerations. This slide lists
12 three of the major issues.

13 First, EPO alleviates anemia in dialysis patients,
14 improving quality of life. On the other hand, some studies
15 have suggested that aggressive use of EPO to achieve higher
16 hematocrit levels may increase mortality risk, as well as
17 the risk for other possible adverse events. Finally, as
18 with any pharmaceutical, greater use may involve greater
19 cost. Any of these factors, along with others, might play a
20 role in developing appropriate treatment guidelines for a
21 population of patients.

22 Addressing these factors involves synthesizing the

1 available data on the outcomes of interest. I will be
2 discussing two types of approaches: traditional evidence
3 review and comparative effectiveness analysis. Although any
4 particular review need not fit squarely into only one of
5 these boxes, it is useful to compare these two types of
6 approaches in terms of the types of information they produce
7 and hence the types of questions they can answer.

8 A traditional evidence review of EPO has two key
9 components. First, the review identifies the key outcomes.
10 In the case of EPO, such outcomes could include the
11 treatment's impact on quality of life and its impact on
12 mortality risk. Other clinical outcomes, such as the risk
13 of nonfatal cardiovascular events, might also be included.

14 For each outcome, a traditional evidence review
15 provides an assessment to the strength of the supporting
16 evidence. For example, a traditional evidence review of EPO
17 might report that the evidence for improvement in quality of
18 life is strongest at moderate increases in hematocrit but
19 that evidence for additional quality of life improvements is
20 less compelling as hematocrit levels are increased even
21 further.

22 The review might also conclude that evidence for

1 mortality effect is strongest only when EPO is used to
2 achieve relatively high hematocrit levels. The review might
3 conclude that the most promising hematocrit target range is
4 at an intermittent intermediate level where there is at
5 least modest evidence of an improvement in quality of life
6 and evidence of increased mortality risk remains limited.

7 While a systematic review provides a useful
8 synthesis of the available evidence for the purpose of
9 assessing which outcomes have been compellingly
10 demonstrated, it does not provide all of the information
11 needed by decision-makers. First, although decision makers
12 must understand the scientific strength of the evidence for
13 various effects, that information alone is insufficient to
14 weigh risks and benefits. In particular, a typical decision
15 maker also wants to understand both the probability and the
16 severity of various outcomes.

17 Second, some decision makers will also be
18 interested in the cost implications of the available
19 options, including the cost of the treatment under
20 consideration, as well as any downstream savings that the
21 treatment might accrue.

22 The Tufts-NEMC EPO case study illustrates how

1 comparative effectiveness analysis extends beyond the
2 questions typically asked in traditional evidence reviews.
3 This slide describes our approach.

4 The analysis starts with an assumed population
5 average EPO dose. We assume that a payer can craft policies
6 that would achieve this average, for example through the use
7 of appropriate guidelines or other levers that the payer can
8 use.

9 Using data from the U.S. Renal Data System, we
10 estimated the distribution of hematocrit levels associated
11 with this average dose. By describing the distribution of
12 hematocrit levels, we attempted to reflect the heterogeneity
13 in patient response to EPO treatment. Based on the results
14 of randomized clinical trials, we estimated the association
15 between hematocrit level and both the quality of life and
16 mortality.

17 Next, we expressed these clinical impacts in terms
18 of changes in quality adjusted life years or QALYs. The
19 QALY is a common metric used in hundreds of studies in the
20 health economics literature. While it does not replace
21 traditional impact measures such as mortality incidents, it
22 does provide a framework to compare disparate outcomes.

1 Finally, we kept track of costs associated with
2 procurement and administration of EPO. Note that we
3 compared all of these outcomes, the benefits, risks and
4 costs to a basic case comparator that assumes patients
5 received 5,000 units of EPO per week corresponding to a
6 population average hematocrit of 27 percent.

7 This slide shows our results. In each of the
8 graphs I will show you, the horizontal axis is the
9 population average EPO dose in thousands of units per week.
10 The vertical axis is an outcome.

11 Our analysis indicates that quality of life
12 increases gradually as average EPO dose increases, but that
13 improvement slows at higher EPO doses. We also concluded
14 that population average mortality risk climbs at an
15 increasing rate as EPO dose climbs. Converting each of
16 these effects to QALYs and netting them yields the result in
17 this third graph.

18 Incremental costs can be estimated from this
19 model, as well. Incremental costs and benefits can be
20 compared by computing the cost effectiveness ratio, which is
21 equal to the incremental cost divided by the incremental
22 benefits measured in QALYs. A lower cost effectiveness

1 ratio is most favorable because it implies that the
2 incremental benefits are achieved at a lower cost. For
3 example, an intervention that costs \$50,000 per QALY is
4 better value than an intervention that costs \$500,000 per
5 QALY.

6 This graph shows our preliminary results on how
7 the cost effectiveness ratio changes as the EPO dose
8 increases. Note that at higher EPO doses, the cost per
9 quality adjusted life year climbs quickly because quality of
10 life benefits begin to decline and mortality risks begin to
11 increase in our model. Keep in mind that we are still
12 working on these results and that the case study is
13 illustrative. Our report describes limitations to the
14 analysis and identifies key research that should be
15 conducted in order to develop a more useful policy model.

16 Importantly, the comparative effectiveness
17 analysis methodology helps identify which assumptions should
18 be further researched to reduce their uncertainty.
19 Sensitivity analysis and uncertainty analysis tells us not
20 only how uncertain each assumption is not also how much it
21 influences conclusions regarding the benefits, risks, and
22 costs of the interventions under considerations. We found

1 that assumptions regarding quality of life gains are
2 critical in this particular case. We also noted that there
3 is a need for development of a disease progression model
4 that accounts for heterogeneity in patient response to EPO
5 treatment.

6 The EPO case study shows how comparative
7 effectiveness analysis can provide useful information to a
8 range of decision makers. First, this type of analysis
9 helps payers to review their policies to see if the
10 interventions they are supporting are consistent with value.

11 Second, providers can use this type of analysis to
12 evaluate the net impact of alternative interventions.

13 Third, the analysis helps to identify those
14 sources of uncertainty that are important to resolve for the
15 purpose of identifying optimal interventions.

16 Finally, comparative effectiveness analysis can
17 take costs into account allowing estimation of cost
18 effectiveness. Alternatively, depending on the needs of the
19 user, costs can be omitted from the analysis and the
20 analysis still facilitates comparison of risks and benefits.

21 That's all I have to say about the EPO case study.
22 Now I'd like to turn to the diabetes screening case study.

1 Before describing the analysis available in the
2 literature, I want to briefly point out what interventions
3 are being used on the ground. The left column in this table
4 lists the criteria CMS uses to identify asymptomatic adults
5 for diabetes screening. The right column lists the types of
6 treatments identified patients may receive.

7 A limitation to the existing literature is that
8 the interventions they evaluate do not match up very well to
9 the list on the proceeding slide. Perhaps the last study
10 listed, conducted by Hoerger et al, comes closest in that it
11 compares universal screening to targeted screening of
12 hypertensive adults only. But even this study does not
13 evaluate many of the risk factor combinations used by CMS.
14 Nor do the treatments assumed by Hoerger et al match
15 treatments used in real populations.

16 The next issue to keep in mind is how different
17 studies model disease progression. The earliest analyses
18 essentially assume that outcomes depend on glycemic level.
19 These analyses assume glycemic levels influence the
20 progression of microvascular disease, including the
21 development of retinopathy, nephropathy and neuropathy.
22 These conditions, in turn, give rise to clinical outcomes

1 including blindness, end stage renal disease, and lower
2 extremity amputation. Finally, these conditions are assumed
3 to be the means by which diabetes causes mortality.

4 The Hoerger et al analysis, which is newer, relied
5 on more recently available data for its model. Hoerger et
6 al retained the microvascular disease process but assigned
7 it a lower level of importance than the previous analyses.
8 They added to the diabetes model the idea that hypertension
9 can give rise to morbidity and mortality by causing
10 cardiovascular disease and potentially mortality.

11 The comparative analysis results highlight the
12 importance of the modeling assumptions when estimating the
13 benefit of screening different age segments of the
14 population. This graph illustrates the relationship between
15 age at screening and the cost per QALY gained. Note that
16 the lower values are more favorable because they imply
17 benefits are achieved at a lower cost. There are two upward
18 sloping lines that suggest that young people are the most
19 efficient to screen. Those results are based on the two
20 earlier analyses conducted by CDC and Chen et al using the
21 model that took into account only microvascular disease.
22 The two downward sloping curves are based on results from

1 the Hoerger et al study. they imply it is most efficient to
2 screen older individuals. That result reflects the
3 inclusion of hypertension in the disease progression model.

4 The analyses we identified revealed the following:
5 first, at least based on the most recent analysis it appears
6 that screening more elderly populations for diabetes
7 produces greater benefits per dollar invested than does
8 screening of younger populations.

9 Second, this result depends strongly on what
10 disease progression model is used.

11 The diabetes screening case study also
12 demonstrates the importance of incorporating issues relevant
13 to stakeholders. Even if the available comparative
14 effectiveness analyses are technically sound, their value is
15 limited if they do not ask the right questions. In the case
16 of diabetes screening, it would be useful to evaluate the
17 impact of incorporating additional screening criteria, of
18 screening at a range of frequencies, and of using a range of
19 treatments for identified patients.

20 Thank you and I will now turn this over to Peter
21 Neumann.

22 DR. NEUMANN: Thank you, and good afternoon.

1 In my presentation I will briefly highlight the
2 activities that an organization producing comparative
3 effectiveness and cost effectiveness information for use by
4 CMS and possibly other payers would pursue and key analytic
5 and operational challenges it would likely face, expanding
6 upon some of the issues raised earlier by Nancy Ray.

7 Presumably the organization would conduct its own
8 comparative effectiveness research and/or award contracts
9 and grants to academic and other organizations to carry out
10 the research. Likely there be in-house staff expertise and
11 activities but some, or even much of the work would be
12 contracted out, as is the case with many existing federal
13 agencies and at international agencies such as the National
14 Institute for Health and Clinical Excellence, NICE, in the
15 United Kingdom.

16 Typically, such research involves synthesizing
17 existing data rather than conducting primary data
18 collection. However, at times the organization might
19 recommend and/or carry out primary data collection on a
20 topic of sufficient importance where there is considerable
21 uncertainty.

22 A central task for the agency would involve

1 setting research priorities and establishing criteria for
2 priority setting. The organization could also sponsor
3 conferences or scientific symposia on a host of issues
4 surrounding the use of comparative and cost effectiveness
5 analysis, including methodological questions as well as
6 ethical, political, and legal issues.

7 Next we consider several placement options for the
8 organization. First, within CMS. A greater role for CMS
9 might seem natural and obvious, given CMS's need to
10 determine what services to cover and pay for. However, as a
11 matter of principle, and to ensure independence, it may be
12 valuable to separate the function of the agency conducting
13 comparative effectiveness analysis from the functions of the
14 agency paying for health care. Notably, when CMS attempted
15 in the past to use cost effectiveness analysis, it ran into
16 stiff political opposition from many quarters.

17 Within AHRQ. As the lead federal agency for
18 health services research, the Agency for Healthcare Research
19 and Quality is a natural candidate to serve as the
20 organization conducting comparative effectiveness research.
21 Moreover, AHRQ has been overseeing comparative effectiveness
22 research through authority stemming from the Medicare

1 Modernization Act. Some observers have argued that placing
2 comparative effectiveness activities outside of AHRQ, and
3 indeed perhaps outside of HHS, would have advantages in
4 terms of institutional independence and insulation from the
5 annual Congressional appropriations process.

6 Another option is placement within another
7 existing agency such as the National Institute of Health,
8 which has sponsored selected research in the area in the
9 past.

10 Yet another consideration would be to add
11 comparative effectiveness research to the FDA's mission. A
12 potential downside is that comparative effectiveness
13 research ideally should focus not simply on drug therapies
14 and devices but instead cover a broad perspective outside of
15 FDA's traditional mission, including medical procedures,
16 diagnostics, care management, and public health programs.

17 Another option would involve creation of a new
18 government agency along the lines of NICE in the UK with a
19 dedicated mission to provide advice for Medicare and other
20 payers on comparative effectiveness research.

21 A final series of options would be to establish
22 some form of quasi-public agency. The agency could operate

1 as an independent single agency with support from various
2 public and private sources. The information and advice from
3 the entity or entities could be distributed as a public good
4 to help target resources to improve health. Medicare and
5 its private contractors could be free to use the
6 recommendations as they see fit.

7 As Nancy Ray noted, variations on this theme are
8 also possible, including an independent commission,
9 Federally Funded Research and Development Centers,
10 Congressionally chartered nonprofits or placement in the
11 private sector.

12 Next, let me turn to some important issues of
13 governance, oversight, and funding. Ensuring the
14 independence of the organization will obviously be critical.
15 One way to help insulate the organization is to separate
16 analysts from the decision makers. That is, maintaining
17 institutional independence between those conducting research
18 and those making reimbursement decisions. Various options
19 are possible. For example, AHRQ could establish Federally
20 Funded Research and Development Centers operated by a
21 university or other nonprofit with guidance from an external
22 board.

1 Maintaining independence for a quasi-public
2 institution will present some unique challenges. The
3 institution could, for example, have a board of directors
4 composed of diverse stakeholders, including government
5 officials, manufacturers, health care providers, academic
6 researchers, and patient representatives. Although
7 organizational separation of the decision maker and
8 assessment functions has the advantage of better insulating
9 the assessment process from political interests, it risks
10 diminishing the relevance of the analytic process.

11 Finally, how the organization is funded, by whom
12 and under what conditions, are questions of critical
13 importance. Options include direct appropriations from
14 Congress, mandatory federal funding, private sector either
15 voluntary funds or user fees, or combinations of government
16 and private funding.

17 Finally, let me mention a number of key analytic
18 and process issues that an organization would confront. A
19 central issue pertains to the rigor and validity of the
20 methods used for comparative effectiveness research. The
21 organization can play a constructive role in improving
22 standards and consistency to the field.

1 A second issue pertains to the perspective assumed
2 in an analysis. In terms of a cost effectiveness analysis,
3 for example, an intervention may be cost effective from
4 societal perspective but not from the perspective of any
5 individual payer. An organization might recommend that
6 analyses be conducted from both a societal perspective, for
7 example because Medicare is a social program funded in part
8 by general revenues, and from a Medicare perspective in
9 order to inform questions about beneficiary health and
10 program outlays.

11 Critics of comparative effectiveness analysis have
12 sometimes worried that published analyses will reflect the
13 hidden biases of investigators and their sponsors. Ensuring
14 that analysts work independently and objectively will be
15 critical issues. It will be important for the organization
16 to have a transparent process. NICE in the UK, for example,
17 has worked to publish its appraisals on its website.
18 Moreover, meetings are held with various stakeholder groups.

19 Ensuring their legitimacy and successful
20 functioning of the organization will also depend in part in
21 having a process whereby decisions are subject to revision
22 and appeal. Identifying research priorities is another

1 important area. Researchers have developed various methods
2 for priority setting for a value to research over the years,
3 including methods for explicitly quantifying the gains from
4 research. Other researchers have attempted to explicitly
5 quantify the impact of research itself.

6 Finally, it will be important for the organization
7 not only to examine new services and technologies but to re-
8 examine a services comparative and cost-effectiveness
9 analysis over time.

10 Thank you very much, and we look forward to your
11 questions.

12 DR. REISCHAUER: When Academy Health was doing a
13 survey of this area, what should be done, they interviewed a
14 number of the people around this table, including myself.
15 One of the questions they asked was to do this right what
16 kind of money are we talking about?

17 I had a flip answer to that, which I won't tell
18 you what it was, but I'd be sort of interested --
19 admittedly, it takes some time to ramp up an effort like
20 this. And presumably there is a stock of areas where we
21 would want to learn more and whittle down that stock. But
22 let's say five years out, what kind of resources would we be

1 talking about, just rough guesstimate?

2 DR. NEUMANN: Well, I knew the first question
3 would be a hard one and you asked a question obviously of
4 great importance. It's hard to know how to answer, frankly.
5 People do talk about numbers in the tens of millions. Some
6 people have thrown out numbers in the billions for this. I
7 think people have thrown out even how do you get your head
8 around this question. Even a very small percentage of total
9 health care spending would still be a pretty big number.
10 Some kind of reasonable fraction of NIH spending would still
11 be a pretty big number.

12 I think if you look at what NICE spends in the UK
13 as some kind of benchmark, for all of its challenges of
14 doing benchmarks, it's probably 10 million pounds or
15 somebody may have a better number than that, but I think
16 it's in that range, rather than billions of pounds.

17 I would think a serious effort in this area should
18 first require some analysis to try to figure out priorities.
19 Are we talking about primary data collection or syntheses?
20 I think syntheses, which is what AHRQ is doing now, is
21 probably tens of millions. I think really doing primary
22 data collection in terms of new trials, you're probably

1 talking hundreds of millions and higher.

2 DR. CROSSON: Essentially the same question but
3 just another wrinkle on it because I've heard the same
4 thing. I've heard numbers from \$20 million or \$30 million
5 to focus on those key spending issues which seem to be most
6 out-of-control to \$2 billion in order to do something wildly
7 comprehensive.

8 But one question I had was you mentioned early on
9 that there could be two different models. One would be to
10 build an entity that fundamentally did all of this itself,
11 did all of the primary research and analysis, versus
12 contracting out. Now it would seem to me that there are
13 pros and cost to those two models I can think of.

14 The question is do you have an intuitive sense of
15 which one of them would be the most efficient?

16 DR. REISCHAUER: Coming from an entity that might
17 expect to get these contracts.

18 DR. NEUMANN: Putting aside any kind of self-
19 interest, I think quickly you probably will start to think
20 about contracting out to people who are experts in the
21 field, in particular clinical areas and perhaps
22 methodological areas, with some in-house expertise, as well.

1 My sense is that is the way NICE has done it in
2 the UK and probably the way AHRQ and other federal agencies
3 have done it that conduct research. There is certainly some
4 intramural capabilities but a lot of it is contracted out.

5 DR. BORMAN: A couple of questions and thoughts.
6 One would be -- and we've talked about it before here -- is
7 the potential for tapping into existing databases. I think
8 that links up to your point about synthesis versus primary
9 data collection, and it also potentially speaks to the
10 notion of maybe the first function is a clearinghouse
11 function, just really to identify where things exist rather
12 than necessarily go much further down that road in some very
13 bureaucratic kind of fashion. Because certainly there are
14 enormous databases out there, some public, some private, as
15 the chapter and your report have pointed out. I would think
16 that that would be much more effective.

17 Do you have any sense of whether there could be
18 value in that sort of initial clearinghouse-ish kind of
19 function that you could break this into some more digestible
20 chunks by types of resources consumed or types of services
21 delivered? Because certainly the kinds of measures you use,
22 the modeling you use, and the volume of various services is

1 going to vary a whole bunch between certain kinds of very
2 low volume but very complex procedure-based things and
3 things that are very high volume but perhaps each individual
4 item like -- just to pull one out of the air -- blood
5 pressure check, is a much more finite, small kind of thing.

6 I ask that because it seems to me that, in
7 addition to the independence that you identified as a key
8 factor, that acceptance is another hugely key factor here.
9 There will have to be some willing transfer of
10 participation, trust, whatever, confidence in this. And the
11 confidence could be in a process rather than an entity. I
12 think that goes along with it not being one primary care
13 source. But if you say okay, we need confidence in a
14 process, certainly from the physician side I see that we use
15 type of service in categorizing so many of our analyses. It
16 just begs the question of would that be a way to break this
17 into digestible chunks early on? Maybe later you'd come to
18 combinations that you might have approach it in that way.

19 And then finally, just a comment about using QALYs
20 and how you then operationalize from some of that. I would
21 guess that part of the sensitivity analysis almost every
22 time is going to have to get down to the actual assignment

1 by some test group of the value. Because when you just sort
2 of survey people, well, is this is a good thing? Would you
3 like to have this benefit, that benefit, subsidize this and
4 not subsidize that, everybody wants everything. It's human
5 nature. And particularly if it's technology driven, we
6 really want it.

7 But when you say well, I'm willing to pay \$10,
8 \$25, \$50 or to have this instead of this, that kind of very
9 soft sensitivity analysis starts to have a lot of real
10 meaning in terms of what really is quality. And having
11 valid quality of life scales for broad categories seems real
12 difficult.

13 So if you could comment a little bit like say
14 about the part about acceptance and clearinghouses and
15 synthesis, and then a little bit about how you get to that
16 end point of sensitivity. What are folks paying the bill
17 really willing to trade? That may be different on the
18 beneficiary side, the plan side, the physician side,
19 whatever.

20 DR. NEUMANN: Many good questions. I guess I
21 would start with research priorities. I do think there
22 would be value in engaging in an analytic exercise to try to

1 figure out where to start. And exercises that do that tend
2 to look at areas of big spending, areas of big health
3 effects, areas where research can make a difference. And
4 that often is areas of big clinical uncertainty. And
5 wherever those analyses lead you, I think, would be good
6 places to start.

7 I do think tapping into data bases, to get to your
8 point, would be valuable. There are many now big
9 comprehensive databases on the private side. And now with
10 Medicare linking databases and outpatient and drug data
11 linked with other traditional inpatient data, I think
12 there's a lot of value to doing that and opportunities to do
13 research where they didn't exist before.

14 Challenges to be sure analytically, and maybe in
15 other ways.

16 I do agree with you that part of the challenge
17 here is not simply one of methods and analysis but process
18 and trust and political will. If you get a good process in
19 place that people buy into, I agree with you that I think
20 good things flow from that. And that's part of the real
21 challenge here.

22 Finally, you mention QALYs, which is an area of

1 great activity in terms of research and great challenges and
2 controversy. We know, for example, there's a lot of
3 heterogeneity in the population about preferences for
4 different things.

5 I think part of the answer is to force people to
6 think about trade-offs and not just ask them, as you say, do
7 you want these things? And how much do you want them? I
8 think you need to ask people about trade-offs and really try
9 to get people to think hard about what they're giving up and
10 what they're getting.

11 But I think that would be an area that the Agency
12 would have to think hard about and maybe it could sponsor
13 some research and also serve as a forum to do good research.

14 DR. BORMAN: Just a quick comment. In my thinking
15 about this, it seems to beg for a pilot, a trial, something
16 we can all agree on that could potentially be an important
17 question that we can, as crispy as any of these can be
18 framed, frame it and go out there and see what are the
19 extant databases that might help and look at a process and
20 starting to outline what might be a process that is
21 reproducible, test it to see if it has acceptance, and start
22 and just see where the glitches are. Because just this very

1 broad brush of yes, let's hop into this area, it sounds
2 great, it's motherhood, it's apple pie, it's the flag,
3 sounds pretty expensive.

4 And so to me it just seems to beg for some kind of
5 pilot.

6 MR. BERTKO: Karen has kind of asked at least got
7 half of my question but I'll start by expressing certainly
8 strong support from having MedPAC consider what, Peter, you
9 and Josh have done. I think just the knowledge of this and
10 the diabetes screening example is a great one. Whether or
11 not the payment issue comes up, whether it should be
12 encouraged, enforced, et cetera, seems important.

13 My question is back to priorities here. You guys
14 have clearly worked in this area for a number of years,
15 thought about it a lot. It's kind of a double question.

16 First of all, would you aim at future treatments,
17 services, devices, drugs or current ones more or less? And
18 then I'll put you on the spot and say since you've thought
19 about it, what would be the top five areas you would start
20 by looking at, if you were to throw your five into the hat
21 with a number of other experts?

22 DR. NEUMANN: Again, I'll just quality it by

1 saying that would be a great piece of analysis to do for
2 next year's meeting.

3 One thing I would say, I don't think this should
4 just focus on drugs. I do think this is a broader question
5 that should focus on services and treatments of conditions
6 and diseases.

7 But if we're talking about Medicare, we might
8 start with the biggest burden of disease, and we can look
9 them up, but it's cardiovascular disease and cancer and
10 diabetes maybe. It depends on how you define diseases.
11 Mental health might fall in. There are probably some other
12 ones that would be important.

13 Burden of disease certainly, I think, is a place
14 to start. But just because something has a burden of
15 disease doesn't mean that's where the money would be best
16 spent. So I think then you have to move to analyses of
17 treatments and where we could best spend research to reduce
18 uncertainty and so forth.

19 There may be other areas, injury and falls and
20 maybe other areas, that are not even traditional medicine
21 that might be looked at, as well.

22 DR. MILSTEIN: Thinking about the range of what

1 this might cost, I think the high end, the annual budget,
2 was in the billions. So as I run the math, a tenth of a
3 percent of current U.S. spending would be about \$2 billion a
4 year. And that was about equal to the high end of the
5 range.

6 One-tenth of 1 percent, some people might consider
7 it expensive. I'd consider it a bargain. And particularly
8 when viewed against the cost of current policy, which is
9 completely uninformed by evidence, largely uninformed -- not
10 completely -- largely uninformed by evidence of comparative
11 effectiveness.

12 So I think \$2 billion, and Medicare's prorated
13 share would be about a third of that, would I think be a
14 real bargain.

15 I'm going to, Peter if you don't mind, put you on
16 the spot and ask you the following question. Because I
17 realize that even though \$2 billion is a very small
18 percentage of current U.S. spending, it's still a lot of
19 money. And where would it come from? So this is a variant
20 of a question I asked you last year, but I'll ask it again.

21 I'm going to give you two different scenarios this
22 time to make the question a little bit tougher. If tomorrow

1 we were to take available evidence on comparative
2 effectiveness and change Medicare policy in ways that I
3 won't -- we've talked about a number of pathways -- but
4 change Medicare policy until such point that in any
5 situation in which -- such that wherever we face treatment
6 alternatives we always picked the most cost effective
7 treatment alternative subject to the rule that we would
8 never ask a patient to accept a lower quality of life. So
9 subject to that.

10 If we were to do that tomorrow, just with the
11 current available evidence, order of magnitude by what
12 percent might American health care spending go down?

13 And then let me ask the hard question. Because I
14 have to know what I'm getting for my \$2 billion.

15 Now here's the hard question. Now imagine that we
16 had the foresight to invest that \$2 billion a year for the
17 next 10 years. And then take a wild guess at the question,
18 10 years from now, after I've substantially built up by
19 evidence, and let's say where I initially bet my money was
20 exactly in the areas that you just suggested we invest.

21 Order of magnitude, a wild guesstimate, by what
22 percentage might American health care spending be reduced?

1 Again, if we were to shift 90 percent of treatment share
2 toward those treatments that were cost effective but we
3 never, in any way, incentivized or asked a beneficiary or a
4 provider to ever pick a treatment that involved lower
5 predicted or likely quality of life for a beneficiary?

6 MR. HACKBARTH: We'll give you 30 seconds to do
7 your calculations, 15 seconds per question.

8 DR. MILSTEIN: I want to say that, to be fair, I
9 did give Peter fair warning at the lunch break.

10 DR. REISCHAUER: Can I just ask Arnie, to see if I
11 understand what you're saying? What you appear to be saying
12 is that you should never refuse somebody a benefit that
13 increases, however marginally, quality of life no matter
14 what the cost?

15 DR. MILSTEIN: Yes. I'm handicapping this.

16 DR. REISCHAUER: No, but then they're going to
17 give you a positive number. They're not going to give you a
18 negative number.

19 DR. MILSTEIN: Let's give him a chance to answer.

20 DR. NEUMANN: Last year I unsuccessfully tried to
21 dance around this and I'll probably unsuccessfully try to do
22 this again.

1 I said something like part of this is a political
2 will question, of course, especially when you get into the
3 things that are marginally better but more costly.

4 But if we were to try to take the other piece, if
5 I understand you, which is just try to get out the waste,
6 the ineffective portion with good comparative effectiveness
7 research that sheds light on things are just not effective.
8 And we would presume that spending \$2 billion or some number
9 would shed light on a lot of things that are just not
10 effective and we're doing them now. And how much that would
11 be, people have speculated. I've heard numbers, 10 percent,
12 25 percent of all of what we do now, and maybe even higher,
13 is sort of waste if we define waste in that way. That
14 there's no evidence that it really works.

15 So I really don't have any empirical number to
16 give you, other than it's probably pretty big, maybe 10
17 percent or 25 percent is waste.

18 I do think it's very, very hard, even with good
19 comparative effectiveness research, to define it well and
20 say there it is and we're going to cut it out because
21 medicine is often in the gray area and so forth.

22 So those numbers are out there. And I guess those

1 are the best numbers that I would just put out there, as
2 well.

3 DR. MILSTEIN: Thank you. I would just say that
4 even if it's half of the 20 percent, it's a massive multiple
5 of the tenth of a percent we would spend.

6 MR. DURENBERGER: By my question I think one of
7 the things I'm trying to get straight in my head is whether
8 or not what we're up to here is promoting the creation of a
9 new entity or we're trying to get it clear in our heads the
10 role of comparative and cost effectiveness and how best to
11 move that into some kind of a mainstream. And I'm hoping
12 it's the latter rather than the former, that the issue of
13 the entity -- regardless of what it might cost -- is a
14 secondary issue to understanding what are the opportunities,
15 what do we know currently about comparative effectiveness.

16 In order to get to that, let me also say that I
17 know little about the subject. But I admire people who do.
18 I think it was like six years ago, Peter wrote his first
19 book on this subject as I recall and asked me to write a
20 little blurb on the back. And I did, not knowing what I was
21 doing, not going that I would be here talking to him here.
22 But I just want to say how much I admire Peter. I don't

1 know Josh well. I just met him for the first time, I guess,
2 today. So anything I may ask is a reflection of how much I
3 know you already know.

4 But when I think about this, I'm thinking about it
5 in the context of just the way Nancy expressed it. We're up
6 to the business of value, the comparative effectiveness
7 analysis compared to the value of drugs, devices,
8 diagnostic, surgical procedures, medical services, and so
9 forth and so on. It's a value question.

10 So when I start with that, I start with 35 years
11 of experience reading Jack Wennberg's data about variation
12 across the country. And I say there's no question about the
13 fact that there are vast variations in value and how we
14 match up health care against specific illnesses. We get a
15 lot of that from that kind of research. So we know it
16 exists. We know what the problem is. This committee has
17 spoken to it many, many times.

18 Starting somewhere about 1987, I remember getting
19 very interested in this subject. And by 1989 a group of us
20 had created something called the AHCPR. And by 1995 or
21 something like that, when some Republicans didn't think it
22 was a good idea, tried to kill it.

1 The same group of people came to the support of
2 then John Eisenberg and a lot of people to re-create what is
3 now AHRQ. Even though I know some of the early examples of
4 lower back pain and things like that, it's always been my
5 expectation that having made the initial investment in that
6 agency, because we couldn't make it in NIH. NIH was the
7 logical place for it but they didn't want the job. So we
8 made it in AHRQ.

9 AHRQ has been taking advantage, in one way or
10 another, of the fact that across America there are places
11 where you can go find value. And some of that will be in
12 practice and some of the people are here in this room.
13 Others will be in large databases maintained by some of
14 those practices, maintained by UnitedHealth Group, which
15 seems to do a lot of this kind of work.

16 In my own community the Institute for Clinical
17 Systems Improvement has been doing something like this,
18 below the radar, for 14 years. It's probably a model in the
19 country. I'm only giving you that not to credential my
20 minuscule knowledge, but to lay the groundwork for the
21 question which relates to how best, in a country like this
22 as opposed to Great Britain -- because we are not Great

1 Britain and we never will be -- how best in a country like
2 this do we raise the value of comparative effectiveness and
3 all of the related research activity that has to go into
4 that?

5 Is there not a better way, whether it's the
6 Medicare Advantage program or it's other programs that we
7 currently are funding in this country, is there not a better
8 way in which to develop the capacity for third-party payers,
9 before we get the individual third-party payers, to help
10 individuals make, and doctors and patients, make the
11 decisions they need to make? And are there examples around
12 this country where that does work?

13 I use the Institute for Clinical Systems
14 Improvement as an example of it. For 14 years they've
15 mainly been developing the guidelines, training the doctors
16 into it, beginning the process of technology assessment,
17 other things that they do. Now they're beginning to move
18 into things like setting up criteria for the use of
19 diagnostics.

20 And again, this may all be embryonic and so forth,
21 but this sort of thing does happen and is more likely, it
22 seems to me, to take place when it is in a community in

1 which there is a practice culture that already values value,
2 if you follow me.

3 So again, I'm just trying to think about how do we
4 get the job done. Coming to Washington, building a new
5 building, blah, blah, blah, blah, blah, whatever billion
6 dollars it is, is not a place I would start. I can tell you
7 that.

8 In Washington we do have a place that is financing
9 this kind of activity all around the country. It's called
10 AHRQ. It doesn't have enough money. It's been barred by
11 some of the language in the Medicare Modernization Act from
12 spending more than X number of dollars. But it's there.

13 So I'm simply suggesting and trying to get your
14 reaction to the fact that -- and it may be one of these
15 options that's in here -- that a very important federal role
16 -- maybe it's a near-term role rather than a long-term role
17 -- is the kind of activity that an AHRQ, properly financed,
18 has been asked to engage in. And to engage -- whether it's
19 the Kaiser Permanentes or it's the Institute for Clinical
20 Systems Improvement, wherever, to engage people who are
21 already out there in the provider community or related to
22 the provider community, to try to get this task of

1 comparative effectiveness accomplished.

2 Somewhere in there is a question.

3 DR. NEUMANN: First, thank you for your kind words
4 and for writing a blurb for my book.

5 [Laughter.]

6 DR. NEUMANN: As I think about this, I would agree
7 with you that I think part of this is a matter for regional
8 and maybe local efforts. You mentioned some, the Institute
9 for Clinical Improvement, and there's the Drug Effectiveness
10 Review Project which is run out of Oregon but it is an
11 alliance of many states and some nonprofits. There's Kaiser
12 and the Blues and Aetna, each of which has their own
13 technology assessment type capability. And I think it's
14 probably very healthy for there to be these kinds of local
15 efforts that are tapping into the community and value in the
16 way they're thinking about it.

17 And perhaps even value in the sense that there's
18 simply not one federal place where that's being done.

19 But I also think there probably is, at some point,
20 a threshold where this becomes an enterprise that's larger
21 than any one individual place can fund and handle.
22 Certainly if we're talking about \$2 billion or doing primary

1 data collection and clinical trials to try to figure out if
2 one service is better than another, it probably exceeds the
3 ability of a local effort to fund. And it's probably a
4 public good in the way that Nancy Ray described that needs
5 to come from the federal government.

6 I'm a huge fan of AHRQ and I think that what they
7 do with the evidence-based practice centers and the local
8 efforts is great. But it tends to be syntheses of existing
9 information, which again is fine. But I think if we're
10 really talking about an ambitious comparative effectiveness
11 initiative, it may be a much bigger effort that needs to be
12 thought about in a different way.

13 MR. HACKBARTH: Dave is, I think, addressing or
14 raising a question that I wanted to get to. I do this
15 little thought experiment in my head. We do have some good
16 things happening in pockets across the country. I try to
17 imagine the path by which, say over 10 years, those are
18 going to grow to the scale that's appropriate for the
19 problem that we're talking about.

20 And I just don't see how those little operations
21 funded in various ways, sponsored by local groups or
22 particular health plans, get to the scale that we're talking

1 about. I just don't see how it happens.

2 That's not to say that I think they ought to be
3 wiped out and that they're bad. But I'm more inclined to
4 approach the problem the way Arnie is framing it, which is
5 there is an enormous need and an enormous economic problem
6 that we face that we know is only going to get worse.

7 If you want different results than you're getting,
8 you probably have to not just tinker with what's happening
9 right now but have a fundamental change, a locus that can
10 support a much larger scale of operation. But also add
11 credibility to the process from a societal perspective that
12 these more isolated local plan-sponsored entities can never
13 bring. Whatever good they do, they're just not up to that
14 task.

15 When you frame it the way you do, do we really
16 need another building in Washington, I cringe. You're good
17 at that. You've done this before; right?

18 MR. DURENBERGER: I've had a lot of practice.

19 MR. HACKBARTH: It's easy to make this sound like
20 a really dangerous, threatening thing. I don't think
21 anybody would seriously argue that overnight we ought to say
22 we're going to spend \$2 billion in the next year, and let's

1 start on the building right away. You're going to ramp up.
2 And you need to think about how to ramp up in an intelligent
3 way that continually adds credibility to the developing
4 entity. You need a plan. You need a strategy to get there.

5 But I, for one, think the problem is huge and
6 boldness is required, not timidity. At the same time,
7 caution in how you ramp up and get there. I think this is a
8 societal issue, a public good that deserve public funding,
9 and a forum where we can have standardization of methods to
10 give added credibility to the results, and a forum as in the
11 case of NICE where people can come and take their best shots
12 at it. We can have an organized public discussion about the
13 quality of the analysis.

14 I just don't see how you get there with this
15 fragmented approach that we currently have.

16 MR. DURENBERGER: Glenn, so I understand my own
17 question and your reaction to it better then, let me ask you
18 a question. Is it your notion, as you look at this, that
19 somehow or other if we were to persuade the Congress to make
20 the investment, that you start with the work, the research
21 work and the development first before we go to the business
22 of requiring that third-party payers must...

1 MR. HACKBARTH: Absolutely. I haven't thought
2 through that strategic series of steps by which you get from
3 where we are to where we need to be. So I don't pretend to
4 have that plan. But I think you need to think that through.
5 And I wouldn't start with the tacks as the first step. I
6 would do some other things first.

7 DR. REISCHAUER: Can I just pile on? Having the
8 group in Minneapolis, the Blues, Kaiser doing this has to be
9 duplicative. There are certain things which maybe have a
10 local component. But if we're dealing with human biology
11 and the application of a piece of technology like a
12 defibrillator that can't vary across the country or across
13 the world really.

14 I would envision, in the long run, this really
15 being something where the developed nations of the world
16 coordinate their efforts and their data to try and inform
17 mankind on what is most efficient way to produce good
18 health.

19 MR. DURENBERGER: Whenever it's a defibrillator or
20 whatever, the way in which it is deployed does vary across
21 the country. Sometimes that variance is not good.
22 Sometimes that variance is very good because it's in the

1 practice of medicine and it's in the way in which technology
2 is deployed in medicine and decisions are made that you
3 begin to create what you're looking for in terms of an
4 advance in medical science.

5 Part of my problem with whatever I call it, the
6 building in Washington, is that that advance does not get
7 adapted very well. If it occurs in Montana or it occurs
8 someplace else, it will take a long time for that sort of
9 thing to get adapted. You just made the argument. If you
10 have to run everything through our local NICE or our local
11 whatever it is.

12 MR. HACKBARTH: You're touching on what I think is
13 a critical point. I apologize for going on here, but these
14 are big issues. I don't think of this as a payment entity.
15 And Peter touched on this in his comments. This entity is
16 not making payment decisions, either coverage-type decisions
17 or how much to pay for individual units.

18 In our system, multi-payers, that would continue
19 to be a decentralized process. This is an information
20 agency to help guide rational decision making. Then payers
21 go off and decide for themselves the pace at which they want
22 to invite a new innovation into their program. Those

1 decisions would remain decentralized.

2 MS. HANSEN: Relative to looking at the process
3 that I think Karen brought up, and one of the components I
4 wondered if can be taken into account or addressed in some
5 ways, just the impact to different economic categories of
6 beneficiaries. And by that I mean more and more is also
7 shifting over to the beneficiary to have some share of
8 costs. I wonder if there is a way to say -- and this came
9 out, I think, in some of the Oregon public meetings that
10 came about -- to say that it's one thing to say this is the
11 most effective or the best solution to what this clinical
12 problem is. But perhaps it's a very expensive one.

13 On the other hand, there are other solutions,
14 let's just take migraine medication. Medicaid policies in
15 Oregon allows four pills a month. But this person may get
16 seven migraines a month. And so he's looking for not just
17 the past, which is the most expensive, but it could do I
18 have a next level of this so that I can get eight pills a
19 month for that amount of dollars, if that was the case?

20 So is there ever some thought about just the cost
21 equation as to what your money can buy besides the pure
22 rigor of the data in terms of the science?

1 DR. NEUMANN: I think typically you are separating
2 the analysis from the decision maker in the sense of, as was
3 earlier said, the analyst is putting the information out
4 there. This is the consequences on cost and on health of
5 using this drug or device or service. The decision maker is
6 then making the decisions typically about whether it's four
7 pills that they'll cover and pay for versus seven, or
8 whether it's third tier versus second tier.

9 So typically those tough decisions certainly don't
10 go away with this information. But it would not typically
11 be the analyst who is making the decision about four versus
12 seven pills or what the out-of-pocket spending should be,
13 what the copay should be.

14 But I do think this information can help inform
15 those type of decisions. If it seems that seven pills a
16 month are reasonably cost effective, for example, a payer
17 might say okay, we'll give you seven and not four and not
18 have you walk around with another couple of migraines each
19 month.

20 MS. HANSEN: I wasn't looking for the analyst to
21 make that kind of local decision, but the ability to array
22 the information for the degrees of effectiveness. So I'll

1 have at least a 70 percent chance that I'll get my migraine
2 reasonably addressed, rather than having a real stomping
3 one. Maybe I'd go for the one that's not going to best
4 level but reasonably good so that I get some mitigation of
5 the issue.

6 So you're saying that just whether or not the
7 analyst will help provide that kind of information for the
8 decision maker to make.

9 DR. NEUMANN: Right. And the analysis and
10 analytic techniques are certainly flexible enough to
11 accommodate lots of different ways to array the information.
12 It will depend on how good the data are to inform certain
13 types of questions. And ideally, the analyst is going to
14 bring information that the decision maker really wants. So
15 you can work together to figure out the kinds of information
16 that's needed.

17 MS. RAY: I just want to add, I think it's
18 important, when you think about moving forward with
19 comparative effectiveness, that the information that is
20 derived, that it can be translated so that patients can use
21 it, that medical professionals can use it, as well as
22 payers. I think, first and foremost, in your mailing

1 materials, is that it has the potential of informing
2 patients and providers to understand better what works and
3 what doesn't work.

4 MR. MULLER: Like Dave earlier, I've been
5 following the work of Weinberg for over 20 years. You
6 always see these estimates that 10 percent or 20 percent of
7 American health care could be redirected. And then I see
8 our struggles here to find a couple hundred million except
9 by payment freezes and realize that some people feel this
10 can all be done by Medicare Advantage. Some people feel it
11 just needs some more accountable health groups with some
12 maybe pre-payment factors. There's some evangelists out
13 there who believe that information technology can solve it
14 all. There's others who feel work redesign can do it all.
15 I often feel we need more investigation of that great
16 cartoon, and then a miracle appears, and figure out exactly
17 how that all works.

18 But that being said, I want to speak a little bit
19 to the constitutional structure of this because I do think,
20 whether one calls it a new building in Washington and so
21 forth, and I look at both examples of the NIH and the Howard
22 Hughes where I think there's been major advances in American

1 medicine through some kind of combination of intramural and
2 extramural expertise where we basically take advantage of
3 all the knowledge around the country, oftentimes in
4 universities but elsewhere, but also we have an intramural
5 set of professionals who work on these things to kind of
6 maintain it so you're not just contracting it all out.

7 I look at the kind of public goods which have ups
8 and does in the last few years like the Census Bureau and
9 the BLS and so forth, where you also try to maintain some
10 kind of public database for the long-term public good.

11 I think somewhere in looking at those things I
12 would say there may be a recommendation here where you
13 create something like the Census that can be maintained in a
14 longer term, but also take the advantage or the expertise
15 there is around the country by funding in a combination of
16 ways.

17 I think Nancy's paper and the comments of Josh and
18 Peter get to that, as well, where we have an effort that has
19 some permanency do it in terms of some cadre -- maybe not
20 immediately reflected in a building in Washington so we
21 don't get into those kind of concerns -- but obviously by
22 the fact that both the NIH and the Hughes is here and the

1 BLS is here and Census, it tells you something about the
2 centrality of where information is used for public purpose
3 in this country.

4 So I think something along those lines, since I
5 think one of the premises of what we talked about here today
6 is not just whether we go forth with this but how do you
7 constitute it.

8 I think one of the advantages it has is not just a
9 permanency, but I think somebody spoke earlier to concerns
10 that these things can get captured. I think one of the ways
11 of making it less likely to be captured is, in fact, to kind
12 of disaggregate it like that through a granting process the
13 way NIH does. NIH has a number of other features, such as
14 peer review and so forth, that allows for there to be less
15 capture. But having processes of peer review for allocating
16 these investigations, having extramural processes where you
17 take advantage of what the Blues are doing and what the
18 universities are doing and so forth, I think would be a good
19 way to go as well.

20 So the parts of the recommendation that we're
21 looking at, I like something like that that has permanency,
22 that takes advantage of the good things that are going on

1 inside the country.

2 Like Bob I agree, this is something that does lend
3 itself to science. And science, in some ways, unlike the
4 classic stuff about states as laboratories for the nation,
5 there's a right way to do things. You can basically say it
6 doesn't have to be reinvented 30 or 40 times, so making the
7 investments and getting it right.

8 I would also go back to the conversation we had
9 last year with Peter, let's just not do drugs. Peter
10 reiterated today, let's look at medical processes. But
11 also, whether you follow some of the stuff that Berwick and
12 others have done, I think we have to be looking at how one
13 actually executes and implements these processes, not just
14 the technology itself but basically understanding the work
15 of medicine.

16 Arnie speaks a lot to this and we try to do it a
17 lot through payment redesign.

18 But I still think one of the reasons we don't get
19 Wennberg's 10 percent to 25 percent is we don't have enough
20 understanding of how the work of medicine really goes forth.
21 I do think investing in that, as well, is a critical part in
22 this. There's a reason that doctors or nurses, et cetera,

1 don't implement the "right stuff." I think an awful lot of
2 it has to do with we don't understand enough about how they
3 really do their work. I do think we should do a lot more in
4 understanding the mechanisms of our work in medicine as well
5 as the technology.

6 So I think, again to reiterate, some kind of
7 quasi-public agency, leave how it's funded to later
8 discussions, that takes advantage of some of the learnings
9 we have from NIH and Howard Hughes, but also some of the
10 permanency that the Census has and relies on intramural as
11 well as extramural expertise, and also looks at not just the
12 technology of medicine but also looks at the work of
13 medicine, I think would be a good way for us to proceed.

14 DR. KANE: Actually, I'm following a little bit on
15 what Ralph was just saying at the end of his remarks, which
16 was I went to two different lectures about decision
17 analysis, one by Zeckhauser and one, I think, David Paltiel.
18 The topic was why don't people take decision sciences
19 seriously? Why don't they take rational thought and
20 implement it into their decision making?

21 I think that goes to Ralph's comment that we don't
22 really understand the process by which this kind of

1 information gets built in to medical decision making either
2 at the payer level or the provider level or the beneficiary
3 level.

4 I guess that's I think it would be really useful,
5 and I think it has to be in the American context, not the
6 British context, but it would be really useful to get a
7 sense of when there is some -- I guess my other concern,
8 before I get into what I think would be useful, is in public
9 health we're always coming up with what you should and
10 shouldn't do off these great cohort studies of longitudinal
11 analysis of health, and there's a lot of analysis of what
12 you should or shouldn't do. But it seems to change a lot
13 over time, so that people kind of get a little burned out
14 with what's the best thing to do for my diabetes today or my
15 diet tomorrow.

16 I worry a little bit that this kind of analysis
17 might be subject to some of the same problems that you are
18 making some -- there is some estimating and probabilities
19 and values and maybe even ethical assumptions made in coming
20 up with your conclusions, even if they have a high point, an
21 optimistic, and a base case and a pessimistic. And that
22 those are subject to change and make the whole analysis

1 change. And people kind of burn out after a while with that
2 and then turn off to all of that.

3 How do you make this stuff really useful, really
4 effective at the levels that we're talking about? And
5 enduring and not something that just sounds like a bunch of
6 ivory tower academics coming up with how many angels dance
7 on the head of a pin?

8 I don't think you are that, but I just have heard
9 from your own colleagues that it's very hard to make your
10 kind of results influence real decision making at the
11 different levels that we care about.

12 DR. NEUMANN: You raise a great question. I think
13 it's an ongoing challenge. Part of it, I think, is a
14 methodological one that we need to be more transparent and
15 clear and educate people about the value of the analyses.

16 I think there is a component here that maybe the
17 expectations are too high in the sense that the analyses are
18 thrown into the political arena and to systems with all
19 kinds of funny incentives to do things. And why people are
20 not rational, in part, is due to the nature of the way
21 decisions get made, given those incentives and given other
22 political challenges, ethical issues. You mentioned

1 behavioral realities. People don't stay on diets and
2 exercise and do things that they should do rationally and
3 all of that.

4 But I don't think that should cause us to stop the
5 analyses. I think we need to do a better job at them and
6 communicating them and making them more consistent and
7 independent and rigorous and everything else.

8 But I do think they will be thrown into the system
9 at the end of the day. And maybe part of it is getting the
10 incentives in a better place and fixing the system, too.

11 DR. CROSSON: I completely support this direction.

12 I'd also like to thank Peter for laying out the
13 issues so well. You probably don't know, but I did my
14 residency training at NEMC and you were comparatively
15 effective in producing me, so I'm willing to take what you
16 say very seriously.

17 [Laughter.]

18 DR. CROSSON: I'm basically following what Ralph
19 and Nancy have said, and that is that I could envision a
20 role for an entity, probably quasi-governmental but I'll get
21 back to that in a minute, that plays a role of first of all
22 leadership, coordination of funding, standardization of

1 process, and verification probably of results without
2 necessarily doing it all and without doing away with those
3 processes, those places and processes and collaboratives and
4 entities like we have in the Care Management Institute that
5 are already doing this.

6 I think our entities -- and we have more than one
7 -- do and would be very happy to collaborate in the process
8 where this work was parceled out and for which there was
9 more funding and complete transparency of results. And I
10 could see that working very well and building on existing
11 structures.

12 And I think the ramp up time in that kind of model
13 could be a lot faster than starting something from scratch.

14 In addition to that then, I think we should look
15 very hard again at AHRQ. AHRQ is not a quasi-governmental
16 agency but AHRQ was created, like the Phoenix, out of the
17 ashes of AHCPR because of the weaknesses of that model and
18 the retaliation by a small group of individuals.

19 I could imagine that AHRQ could be re-chartered in
20 a way, re-funded in a way, perhaps the base of funding
21 broadened to be a combination of private and public funding,
22 and made more secure than it is now, and act as that

1 coordinating entity.

2 I could imagine us coming out with some very
3 specific recommendations to that end.

4 MS. BURKE: I wanted to go back to a comment that
5 Dave made, but in part actually also support what Jay has
6 said.

7 Nancy did really a very terrific job of laying out
8 for us really two things in the paper as she describes it.
9 That is one, the reasons that this kind of information might
10 well be valuable to us and how it might be used; and then
11 secondly, how one might create a structure that, in fact,
12 would do it.

13 To Dave's point, however, I think perhaps the
14 value added by the Commission might well be in the first
15 case and less so in the second. And that is around the
16 discussion of confirming the value of an organized effort to
17 produce information like this, how it can contribute to a
18 decision making process going forward that has an enormously
19 positive impact on our delivery system and the need for
20 consistency and quality in that kind of information and some
21 of the issues that arise in the course of how one produces
22 it and where it comes from.

1 I worry a little bit about to what extent we can,
2 in fact, and I don't disagree with Jay's view in terms of
3 AHRQ. I, in fact, cochaired the Academy work on this issue
4 and the material that was ultimately, as a result of that,
5 that Bob commented on in terms of the reviews and
6 consultation that took place over a long period of time in
7 completing that report.

8 But I worry a little bit about us trying to come
9 up with a definitive answer on exactly what is the right
10 structure. One of the things that we found in the course of
11 the Academy's work was the complexity around that question
12 and the politics around that question. Dave's point and
13 Jay's point, as well, as to the reasons that we have AHRQ
14 are evidence of exactly how complicated those politics get
15 in terms of the financing, the structure, the authority, the
16 competing demands among different factions.

17 Which is not to suggest that the Commission might
18 not help contribute to that by raising some of the pros and
19 cons, as Nancy has very nicely done in the course of this
20 paper.

21 But I would caution, and it will be left to people
22 other than Ralph and I who won't be here in the course of

1 your work over the next year or so, that having folks in
2 from those agencies -- not that you both haven't done a
3 great job in talking with us today, and Nancy hasn't in the
4 course of doing her paper -- that there really are a lot of
5 issues around how you structure it, what the financing might
6 be, where the cooperation might come. Dave's point that NIH
7 fundamentally didn't want to do this, AHRQ has stretched
8 their necks in a variety of ways.

9 But again, it's not clear to me whether working
10 towards a single answer by the Commission is necessarily the
11 best value added by the Commission in the courts of its
12 work. The reasons why, the value of the work, the issues
13 that might be addressed in the course of how it's best
14 produced.

15 But again, I simply reflect the complexity of the
16 questions we engaged at the Academy level where we didn't
17 have the same kind of responsibilities of the Commission in
18 trying to sort that question out. So again, I don't
19 disagree where Jay gut but query whether or not, in the
20 course of the Commission's work, that's necessarily where
21 you want to work towards a single answer, this is the right
22 entity to do exactly this. But underscoring the reasons for

1 doing it and moving in that direction, I think might be
2 perhaps better done here.

3 MR. HACKBARTH: So what I hear you saying, Sheila,
4 is that you certainly think we're not ready to do that at
5 this point. And you even question whether we can devote
6 sufficient time and attention on an ongoing basis to come up
7 with a definitive answer and it ought to be left to others
8 to do so?

9 MS. BURKE: Simply in the following way: I mean, I
10 think there are enormous skills around the table and people
11 with lots of different expertise that could be brought to
12 that question. But I think in the normal course it would
13 involve bringing the NIH to talk with us about what their
14 view is on this topic. What is AHRQ's view on this topic?
15 What is the view of folks who would like to see an SEC
16 created?

17 It would seem to me that the staff has done
18 terrific work. But if, in fact, the Commission wanted to go
19 in that direction I think it is a fairly complicated
20 question. There are a lot of folks that can talk to us
21 about how you structure governmental entities or not, and
22 what the source of funding might be. There are a lot of

1 politics on the Hill because of the jurisdictional issues,
2 whose authority does it fall within? Does it, in fact, come
3 from appropriated funds? Does it come out of the
4 entitlement programs?

5 There are all those sort of questions that arise
6 in the course of creating federal entities that all of us
7 have gone through. The Commission may choose to do that.
8 But I think it would take more than simply a staff paper
9 doing pros and cons. It's a much deeper question with lots
10 of different issues that have to be addressed.

11 I do think there's an enormous amount to be done
12 even improving the reasons. We all agree, I think,
13 substantively on why you would want to have this kind of
14 information produced and how it can, in fact, benefit us
15 notwithstanding some of the issues that arise in terms of
16 the questions about the information and how applicable it is
17 and how practical it is that people put it into play on a
18 daily basis.

19 That, in and of itself, is a huge question and one
20 that I think we could easily address -- not easily address
21 but we certainly can address.

22 But the second question, I think, is a complicated

1 one. The Commission may choose to take it on. But I think
2 it is not something that, on the basis of a single staff
3 paper doing pros and cons. I think there are just huge
4 issues that have to be dealt with that you may choose to
5 take on. But I simply say, having gone through it with the
6 Academy, they are not simple questions and not easily dealt
7 with in a short period of time, I think. Although I think
8 Nancy did a terrific job of summarizing a lot of those
9 critical questions.

10 But I simply reflect it was a complicated issue
11 and not one where people came easily to an answer.

12 MR. HACKBARTH: Let me use Sheila's comment to
13 frame the question. We have before us a draft
14 recommendation. In fact, would you put that up, Nancy, so
15 everybody can see it.

16 I don't want to go through and modify language,
17 but I think we could all quickly identify phrases here that
18 we might want to modify based on the discussion, whether we
19 add modifiers to entity, whether it's produce comparative
20 information or sponsor and produce, whether the charge
21 includes -- as Ralph suggested, research as to how and why
22 information is applied. There are a lot of potential

1 modifications.

2 So I'm going to try to strip it down to a more
3 basic question, and that is how many commissioners would
4 like to see us attempt to craft a bold-faced recommendation
5 in this spirit if not with this exact language? As opposed
6 to how many would prefer Sheila's recommended course, which
7 is to talk about these issues, help frame the question, but
8 stop short of trying to make a bold-faced recommendation?

9 MS. BURKE: May I alter that just slightly in the
10 following way, Glenn? I do think it makes sense, my own
11 personal view, for the Commission to, in fact, come to a
12 recommendation that relates to the value and importance of
13 the development of this kind of information and its
14 application.

15 My hesitancy is around a recommendation specific
16 to the creation of an entity to do it.

17 So I would not at all oppose moving to a
18 recommendation around the subject matter. It is really this
19 that says establish an entity, which I could read in 20
20 different ways, including doing something different than
21 AHRQ.

22 So my concern is moving towards a recommendation

1 specifically related to the creation of an entity, not
2 towards underscoring the value and importance of the
3 development of this material and its application.

4 MR. HACKBARTH: That's helpful. So to coin a
5 phrase, there are two paths here.

6 [Laughter.]

7 MR. HACKBARTH: So let's focus on the concept, if
8 not the exact word of create an entity, a capability, as
9 one potential focus of a recommendation, develop a
10 capability.

11 And then the other would be a recommendation that
12 doesn't focus on entities or capabilities so much as the
13 importance of this area. It might be more broadly stated as
14 the importance of investing in the development of
15 comparative effectiveness information for the future.

16 I may be trying to make a false distinction here
17 but there's a group of people who want something concrete
18 and there are a group of people who think the topic is
19 important but I want to stop short of concrete.

20 DR. REISCHAUER: But not a building.

21 MR. HACKBARTH: But not a building, right.

22 So what I'm trying to do is get a sense of the

1 proportions on each side of that. Bill, do you have a way
2 to help me make the question clearer?

3 DR. SCANLON: I think part of the problem, and
4 maybe Sheila can correct me if I'm misinterpreting you, but
5 part of the problem is where we are in terms of something
6 concrete is not very concrete. And I worry about the idea
7 of, in some respects, passing the ball to the Congress with
8 telling them you go specify this.

9 The reality would be that they may come back the
10 way they did with pay for performance, and say now what do
11 you guys actually mean by this?

12 We should be endorsing the concept, which I think
13 is your second alternative, is something that I'm
14 comfortable with. And then the issue is should we be
15 willing to take on some of the kind of work that Sheila's
16 talking about over the next few years to be able to give the
17 Congress some more really concrete ideas, something that
18 they can then put their arms around.

19 I think right now we don't have that. As you
20 said, entity here can be interpreted many, many ways.

21 MR. HACKBARTH: Did you have a favored noun for
22 describing this, if it's not entity? Maybe capability is

1 sufficiently broad and generic.

2 MS. DePARLE: I feel like we've said that before.
3 I think we said something almost like that, or should
4 invest. My concern is, I've listened carefully to what
5 Sheila said and I'm sympathetic to it. But I think we run
6 the risk of being too subtle here. I don't think there's
7 any way to avoid the food fight that will have to occur.

8 MS. BURKE: That may be that case.

9 MS. DePARLE: So I'm ready to just go ahead and
10 plan a flag and say we should establish an entity.

11 MS. BURKE: So if you're asked the question, the
12 natural question that the Congress could well ask, is do you
13 mean AHRQ? Do you mean -- to Glenn's point, I don't
14 disagree with you that we've said there is value in this
15 information. I agree and I certainly support going beyond
16 that.

17 My question is are you prepared today to say what
18 the entity is? Because that's next question. The next
19 question is well, do you mean we need to do something other
20 than AHRQ? Do you mean you want to give this to NIH? Do
21 you mean that you want to create a separate freestanding
22 federal entity? Do you mean you want to support --

1 MS. DePARLE: I could answer that because I think
2 we've gotten the data.

3 MS. BURKE: My only point is is the Commission
4 prepared to answer that?

5 MS. DePARLE: I don't know about other people.

6 MS. BURKE: That's my question.

7 MS. DePARLE: I think we have today the most
8 comprehensive survey of the landscape that I've seen.

9 MS. BURKE: So what's the answer?

10 MS. DePARLE: I would say AHRQ, based on Peter's
11 analysis and everybody else's. That may not be where my
12 colleagues are but I think I could -- and I think we should
13 set forth all of the pros and cons.

14 MS. BURKE: I would say AHRQ, too. It wasn't
15 clear to me that that's where we had come in the course of
16 the discussion.

17 MR. HACKBARTH: A potential course is to have a
18 recommendation that's broad and say refers to an entity. To
19 some people, I think entity is important in terms of going a
20 step further than we've been before. But frankly
21 acknowledge in the text that we are not prepared to say a
22 particular entity. We can go through some of the obvious

1 candidates, including AHRQ, and lay out the pros and cons of
2 those. Which would be a little less presumptuous than to
3 say we know the right entity based on what we've done thus
4 far. But use of a term like entity would be, I think, an
5 important step forward from the general discussion we've had
6 to this point.

7 We need to move on. Obviously, this isn't a final
8 vote. I'm just trying to figure out what we need to do for
9 our next meeting and where we are, how divided we are on
10 this.

11 So let me, at the risk of gross
12 oversimplification, ask people who would like a
13 recommendation that calls for an entity with appropriate
14 modifying language? Could I just see those hands? If
15 somebody would take a note on this, it would be helpful for
16 me in following up with commissioners.

17 DR. KANE: Can you also say that it would focus on
18 Medicare program priorities as opposed to the general --
19 since it's MedPAC, should we sort of bring just the
20 priorities to be Medicare?

21 MR. HACKBARTH: Actually, that would not be my
22 preference but we can talk some more about that.

1 MR. HACKBARTH: Okay, the hands of people who
2 think we ought to stop short of that are Bill, Nick...

3 DR. WOLTER: I'm contemplating.

4 MR. HACKBARTH: Karen, Sheila.

5 MS. BURKE: Again, I don't want to prolong this,
6 but my only concern is if you say that, then the question
7 would be why didn't you say AHRQ? I worry that saying that
8 in a vague way will undercut those of us who arguably think
9 it ought to be AHRQ if you're going to specify. I worry in
10 the absence of a specificity, someone will presume that that
11 is what you didn't do. That concerns me.

12 DR. REISCHAUER: Wouldn't the text in all of this
13 describe the pros and cons?

14 I actually am not an AHRQ fan. I'm a public-
15 private entity. And I don't think there's any way a
16 government agency can do what I think has to be done.

17 MS. BURKE: But just to complicate it further, in
18 the course of talking about AHRQ, one of the questions was
19 whether AHRQ took responsibility of creating an opportunity
20 for a public-private partnership outside of AHRQ, that they
21 were the place to essentially do one of these FFRDCs.

22 That, in fact, the thought of many of us, in the

1 course of the earlier conversation, was to do exactly that
2 for that exact reason, that it ought not happen in AHRQ,
3 can't happen in AHRQ as it's currently constructed, but AHRQ
4 ought to be the place were it, in fact, occurs.

5 I don't disagree with you at all.

6 MR. HACKBARTH: There are lots of further
7 important issues on this, and we need to cut it off right
8 now.

9 I'd just like to address a comment to the
10 audience. I want to make clear the purpose of this show of
11 hands was not to take a definitive vote on the question. It
12 was really to help guide me and the staff on what to do
13 between this meeting and the next meeting.

14 So I would urge that people not run off and report
15 this as MedPAC voted to do such and such. That's not what
16 it was. We're short of that. But with this guidance, this
17 information, we can now go back to commissioners between
18 meetings and try and flesh out these ideas and find a way to
19 common ground, I hope.

20 Thank you, Josh and Peter. As always, excellent
21 work. We may be seeing you again at some point in the not-
22 too-distant future.

1 Good work, Nancy. Thank you for your help on
2 this.

3 We are going to dramatically switch gears here and
4 move from grand questions of the broad health care system
5 and its future to talking about physician practice expense.

6 We are running behind, and I apologize for that.
7 I didn't want to cut that last discussion short.

8 Next up is practice expense, and I'm hoping that I
9 will be a better leader and lead us through this more
10 efficiently. So with that inspirational comment to start
11 you off, you're up.

12 MS. RAY: Last fall CMS proposed major changes to
13 its method for calculating practice expense payments. In
14 its final rule, CMS adopted these changes. I'm going to
15 take you through the impact of these changes and Ariel will
16 talk to you about one of our concerns.

17 Just a little background to frame this topic.
18 This work fits into our broad agenda to examine physician
19 payment issues. In particular, the accuracy of payments.
20 Recall that in our March 2006 report we made a series of
21 recommendations to improve CMS's process for reviewing work
22 RVUs. These recommendations address the concern about the

1 mispricing of services in the physician fee schedule. The
2 Commission and others have argued that accurate pricing may
3 be leading to increased volume for certain types of
4 services.

5 Inaccurate pricing is also an issue on the
6 practice expense side. In our June 2006 report, we raised
7 concerns about the age of the data CMS uses to calculate
8 practice expense payments and some of the assumptions CMS
9 uses to estimate the practice costs of imaging services.

10 So what are practice expenses? Just a brief
11 reminder, practice expense payments pay for the expense of
12 operating a practice. Direct practice expense payments
13 cover the cost of non-physician clinical labor, medical
14 equipment, and medical supplies. Indirect practice expense
15 payments cover administrative labor, rent, utilities, and
16 other expenses. Practice expense payments are important.
17 They account for about half of the payments to physicians.

18 So CMS implemented, in January 2007, six major
19 changes to how it calculates practice expense payments, how
20 it calculates the method and the data it uses. So just real
21 briefly, CMS now calculates direct practice expense costs by
22 summing the nursing costs, medical equipment costs, and

1 supply costs for each service, holding everything else
2 constant. This change benefits office-based services that
3 use high cost equipment and supplies. CMS also changed how
4 it allocates indirect costs to each service. Ariel is going
5 to talk to you more about this.

6 But indirect costs are important because they
7 account for, on average, two-thirds of a specialty's total
8 practice expense costs.

9 CMS accepted and used more current practice cost
10 data from eight specialty groups. Under a BBRA provision,
11 specialty groups could choose to submit more current
12 practice cost data. CMS used the new practice cost data
13 from the eight groups and older data for most of the other
14 groups to calculate indirect practice expense RVUs. So
15 doing so favors those services primarily performed by these
16 eight specialty groups: cardiology, radiology, radiation
17 oncology, dermatology, urology, gastroenterology,
18 independent diagnostic testing facilities, and allergy.

19 Another change CMS made is that they are now using
20 the same method to calculate practice expense RVUs to
21 services involving physician work and services not involving
22 physician work. This refers to the so called non-physician

1 work pool. Before 2007, practice expense RVUs that did not
2 involve physician work were based primarily on charges.

3 CMS is also using more current volume data.
4 Again, this change will benefit faster growing services like
5 imaging, holding everything else constant.

6 Finally, CMS is using the 2007 work RVUs that
7 include the budget neutrality adjustment to allocate
8 indirect costs to specific services. Recall CMS just
9 completed its third five year review of the work RVUs and
10 this resulted in increasing work RVUs for some E&M services
11 and major procedures. To implement this change budget
12 neutral, CMS decreased all services work RVUs by 10.1
13 percent.

14 So you can see that once CMS implements all of
15 these changes in 2010 practice expense RVUs, on average,
16 will increase for E&M services, other procedures and tests,
17 and decrease, on average, for imaging and major procedures.

18 There are a lot of moving parts here. As I took
19 you through, there are six new moving parts to the method
20 and the data. So to better understand these changes, we
21 isolated the effect of first changing the methods and then
22 using new data.

1 So the blue bar here shows the impact of using the
2 new methods and the new volume data. The green bar adds to
3 that the impact of using the new practice cost data for
4 eight specialties and the older practice cost data for most
5 other groups. The yellow bar shows the impact of all the
6 changes including using the 2007 work RVUs.

7 First, the change in the methods, the blue bar.
8 You can see it had a positive effect for E&M and other
9 procedures and tests and a negative effect on imaging and
10 major procedures.

11 Next, let's look at the impact of using the new
12 practice cost data for some specialties and old data for
13 other specialties. When the green bar is higher than the
14 blue bar, then the newer cost data had a positive effect,
15 which it did for imaging services, other procedures, and
16 tests. By contrast, it had a negative affect on E&M,
17 services, and major procedures.

18 Finally, we move to the yellow bar and that
19 includes the effect of all of the method changes and data
20 changes that CMS will make in 2010. So you'll see that for
21 E&M and major procedures, using the 2007 work RVUs offset
22 some of the losses from using the newer practice cost data.

1 By contrast, for imaging, other procedures, and tests, using
2 the 2007 work RVUs offset some of the gains from using this
3 practice cost data.

4 Now the effects on individual services, however,
5 can sometimes differ from the service category. And I just
6 want to highlight two examples for you here, but I'd be
7 happy to answer any other questions you have.

8 First, looking at E&M services. In 2010, on
9 average, practice expense RVUs will rise by an average of 7
10 percent. But for nursing home visits, however, practice
11 expense RVUs will fall by 5 percent. This is because the
12 five-year review did not increase the value of its work
13 RVUs. And remember, the work RVUs have this sort of
14 indirect effect on practice expense because work RVUs are
15 used to calculate indirect practice expense values.

16 The second example I'd like to highlight here is
17 with major procedures. Here is where you can see the effect
18 of using more current practice cost data for some groups and
19 not for other groups. On average, across all major
20 procedures practice expense RVUs fell by 8 percent.
21 However, practice expense RVUs increased by 37 percent for
22 coronary angioplasty. That is because it is a procedure

1 primarily performed by cardiology and this specialty was one
2 of the eight groups that submitted the newer practice cost
3 data, and this specialty accounts for about 94 percent of
4 the total volume of these procedures.

5 So at this point I'm now going to turn -- Ariel
6 will discuss some issues we have.

7 MR. WINTER: Now we'll focus on how CMS calculates
8 indirect practice expense, which includes administrative
9 staff, office space and utilities, and other expenses.

10 Because indirect costs cannot generally be traced
11 to specific services, CMS has had to develop a method for
12 allocating these costs to individual codes. It's important
13 to keep in mind that this process is not an exact science
14 and there is no single best method for allocating indirect
15 costs.

16 Nevertheless, we'd like to propose four broad
17 principles that we think should guide any indirect
18 allocation method. First, the method should be based on
19 factors that actually drive indirect practice costs. For
20 example, they should probably include non-physician clinical
21 labor because indirect costs are probably related to the
22 amounts of clinical labor that's required for a service.

1 Second, it should avoid creating incentives that
2 favor certain services or sites of care over others.

3 It should limit the administrative burden on CMS
4 and providers.

5 Finally, it should be reasonably understandable.

6 This slide addresses an issue that Nancy Kane
7 raised at our September meeting. Practice expenses include
8 costs that are fixed in the short run, such as rents and
9 utilities, and variable costs such as clinical labor and
10 supplies. Most of these fixed costs can be classified as
11 indirect costs. Some researchers have proposed that
12 Medicare should only pay for a practice's fixed costs until
13 those costs are covered, perhaps by making a periodic lump
14 sum payment that varies based on the practice's
15 characteristics. Medicare would pay for the variable costs
16 of the service on a per service basis.

17 Although this idea is conceptually appealing, it
18 would be quite difficult to implement in practice. To
19 estimate a practice's fixed costs, CMS would need to
20 collect extensive data on practice characteristics such as
21 their size, the number of offices they have, their service
22 mix, and Medicare share of volume.

1 CMS would also need to develop a manageable number
2 of homogeneous payment classes, which would be difficult
3 given the wide variety of practices.

4 Finally, there could be opportunities for
5 physicians to increase their payments by changing their
6 practice characteristics, for example by increasing their
7 number of offices.

8 Given these difficulties, it appears to be more
9 feasible to pay for indirect costs on a per service basis,
10 which is what CMS currently does.

11 CMS follows a two-step process to calculate
12 indirect RVUs per service. First, they create pools of
13 indirect costs for each specialty, which is the top box on
14 the slide. One of the key data sources used to create these
15 cost pools is physician survey data on practice costs,
16 including the more recent cost data for some specialties
17 that Nancy discussed. One point to remember is that the
18 size of a specialties' indirect cost pool influences how
19 many indirect RVUs their services receive.

20 Once CMS creates a cost pool for each specialty,
21 they allocate the cost pool to the services the specialty
22 performs. In general terms, this allocation is based on

1 each service's physician work RVU and direct cost RVU, which
2 includes non-physician clinical labor, medical equipment,
3 and supplies. Services with the highest work values and
4 direct costs receive the most indirect expenses.

5 CMS chose to use both physician work and direct
6 costs in the allocator to balance services performed by
7 office-based and hospital-based specialties. Hospital-based
8 specialties perform services with low direct cost but higher
9 work values. Thus, if the allocator was only based on
10 direct costs, it would be difficult to allocate indirect
11 expenses for these specialties.

12 On the other hand, office-based specialties
13 generally perform services with lower work values but higher
14 direct costs.

15 This chart assumes that all services are provided
16 by only one specialty. But in reality, most services are
17 provided by multiple specialties. In these cases, the
18 indirect cost is a weighted average of each specialty's
19 indirect costs for that service.

20 Here we have the full formula for allocating
21 indirect costs. First, CMS multiplies the direct cost of
22 the service, that is its clinical labor, equipment, and

1 supplies by an adjustment factor. This factor is the ratio
2 of the indirect cost to direct cost for the specialty or
3 specialties that perform the service. Because this ratio is
4 greater than one for most specialties, this adjustment
5 increases the overall importance of direct costs in the
6 allocator. As a result, direct costs account for about one-
7 third of the allocator, on average, instead of one-quarter.
8 Finally, the adjusted direct cost is added to the physician
9 RVU, which accounts for about two-thirds of the total
10 allocator on average.

11 If the service has a low work RVU, than the non-
12 physician clinical labor cost is used instead. This is done
13 to accommodate services that have no work RVUs such as the
14 technical component of imaging studies. For these services,
15 the non-physician clinical labor is counted twice because
16 it's also included in the direct cost portion of the
17 allocator.

18 We have several concerns with CMS's indirect
19 allocation method. First, it's complex and difficult to
20 understand. Second, it includes medical supplies and
21 equipment even though the relationship between equipment or
22 supply costs and indirect costs may not be linear. For

1 example, a \$1,000 supply probably does not require 10 times
2 as much office space and utilities as a \$100 supply. Thus,
3 allocating more indirect costs to services that use
4 expensive supplies and equipment may overvalue those
5 services.

6 A third concern is that the current allocator
7 counts clinical labor twice for services like imaging that
8 have no work RVUs. It's unclear why these services should
9 be treated differently. Physician work and non-physician
10 clinical labor are, to some degree, substitutable. If the
11 service involves no physician work, then its clinical staff
12 costs should be higher, so there's little justification to
13 count the clinical staff cost twice.

14 This adjustment increases indirect RVUs for
15 services with no physician work, which increases the
16 incentive to perform them.

17 Finally, the use of specialty-specific cost pools
18 makes the method more complex and may also create
19 distortions in the RVUs. As Nancy noted, CMS uses more
20 recent practice cost data for some, but not all, specialties
21 in creating these cost pools.

22 The eight specialties that recently submitted data

1 tend to have larger cost pools than other specialties, which
2 increases the amount of indirect RVUs assigned to their
3 services.

4 On the other hand, some stakeholders believe that
5 the use of specialty cost pools based on physician survey
6 data makes the method more resource based. We designed two
7 alternative allocation methods that illustrate ways of
8 addressing these concerns, both of which would use existing
9 data. In doing so, we are mindful of the four broad
10 principles that we outlined on slide eight.

11 In developing the two alternatives, we played
12 around with lots of different permutations with different
13 trade-offs. But we settled on two specific approaches or
14 alternatives in order to be able to model impacts. You can
15 certainly make a case for other iterations.

16 This table summarizes the two alternative methods
17 that we chose to model. Our first alternative does not use
18 equipment or supplies and does not double count clinical
19 labor if the service has no physician work. Thus, it limits
20 the financial incentive to perform services that use costly
21 equipment and supplies or have no physician work. This
22 allocator is based on the non-physician clinical labor and

1 physician work for the service. The underlying concept is
2 that indirect costs are related to the amount of labor
3 involved in a service, whether provided by a physician or
4 non-physician clinical staff.

5 This option does use the ratio of indirect to
6 direct costs for the specialties that perform a service,
7 which is applied to the non-physician clinical labor part of
8 the allocator. It also uses specialty specific cost pools,
9 which offset some of the effect of dropping equipment and
10 supplies from the formula. This is because specialties such
11 as radiology that use expensive equipment and supplies
12 should have larger indirect cost pools, which means their
13 services will receive more indirect RVUs, other factors
14 being equal.

15 Now we'll describe option two. This option uses
16 all the direct costs -- the clinical labor, equipment, and
17 supplies -- in addition to physician work. Like option one,
18 it does not double count clinical labor for services with no
19 physician work. Unlike option one and the current method,
20 it is not use specialty-specific indirect cost pools.
21 Instead it uses a single cost pool across all specialties
22 which equals the total amount of indirect RVUs in the

1 current payment system. This change makes the method less
2 complex and reduces distortions created by using more recent
3 cost data for some but not all specialties to construct the
4 cost pools.

5 Although it does not use specialty cost pools,
6 option two does use each specialty's ratio of indirect to
7 direct costs as derived from survey data. So the survey
8 data continues to play a role but it's much more limited.

9 This chart shows the impact of options one and two
10 on the new fully implemented practice expense RVUs. The
11 title says 2007 but it would actually be 2010 because the
12 changes will not be fully implemented until then. And the
13 modeling was done by our contractor, NORC.

14 Both the baseline and the two alternatives include
15 the new methods and new data that CMS began implementing in
16 2007.

17 Under option one, which is the yellow bar, PE RVUs
18 would shift from imaging, tests, and other procedures to E&M
19 services and major procedures. RVUs would be lower for
20 imaging and tests because these services are more likely to
21 use expensive equipment and supplies or to have no work
22 RVUs.

1 RVUs would be higher for E&M and major procedures
2 because these services are relatively small equipment and
3 supply costs. Major procedures would also increase because
4 they have higher work RVUs and work RVUs account for a
5 larger portion of the allocator under option one, compared
6 to the current method.

7 Under option two, which is the green bar, PE RVUs
8 would increase for E&M services by 7 percent while the other
9 categories would decline by between 3 and 7 percent. These
10 effects occur primarily because specialty-specific cost
11 pools are not used in this option, whereas they are used in
12 the current method. Services performed by specialties with
13 larger indirect cost pools, such as radiology, cardiology,
14 dermatology, and orthopedic surgery, would decline. That's
15 why we see an overall decline for imaging, major procedures,
16 other procedures, and tests.

17 Conversely, services performed by specialties with
18 smaller indirect cost pools would have higher RVUs under
19 this option. These specialties include physical therapy,
20 emergency medicine, and family and general practice. And
21 this accounts for the increase in E&M RVUs.

22 Option two would have an indirect effect on

1 spending in other parts of Medicare. This is because option
2 two would physician fee schedule rates for outpatient
3 therapy services, which is not shown on the slide, and these
4 rates apply to therapy services provided in other settings
5 such as hospital outpatient departments. So if therapy
6 rates under the physician fee schedule increase, this would
7 increase spending at the hospital outpatient setting.

8 The issue is that under current law this
9 additional spending could not be offset by budget neutrality
10 adjustment in either the physician fee schedule or the
11 outpatient PPS, so there would be a net increase in Part B
12 spending.

13 To summarize our presentation, for 2007 CMS used
14 new method and new data to calculate the PE RVUs. On net,
15 these changes resulted in higher PE RVUs for E&M services,
16 other procedures, and tests and lower RVUs for imaging and
17 major procedures.

18 The use of new practice cost data for eight
19 specialties may distort the RVUs for practice expenses
20 because cost data for other specialties are based an older
21 survey. This factor has a large impact on PE RVUs.

22 In our June 2006 report, we said that CMS should

1 regularly collect practice cost data from all specialties
2 and use this data in calculating RVUs. This would create a
3 level playing field for all specialties.

4 Finally, we have some concerns about CMS's method
5 for allocating indirect costs. We've developed two
6 alternative methods to illustrate approaches that would be
7 less complex and minimize financial incentives to perform
8 certain services over others. Both methods would
9 significantly redistribute PE RVUs among services. So we'd
10 like to get your feedback on these alternative allocation
11 approaches and anything else we've presented today.

12 Thank you.

13 DR. BORMAN: I think you all have done a really
14 nice job of laying out the issues and modeling some of the
15 many permutations. As you two know better than I do, if you
16 took all the six changes and all the various ways you could
17 put it together, you could have a sea of modeling out there
18 that just confuses the issue further. So I applaud you for
19 picking a couple and using them illustratively.

20 I come away from the analysis not ready to go to
21 the point of advising you about these models or taking that
22 forward. What I take forward from some of this, and it may

1 be a very jaundiced view, is that number one, this is a very
2 complex system. And it is one, frankly, that many of us
3 struggle to understand and retain the understanding. Almost
4 every time I look at this I have to go back and look at some
5 of the primary definitions. And yet I think I go to enough
6 forums about this that I may be a little more knowledgeable
7 than some. So number one, it says it's a very complex
8 system.

9 Having said that, to me that raises the corollary
10 question does this start to take us down a road of saying
11 that the RBRVS has become so complicated, where does it fit
12 in in meeting our needs? And I think it's a big philosophic
13 question, one that you weren't trying to answer here. But I
14 think it is a national follow-on of some of the arcanery of
15 this, is that first point.

16 I think another thing that I come away with is, as
17 you've nicely summarized, there are a lot of moving parts
18 here and they're moving over a relatively short interval.
19 There's the work RVU shift, there's the PE RVU shift.
20 there's the DRA provisions. There's a lot of moving parts
21 here. And each of them was changed in a different way.

22 The work RVU part was the separate work adjuster.

1 The PE thing was the whole deal. It's a transition thing.

2 This is a very complex thing.

3 I think we would take a huge chance at making
4 something worse or finding ourselves saying something that a
5 year down the road we'd have to walk away from and feel
6 pretty foolish about if we don't let this play out just a
7 little bit. Physicians are very creative people about
8 learning how to work within these systems. Some might say
9 manipulate, but I'm going to say work within.

10 There could be all kinds of permutations of these
11 changes that we can't even imagine right now. And I would
12 argue for a little bit of a stopped clock here a little bit
13 to know where we're going to end up before we start looking
14 at alternatives and potentially making recommendations about
15 alternatives, and going down different roads at least within
16 the context of an RBRVS system as it's currently designed.

17 Because I think there is great danger in that. We
18 don't know where we are now, frankly, and particularly
19 because of the data lag relative to -- it doesn't reflect
20 the changes that we've already made.

21 So I think there's a huge issue here. I think
22 it's wonderful to examine and I think it's very important,

1 number one, to educate people on what the system is, remind
2 us all of the factors that are in it, remind us all how
3 complex it is, that we do need to keep our finger on the
4 pulse of this, that there are some -- hopefully there will
5 be better data out within a year with regards to better SMS-
6 like data. And now matter how you slice it, some of that
7 information is important.

8 But for example, there are even little pieces of
9 this that become hugely important like the practice expense
10 per hour. If you have a specialty that works 60 hours a
11 week on average versus 45 hours a week, you indirectly
12 advantage the people who work less because your PE per hour
13 is, by definition, higher.

14 There's all kinds of little pieces of this that I
15 think we need to have uniformly collected data by
16 specialties, have a sense of what those data are before we
17 say specialty specific data don't play a role here, give it
18 a little time to let the permutations or the ways to move
19 within it become more obvious, and remind ourselves that
20 this raises a bigger issue of the whole complexity of this
21 system.

22 The other thing that I do think is an important

1 point that I would ask everybody to remember is this shows
2 you how much the work values also play into the PE values,
3 and they're a huge piece of this. And so every time you do
4 something to the work values you also, by definition, change
5 the PE values.

6 The flip is not true. And that brings arguments
7 for how you handle changes to those. So a word of caution
8 about that.

9 MR. HACKBARTH: Let me ask you this, Karen. I
10 hear you say no recommendation. But I thought I also heard
11 you say that you think that the illustrative examples are a
12 reasonable way of showing the implications of some of these
13 assumptions. And so you're not objecting to including the
14 illustrative examples?

15 DR. BORMAN: I absolutely support showing some
16 illustrative examples. And I also think they implied that
17 in the background some of what's gone on, and maybe why it
18 seems illogical, is someone out there is looking at the
19 endpoint. And how much we can afford to move some of these
20 things around.

21 MR. HACKBARTH: Just one other question. In
22 talking about the examples, the presentation in the paper

1 lay out some guiding principles, one of which is that we are
2 to collect uniform data across specialties, as opposed to
3 depend on specially-developed and submitted data.

4 But I thought I heard you maybe question that, as
5 well.

6 DR. BORMAN: I agree with the point of uniformly
7 collected data. The point about making this specialty
8 specific adjuster go away, I'm not so sure about.

9 MR. HACKBARTH: So to sum up, what I hear you say
10 is no recommendation but you don't have any major objection
11 to any the component parts of the analysis or presentation.
12 Okay.

13 MS. RAY: I just want to mention that the AMA is
14 currently fielding a multispecialty practice cost survey and
15 they're going to be collecting -- the plan is to collect
16 data through the end of this year. And the goal would be
17 for CMS to use the data in calculating the rates for the
18 2009 fee schedule.

19 MR. HACKBARTH: Other comments?

20 DR. CASTELLANOS: I'm going to be a little bit
21 more practical. There's no question we want accuracy of
22 payments. We want to make sure that Medicare is paying for

1 the service they get. On the other hand, it's important
2 that the physician gets paid for his services, too. So it's
3 a two-way street. We all agree that accuracy of payment is
4 very, very, very important.

5 I guess the problem I have here is some of the
6 issues, without being redundant and commenting on Karen's
7 comments, is I'm not quite sure why we're doing this at this
8 point. As we just heard, the data that has been collected
9 is from the eight specialty groups. But every specialty,
10 every person, every medical society had the opportunity and
11 was invited to provide the data. It was their choice not to
12 provide the data. It was these eight specialties that went
13 out and spent the money to collect the data and then give it
14 to CMS.

15 You can't say it was just the specialties that
16 were interested in doing it. Obviously, they had an
17 interest in doing it or they wouldn't have done it. But
18 every specialty and every society had that opportunity.

19 As you found out, we are collecting new data. The
20 AMA is sponsoring it and it is being financed by CMS.
21 That's starting this spring, is my understanding, and it
22 will be available hopefully later on in the year and

1 hopefully can be implemented in the 2009 program.

2 What I'm concerned about is a comment that was
3 made by Jay Crosson about two months ago when he was talking
4 about hospitals and capital expenses. If you remember at
5 that time, he was talking about California and how they
6 changed some of their rules and regulations. They had to
7 improve the hospitals because of the earthquakes and
8 building new, and he was talking about capital improvements
9 and funding. It's hard for somebody in his situation,
10 spending billions of dollars, to not have some
11 predictability of reimbursement.

12 Well, it kind of comes down to me. I'm a small
13 businessman. I run a practice. I have costs. I have
14 employees. I have to buy equipment. And I buy equipment on
15 a good business decision. I look at the cost of the
16 equipment and I look at my reimbursement and whether I can
17 afford it, and whether it's the best thing for my patient.
18 And then I make these decisions based on these criteria.

19 What I have a real concern, especially with the
20 option number one, is that I think the rug is going to be
21 pulled away from a lot of the specialties that use high cost
22 equipment and supplies. First of all, you're limiting the

1 financial incentive to perform these services using this
2 costly equipment. Second of all, I think you're going to be
3 asking me or forcing me to use less sophisticated equipment.
4 When something new comes out and it's been shown to be
5 evidenced-based and accurate, I'm going to consider
6 purchasing that so I can provide a better service for my
7 patient. If I don't have that opportunity, I'm going to
8 have to send that person to another site, probably the
9 hospital setting, which we all know is going to be more
10 expensive. So I don't really know what we're accomplishing
11 by doing that.

12 The third issue is an issue of, as Karen said, we
13 have a lot of moving parts right now. The changes made by
14 CMS have been implemented January 1, 2007. We have two
15 months of an experience to date. We don't have a dataset
16 that's accurate. We're going to get it. We hope we're
17 going to get it, I should say.

18 We've made some changes specifically against the
19 imaging equipment because there's no question, we want to
20 make accuracy of payments correct. But we don't know what
21 the effect of the DRA is going to do on equipment yet. We
22 just don't know that. So I guess it goes back to my first

1 point. I don't see the rush of doing anything here today.

2 To answer your question, Glenn, I think it's great
3 to have these examples. I think option one is going to hurt
4 the high equipment specialty field. I think it may impart a
5 significant problem of safety to the patients, especially in
6 some of the procedures like radiation therapy not using the
7 best, latest equipment.

8 Thank you.

9 MR. HACKBARTH: Let me ask Mark a question. What
10 is the plan for using this material? Is it planned for
11 inclusion in the June report? Or is this just to further an
12 ongoing discussion in the Commission? How do you see it
13 being used?

14 DR. MILLER: A couple of ways and reasons that we
15 got into this. Once again, there were a couple of
16 commissioners who, when this was in progress and being
17 discussed by CMS, decidedly had interest in kind of knowing
18 better what was going on because it's so complex.

19 Two, we also have a responsibility as a Commission
20 to respond on federal regulations. This was a regulation.
21 We needed to comment on it. Part of the exercise was also
22 to make sure we understood what was going on.

1 I think the third reason that we did it is people
2 don't understand this, and we have people on the Hill --
3 part of our mission as a Commission, I think, is also to
4 educate even when we don't make a recommendation. So I
5 think part of the exercise was to go through and take this
6 beast apart and try and figure out what was driving what.

7 As you can tell, and I know it's very hard to
8 follow. I've been through it with these guys a couple of
9 times and I barely hang on each time that they take me
10 through it.

11 I didn't anticipate necessarily sets of
12 recommendations out of this. I did anticipate publishing it
13 in the June report as an exercise and as kind of
14 disentangling this to make people understand it as a service
15 to -- hopefully as a service to the Hill, so that they
16 understood. Because I believe that people go to the Hill
17 staff and talk to them about the implications of this. And
18 I think they often don't understand what's going on behind
19 it.

20 So I really saw it as a chapter in June to make
21 sure that people understood what had happened, basically.

22 MR. HACKBARTH: Thanks, Mark.

1 I agree that this is an important element of our
2 mission, just education, help people understand the
3 sensitivity of this to different types of assumptions and
4 how money is redistributed. I agree with Karen that we
5 should stop well short of a recommendation at this point.

6 I would also have no objection myself to adding
7 some language about your stability in payment point. I
8 think that's a legitimate policy concern, that you don't
9 want to keep yanking on these things, especially things that
10 shift around a significant amount of money. There are
11 consequences of that, and they are not generally good
12 consequences. So I think that that would be an important
13 addition to the discussion

14 A couple more comments and then I'd like to move
15 ahead to try to keep us reasonably close to on time.

16 DR. MILSTEIN: These refinements that have been
17 laid out for us are primarily aimed at the objective of
18 better assuring equity or fairness across specialties.
19 Every time we see one of these analyses, I keep going back
20 to the MMA language about CMS beginning also to refinance
21 payment systems to pay what an efficient provider requires
22 to deliver a service. I've realized that there are a lot of

1 ways of defining efficiency, but one of them is what we call
2 production efficiency meaning what kind of practice expense
3 resources are required to produce a unit of billable
4 service.

5 Have there been any analyses within specialty on
6 degree of variation in practice expense per unit of service?
7 As long as we're talking about refinements, we might think
8 about are there ways in which CMS might better address the
9 MMA directive from Congress to begin to better gear its
10 payment system to what an efficient provider might require?

11 MR. WINTER: I'm not aware of any such studies
12 offhand, but it could be something that the MGMA has worked
13 on because they do survey practices about their practice
14 costs, and they may make some adjustments based on type of
15 service. So we can look into that.

16 DR. KANE: Years ago I got involved with trying to
17 help figure out physician practice expenses. I can tell you
18 that all efforts to microcost this rationally are
19 impossible. So forget about that. I just point out that
20 they are fixed and we're paying on a variable cost basis.
21 But I know already we can't come up with a way to
22 incorporate that.

1 I think as a Commission, perhaps what would be
2 useful is to say what should be the goals of this payment
3 system? And then are we getting there? I think we have, at
4 times, said we don't think we are meeting the goals. And
5 the goals seem to be things like appropriate use of service
6 and ability to attract in residents into this field.

7 If we really want to go down that path of ability
8 to track residents into this field, we have to bring in
9 what's the physician income by specialty? Is it a
10 reasonable income? And if it's not -- and I know that's an
11 ugly subject and a lot of people just don't want to go
12 there, and I don't blame them.

13 Given that we can't do this microcosting remotely
14 accurately and just forget, that's a silly idea to even
15 think you're going to get there, how can you most reasonably
16 allocate in a politically defensible way is really the
17 question? It's all buried in all these details.

18 So what I see really are three questions that this
19 paper raises that we could discuss if we really wanted to
20 and make a comment on. One is is it reasonable to do bottom
21 up allocation of the direct costs? I think so, as opposed
22 to the alternative way, which I think was pretty random, top

1 down and even more diffuse than the bottom up.

2 Two is is it reasonable to include equipment and
3 supplies, which are in the direct costs already. So you're
4 getting the direct costs built in. What's happening is the
5 indirect costs are being allocated on the basis of your
6 direct costs. Do you want to include the added costs of
7 equipment and supplies to the overhead allocation? I agree
8 that I don't see that there's any direct relationship
9 between the equipment and supplies and overhead costs. They
10 certainly add to your direct costs, and that should be
11 recognized. But there's no study that says that makes your
12 rent higher.

13 The third question is should Congress -- this
14 relates to your studying of your cost pools and your
15 specialty costs. Should Congress mandate that CMS or
16 someone other than AMA -- but maybe it's AMA -- collect this
17 specialty cost data on a regular basis so that it can be
18 updated routinely and put in here so that it's equitable and
19 it's done all at the same time, all for everybody, instead
20 of eight specialties do it and the others don't and so we
21 end up having this unevenness?

22 Those are the three questions I see that have to

1 do with whether we think it's a reasonable arbitrary
2 exercise or not. And everything else, we're just guessing
3 at what we're trying to do here.

4 DR. BORMAN: Just the piece, because I purposely
5 stayed away from it, about whether your directs influence
6 your indirects. I would agree with you they don't
7 necessarily one-to-one track. But I would just offer the
8 example, if you have an expensive piece of equipment that
9 requires structural stability, you have to have a bigger
10 space for it, you have to have different air-conditioning
11 for it, you have to have lead shielding.

12 There are some things for which there will be a
13 relationship. And I think we just don't know that well.
14 And I would be a little bit hesitant about saying X, there's
15 no relationship, or Y, there's a one-to-one.

16 DR. KANE: And that's the problem. We don't know.
17 But then you put it all in there and you're saying that
18 everything that's more expensive gets a higher overhead
19 allocation. And I don't think that's justified either.

20 So maybe we have to get a more deeper study on
21 what types of equipment require more space. But other than
22 that -- and that's another -- we could recommend that if we

1 think that's a really, really important piece of it.

2 MR. HACKBARTH: Ariel, you look like you have a --

3 MR. WINTER: One quick comment. Option one
4 recognizes, to some extent, there's a relationship between a
5 practice having equipment and higher overhead because you're
6 still using the specialty-specific cost pool. So a
7 specialty like radiology has a higher cost pool. That's
8 still going to be reflected.

9 What's changing is how that cost pool is
10 distributed among their services. So more of it will go to
11 services with higher clinical labor and higher work and less
12 of it to services with higher equipment and supplies. But
13 it's still in the cost pool in option one.

14 DR. CASTELLANOS: Not to this point, but one other
15 comment. I think it was brought up at the public testimony
16 this fall that CMS cuts back on the direct costs because of
17 budget neutrality by a third. But they also cut back on the
18 indirect costs by two-thirds. And if you look at the
19 Federal Register, it's step 25. And you'll see that. If
20 you don't have it, I'll be glad to show it to you.

21 MR. HACKBARTH: Okay, we need to leave this for
22 now.

1 When I think of physician payment, as I see what
2 we're doing, we have two decidedly different tracks. As
3 part of our ongoing educational informational role for the
4 Congress, I think it's useful for us periodically to look
5 behind the curtain at the very technical, even arcane work
6 that needs to be done to make this system work and try to
7 refine it over time.

8 The other track, which to me is the more
9 fundamental one for the Commission, is that several
10 commissioners, Bill and Arnie and Karen and others at
11 different times, have raised the question whether physician
12 payment policy ought to be guided solely by an increasingly
13 complex effort to identify the resources and professional
14 knowledge and skill that go into individual services. Or
15 whether physician payment policy ought to be guided by other
16 considerations such as value of services rendered or even
17 our need to have an adequate supply of different types of
18 physicians.

19 That latter track, to me, is a very important one
20 that we need to come back. I love this stuff. I love the
21 practice expense stuff, but there's life after practice
22 expense.

1 Thank you very much.

2 Next is Medicare Advantage. Who in this
3 illustrious cast is the -- Jennifer.

4 MS. PODULKA: If you don't mind bearing with me,
5 we're going to start in the middle a little bit since we are
6 having technical difficulties with our slides.

7 Imagine a slide up here that talks about Medicare
8 Advantage which Carlos and Scott will be doing after a brief
9 interlude to update you on special needs plans, which are
10 one type of Medicare Advantage plan.

11 As you may recall from the last season of this,
12 SNPs were created by the MMA to serve three distinct types
13 of Medicare beneficiaries: those are dually eligible for
14 Medicare and Medicaid, those who reside in an institution or
15 in a community with a similar level of need, or those who
16 are chronically ill or disabled.

17 SNPs function like and are paid like other MA
18 plans. The key difference is that they must include the
19 Part D drug benefit and, in exchange, they are allowed to
20 limit their enrollment to those targeted populations I just
21 described.

22 Since SNPs were first introduced, they've grown

1 quickly. In 2005 there are 125 SNPs available. Last year
2 that more than doubled to 276 and it continues to grow for
3 2007, although the information I'm going to present today is
4 a bit dated in that we focus on 2006.

5 If you note in the bar on the left, in 2006 of the
6 276 total SNPs available, more than 80 percent were for dual
7 eligible beneficiaries. The bar on the right shows that in
8 July of that year there were more than half a million
9 beneficiaries involved in SNPs with most enrolled in the
10 dual eligible plans.

11 We further examined the SNPs available in 2006 and
12 found that only 13 percent of them were offered by parent
13 organizations that focused exclusively on providing SNPs.
14 That's shown by the red pie slice there. The other 87
15 percent of SNPs were offered by parent organizations that
16 also offered regular MA plans, which suggests to us that
17 these organizations offer SNPs as one of a menu of options.

18 Breaking out the pie a little bit more, the next
19 few slices, green and lavender, show that about 60 percent
20 of SNPs were, in fact, offered alongside other MA plans in
21 the same exact service area.

22 As I mentioned, I'll be coming back next month

1 with some updated information about SNPs in 2007, but I
2 wanted to leave you with some questions to keep in mind.
3 First, SNPs offer the opportunity to improve the
4 coordination of care for special needs beneficiaries, but we
5 question what their exact role should be.

6 Two, should Congress and CMS expect SNPs to behave
7 differently or be special, going beyond what regular MA
8 plans offer?

9 Three, to what extent does SNPs ability to limit
10 their enrollment matter to their mission? And can this
11 mission be achieved by regular MA plans?

12 Finally, the MMA authority that created SNPs
13 scheduled them to expire after five years so they'll be
14 going away after 2008 if Congress does not act. So we
15 questioned, should they be extended in their current form,
16 extended with structural changes, or allowed to expire?

17 Leaving you with those questions in mind, Carlos
18 will now begin describing MA findings.

19 MR. ZARABOZO: First, we'll start with a look at
20 the enrollment numbers for 2007. Enrollment in Medicare
21 Advantage plans grew by 700,000 between August 2006 and
22 February 2007 primarily coming from growth in private fee-

1 for-service plans. Those plans grew by 66 percent in this
2 six month period. So now about 70 percent of enrollees in
3 Medicare Advantage are enrolled in private fee-for-service
4 plans.

5 The enrollment patterns in private fee-for-service
6 in 2007 are similar to what they were 2006. Over three-
7 quarters of the enrollment comes from counties that were
8 historically paid at floor rates, that is counties with a
9 minimum Medicare Advantage payment rate established by
10 statute.

11 Private fee-for-service continues to draw
12 significant enrollment from rural areas. About 41 percent
13 of the enrollment is from rural counties, about the same
14 percentage as last year. So currently, about 5 percent of
15 the total Medicare population in rural areas are enrollees
16 of private fee-for-service plans.

17 Just as a reminder of how these plans are
18 different from other plans, they are not coordinated care
19 plans and do not have networks of providers. Generally,
20 enrollees can use any Medicare provider. Thus in rural
21 areas, for example, these kinds of plans do not have the
22 kinds of costs that HMOs and PPOs incur in forming and

1 administering networks. Private fee-for-service plans also
2 are treated differently in that they do not have to meet the
3 quality standard requirements that apply to network plans.

4 As you'll see in the next slide, the program
5 payments made to private fee-for-service plans and the
6 benchmarks for such plans are substantially higher than
7 Medicare fee-for-service expenditure levels and higher than
8 program payments made to other plan types.

9 Here are some numbers from a table that is
10 familiar to you from the March report to the Congress and
11 from past presentations. Scott has analyzed the payments
12 and benchmarks in Medicare Advantage and found that overall
13 in 2006 benchmarks for MA plans exceeded Medicare fee-for-
14 service expenditures by 16 percent and Medicare Advantage
15 program payments exceeded fee-for-service expenditure levels
16 by 12 percent.

17 On this slide we've added an additional row that
18 shows the level of rebates in each plan type expressed as a
19 percentage of fee-for-service expenditures across the
20 enrollment, across the counties where they are enrolled.
21 This again is as of July 2006. The rebate dollars are the
22 funds that are used to provide enrollees of MA plans with

1 extra benefits.

2 The availability of extra benefits financed by
3 rebate dollars is what has generally driven the growth in
4 Medicare private plans. The extra benefits are benefits
5 that plans offer that are not covered by Medicare or
6 enhancements of the Medicare benefit package through
7 reductions in out-of-pocket expenditures including
8 reductions in premiums for Part B and Part D.

9 The extra benefits have been Medicare private
10 plans attractive to beneficiaries and, in particular,
11 attractive to lower income beneficiaries who are not
12 eligible for Medicaid or other supplemental coverage such as
13 employer-sponsored retiree coverage and who find Medigap
14 premiums too expensive as a supplement coverage.

15 The argument has been made that the program
16 payments in excess of fee-for-service expenditure levels in
17 Medicare Advantage are worthwhile expenditures because they
18 provide extra benefits to enrollees. The Commission has
19 expressed this concern about the effect on beneficiaries who
20 currently get these extra benefits if Medicare Advantage
21 benchmarks were to be reduced. However there's some equity
22 and efficiency issues that need to be considered.

1 Among the equity issues is the overall point that
2 the Commission has raised frequently, which is that the
3 Medicare program should be financially neutral between fee-
4 for-service Medicare and the option of private plans. There
5 are also equity concerns affecting beneficiaries in terms of
6 access to plans. For example, in 2007 fewer than 40 percent
7 of rural beneficiaries have access to an HMO plan which is
8 the plan type that offers the highest level of extra
9 benefits in Medicare Advantage. In addition, there
10 continues to be significant geographic variation in the
11 level of benefits that beneficiaries have access to in
12 different types of plans across country.

13 Beneficiaries must also elect to be in a private
14 plan. In some cases, this involves restricting a person's
15 choice of providers. We know that, for example, that
16 disabled Medicare beneficiaries, those under 65, are much
17 less likely to enroll in private plans.

18 We'd also point out another equity issue here
19 which is that when rebate dollars are financed by program
20 payments that are higher than Medicare fee-for-service
21 expenditure levels, then the extra benefits are being funded
22 through taxes in Medicare Part B premiums from all Medicare

1 beneficiaries, not just those enrolled in these plans. Only
2 some Medicare beneficiaries, therefore, derive a benefit
3 from the way in which the MA program is financed while the
4 majority of Medicare beneficiaries are paying for the
5 benefits that only some beneficiaries receive.

6 On the question of whether the MA program is an
7 efficient means of providing extra benefits to enrollees,
8 here is the table that you've seen before, with one row
9 ended. The last row shows where plan bids are in relation
10 to fee-for-service Medicare expenditure levels. That is,
11 how much does it cost different plan types, on average, to
12 provide the Medicare Part A and Part B benefit package
13 compared to fee-for-service expenditure levels? As you can
14 see, on average it is only HMOs that are providing the
15 Medicare Part A and Part B benefit at less than Medicare
16 fee-for-service expenditure levels. Their bids for A and B
17 services come in at 97 percent of fee-for-service.

18 At the other end of the scale from HMOs are
19 private fee-for-service plans. Although the value of the
20 rebates they provide to enrollees is about 10 percent of
21 Medicare fee-for-service expenditure levels, the program
22 payments to these kinds of plans are 19 percent above fee-

1 for-service expenditure levels and, thus, only about half of
2 the amount is used to finance extra benefits for enrollees
3 in these plans.

4 For HMOs what the 97 percent means is that, on
5 average across HMO plans, some of the extra benefits are
6 financed by rebate dollars that are generated because these
7 plans can provide the Medicare benefit package at a cost
8 that is lower than the level of Medicare fee-for-service
9 expenditures.

10 Another way of looking at the 97 percent figure is
11 that if benchmarks are reduced there could still be extra
12 benefits provided to enrollees in the Medicare Advantage
13 program.

14 Given that some plans are able to have low bids
15 and can generate rebate dollars with bids below fee-for-
16 service, this slide shows that about half of enrollees in MA
17 in 2006 would have been able to receive extra benefits if
18 benchmarks had been at 100 percent of fee-for-service
19 expenditures. About half of enrollees would have had no
20 extra benefits and these enrollees would have been
21 disproportionately enrollees of PPOs and private fee-for-
22 service plans.

1 These figures show what would have happened had
2 plans bid exactly as they did in 2006 and it assumes that
3 beneficiary enrollment would have been exactly the same as
4 it was in 2006. This, of course, is an unlikely set of
5 assumptions. We know from the history of private plans in
6 Medicare that a reduction in plan payments would likely lead
7 to a reduction in plan participation in Medicare, a
8 reduction of the level of benefits and plans, and reduced
9 beneficiary enrollment in plans because of the reduced
10 benefits and access. This is what happened beginning in the
11 year 2000 after the Balanced Budget Act of 1997 introduced
12 payment changes in Medicare just as the managed care
13 industry was facing a restructuring resulting from what was
14 known as the managed-care backlash.

15 We'll now turn to Scott, who will discuss possible
16 ways of implementing the Commission's past recommendations
17 dealing with benchmarks in MA.

18 DR. HARRISON: As I'm sure you remember, the
19 benchmark is a bidding target under the bidding system for
20 MA plans that began last year. The local MA benchmarks are
21 based on the county level payment rates that were used to
22 pay MA plans before 2006. Those payment rates were at least

1 as high as per capita fee-for-service Medicare spending in
2 each county, with some counties having rates significantly
3 higher than fee-for-service as a result primarily of minimum
4 or floor rates.

5 In the past, the Commission has recommended moving
6 benchmarks to 100 percent of fee-for-service spending.
7 However, as Carlos has illustrated, such a move would
8 immediately reduce benefits that plans offer, which may
9 cause many plan enrollees to leave their plans and even
10 cause plans to leave the MA program. Thus, the Congress may
11 wish to protect current plan enrollees from large shocks to
12 their plans.

13 At the same time, however, leaving benchmarks well
14 above fee-for-service levels encourages the growth of
15 inefficient plans and enrollment in such plans makes future
16 reductions more difficult.

17 In this section, we will discuss specific
18 approaches to a transition to move benchmarks gradually
19 toward 100 percent of fee-for-service expenditure levels and
20 we will look for your suggestions on the pros and cons of
21 these different options.

22 The first three approaches I'm going to describe

1 are all glide paths to get the rates back toward 100 percent
2 of fee-for-service spending. First, the Congress could
3 freeze benchmarks or perhaps instead limit growth to a
4 minimum update until fee-for-service catches up to the
5 benchmark. This policy would begin to address all areas
6 with benchmarks above fee-for-service immediately, but it
7 would take years and maybe even decades for fee-for-service
8 levels to catch up in some areas. Under this approach,
9 beneficiaries might not see big changes in their benefits
10 for a few years, perhaps giving plans a chance to increase
11 efficiency to maintain or grow enrollment.

12 Or Congress could set a maximum for the benchmark
13 at some percentage of fee-for-service and gradually reduce
14 that percentage until it reached 100. For example, assume
15 the cap was set at 140 percent and reduced by 10 percentage
16 points each year until all benchmarks were set at local fee-
17 for-service spending in year five. So in year one all
18 benchmarks higher than 140 percent would be reduced to 140
19 percent. In year two all benchmarks would be limited to 130
20 percent of fee-for-service, and so on.

21 This policy would first address areas with the
22 largest discrepancies between benchmarks and fee-for-service

1 costs and would bring all benchmarks down to fee-for-service
2 within five years. While the reduction in benefits would
3 not be immediate, there would be significant reductions
4 annually. Enrollees in areas where plans are not
5 competitive with fee-for-service Medicare are likely to see
6 rapid reductions in their plan benefits.

7 Under another approach we could blend an area's
8 fee-for-service rate with its historical benchmark and the
9 historical benchmark could be weighted lower each year until
10 it was eliminated. For example, in the first year the blend
11 could be 80 percent historical and 20 percent fee-for-
12 service. In year two, the weighting could be changed to
13 60/40 until we reach year five in an example and then it
14 would be at fee-for-service.

15 Advantages to this policy include that reductions
16 would begin immediately would be proportionate to the
17 discrepancies between benchmarks and fee-for-service costs.
18 For areas where the benchmarks were not relatively high the
19 annual reductions would not be large. All benchmarks would
20 be reduced to fee-for-service in five years and therefore
21 those areas with relatively high benchmarks would see large
22 reductions each year. As with other transitions, the budget

1 savings would build gradually in these.

2 Now I want to talk about two other types of
3 approaches. The Commission has already recommended to
4 address double payment for indirect medical education costs,
5 the double payment for those, immediately. Under this
6 approach the effects, however, would be concentrated in a
7 few areas. Other areas with benchmarks well above fee-for-
8 service would not face any reductions. This option by
9 itself would not move benchmarks much of the distance toward
10 100 percent of fee-for-service. However, the IME could be
11 removed to calculate the proper fee-for-service spending in
12 an area and one of the approaches that I discussed on the
13 less slide could be used to actually do the moving of the
14 benchmarks towards fee-for-service.

15 The final approach I will discuss today is to use
16 plan bids to help determine the benchmarks. There are
17 several versions of this option. We focus here on the
18 approach that would operate like the bidding system that is
19 used to set the regional benchmarks. Plan bids in an area
20 would be averaged and blended with the area's fee-for-
21 service spending to calculate a benchmark. Part D bidding
22 works similarly except there's no fee-for-service component.

1 Under this type of policy, Medicare would continue
2 to use local competition to influence plan payments which
3 are thus more likely to reflect the costs of efficient
4 providers. Average bids for the Medicare Part A and B
5 benefit package are currently well below the benchmarks and
6 are often below fee-for-service costs. Therefore, the
7 resulting benchmarks may approach fee-for-service spending,
8 although it is likely that program costs would end up
9 getting to 100 percent.

10 The MA demonstration scheduled to begin in 2010
11 uses a variation of this approach where the fee-for-service
12 premium would be affected, in a limited manner, by plan
13 bids. If the Medicare fee-for-service program became a full
14 participant in the bidding, we would arrive at a premium
15 support system where beneficiaries in some areas would have
16 to pay additional premiums to stay in fee-for-service.
17 Under that scenario MA spending would equal 100 percent of
18 fee-for-service spending.

19 Now let's move away from the benchmark discussion
20 briefly. We would like your input on one more issue.

21 For the first time, insurers are offering high
22 deductible health plans linked with a Medicare Medical

1 Savings Account or MSA. As of February 1st, there are more
2 than 2,000 beneficiaries enrolled in MSA plans under
3 Medicare.

4 In our March report, we noted our concern that MSA
5 plans enjoy an advantage over other MA plan in the bidding
6 process. When an MSA plan bids below the benchmark, the
7 full difference between the bid and the benchmark is
8 deposited in each enrollee's MSA account. Other MA plans
9 receive 75 percent of the difference between their bid and
10 the benchmark as a rebate to provide extra benefits to
11 attract enrollees. So we believe that this policy provides
12 MSA plans with an unfair advantage over other types of MA
13 plans in attracting enrollees.

14 Now we'd like to hear your views on all of the
15 subjects we've discussed thus far.

16 MR. HACKBARTH: Can I just ask a question?
17 Earlier in the presentation Carlos was talking about how the
18 added benefits are financed. And some of it comes from
19 taxpayers, either through the payroll tax, the funds, the
20 Part A Trust Fund or general revenue taxes that fund Part B.
21 But the other part of the funding comes from beneficiary
22 premiums for Part B.

1 I was wondering if you can give at least a rough
2 estimate of the portion of the Part B premium that is
3 attributable to payments above 100 percent?

4 DR. HARRISON: We figure that about \$2, give or
5 take a little bit, would be actual Part B premium payments
6 all beneficiaries would pay for the fact that the Medicare
7 Advantage program is getting paid more than the fee-for-
8 service sector.

9 DR. REISCHAUER: That's a month?

10 DR. HARRISON: That's a month.

11 MR. HACKBARTH: To the extent that the program
12 grows and to the extent that the program grows, in
13 particular in plans that are receiving the largest subsidy,
14 if you will, that number also will grow.

15 DR. HARRISON: That number would also grow, yes.

16 MR. BERTKO: Not unexpectedly, I've got a few
17 comments.

18 First off, is no question about any of the numbers
19 presented here. But it's also useful to think about what
20 the numbers look about in 2007. The 2006 numbers are higher
21 for a couple of reasons. One, they include a technical
22 error that CMS made that was corrected on the budget neutral

1 risk adjustment factor, and it was substantial.

2 Plus, the effect of the phase-out goes from 100
3 percent of a 75 percent number -- and you don't want to know
4 all the prongs on that. Let's just say the difference in
5 those two combined factors -- and Scott and I haven't
6 discussed this but I think if I say 4 to 5 percent reduction
7 I'm hoping you will nod or at least not complain.

8 So the comment that that is that while all the
9 numbers in here are appropriate for 2006, the 2007 and the
10 differences are all smaller. So he's almost nodding.

11 DR. REISCHAUER: So the implication of that is
12 then moving that 100 percent and a level playing field won't
13 be such a big adjustment?

14 MR. BERTKO: It will be a smaller adjustment, Bob,
15 yes. But it also should be a smaller number towards, among
16 other things, the number Glenn just referenced.

17 DR. HARRISON: I wish that were true, but I don't
18 want to put out a new number now because we don't have the
19 enrollment yet, and we probably will by April. But there
20 are a couple of factors that drove the number back up a
21 little bit this year.

22 One is that last year what we had was a 75/25

1 blend of demographic risk. The risk ratio was larger than
2 the demographic ratio by a decent amount. And so that's
3 going to affect the numbers.

4 And then the other thing we need to sort through
5 is the normalization of 2.9. We'll get back to you in April
6 with what the 2007 numbers show.

7 DR. MILLER: Scott, one other thing. Doesn't it
8 also depend on where the enrollment ends up?

9 DR. HARRISON: Yes, it does. In fact, even
10 between the end of 2005 and the middle of 2006, just from
11 the enrollment shift we added a point.

12 MR. HACKBARTH: Just to make sure that people are
13 following that, so when we present statistics, as Carlo did,
14 that the average payment is 112 percent of fee-for-service,
15 the average benchmark is 116, that calculation is a
16 reflection of where the beneficiaries are enrolling and in
17 what types of plans. So the extent that the high payment
18 levels encourage people to go into private fee-for-service,
19 the plans that are receiving the largest subsidy, even
20 though John is correct that there may be some other factors
21 tending to push down the payment rate, those references to
22 fee-for-service are driven up by the composition of the

1 enrollment.

2 MR. BERTKO: Can I go on to my next points now?

3 We could do this probably all afternoon, but we won't.

4 The next is just a modest comment, I think, and
5 I'll put this more a question on the 112 percent page and
6 the efficiency page. I believe that those are claim
7 benchmarks that you're referring to with that relatively
8 small marginal cost that CMS pays to actually pay the claims
9 through its fiscal intermediaries?

10 DR. HARRISON: Are you talking about the fee-for-
11 service numbers?

12 MR. BERTKO: Yes.

13 DR. HARRISON: I've been assured a couple times,
14 because I've heard this before, by the actuaries that they
15 have included all appropriate admin costs and payment
16 adjustments that happen after the fact.

17 MR. BERTKO: That's the one that's back and forth
18 is, I believe, the marginal cost as opposed to allocating
19 any other parts of CMS towards it.

20 DR. HARRISON: That's probably right. I don't
21 know that, but that's probably right.

22 MR. BERTKO: There's a building in Baltimore,

1 among other things.

2 And lastly on just that adjustment, there also is
3 the still missing VA/DOD costs, which are appropriate and we
4 think we will know what that number is next year but not
5 this year. We definitely won't know it this year.

6 Having said that, a couple of other comments here.
7 This is a bit towards people moving to private fee-for-
8 service. Our company in particular, and several others,
9 offers regional PPOs, coordinated care plans in the
10 nomenclature of the MMA, and private fee-for-service. What
11 I would call the value to beneficiaries, what they pay
12 versus what they get, is actually in almost all cases
13 bigger, better in the PPO plans and the preference of
14 seniors is for choice of providers.

15 Somewhere down the road I think they will age into
16 this. They will find that the preference is better and they
17 will move that way. So far this really reflects what
18 seniors appear to want.

19 Another comment along the way is just that the
20 current payment system, including the floors -- at least to
21 my reading -- reflects the intent of Congress to spread the
22 alternatives to traditional Medicare to rural areas among

1 others and to exurban areas. It's been successful at that.

2 As we think through this, my comment is -- kind of
3 addressing Scott's part in what we do, if anything, and when
4 -- we are serving rural and underserved areas. We are
5 serving low-income people who otherwise couldn't afford
6 Medigap plans or don't have ESI-type of plans and anything
7 we would do, I would hope, would minimize disruption. This
8 is a year in which payment levels were low, I think, across
9 the industry. The revenue increase in Medicare Advantage
10 averaged about 1 percent. And for the most part plans
11 stayed where they were. A few more came in and there were
12 relatively few withdrawals, even in a 1 percent era being a
13 relatively tight type of thing to do.

14 The last one -- and now I sound like Jay here --
15 in spite of the formal name called care coordination and
16 private fee-for-service being out of it, the big players in
17 this game -- and it's ourselves and a couple of others --
18 have put together fairly good infrastructure that, in the
19 absence of networks -- although you can have private fee-
20 for-service network-type things, they're not today -- but
21 they do do a fair amount of care coordination. The whole
22 discussion we had this morning on readmission rates, we're

1 showing success in reducing readmission rates by the ones by
2 doing near real-time calls. We get an admission. It shows
3 up in our claims system. We ask but can't tell doctors,
4 hospitals, and patients to call. But they do 90 percent of
5 the time. And we talk to them.

6 We had a comment here earlier about the 30
7 discharge letters you hired. We're spread out. We have --
8 I don't know the exact number -- between 50 and 100 nurses
9 working telephonically to call people up and help them with
10 their discharge. The stuff works. It's not technically a
11 coordinated care plan but there's a bunch of stuff we're
12 doing and we're on the way to doing more of it.

13 So this is a little bit of the old chicken and
14 egg. We're trying to do benefits for people that are spread
15 out across the country, save money, offer care coordination.
16 I would agree it's not perfect in a lot of ways yet, but
17 we're achieving some amount of success along the way.

18 MR. DURENBERGER: I just want to follow on John's
19 comments, and I think they're appropriate even though
20 they're not well known, which is one of the problems with
21 not having had any congressional oversight on anything
22 including this issue.

1 My comments are, and I don't want whatever I say
2 to be misconstrued because I have been in favor of
3 privatizing Medicare since 1981. I've been engaged in the
4 original HMO demonstrations, the cost demonstrations, and
5 the risk demonstrations in the mid-80s, all the way up
6 through various kinds of specialty efforts including
7 Medicare+Choice. I guess John and I met on the competitive
8 bidding demonstration in 1998.

9 So I have no doubt in my mind but what there is an
10 appropriate role for private health plans in the Medicare
11 program and any comments that I make are related to that and
12 I think that any comments that many commissioners make
13 relative to 100 percent of traditional Medicare are meant
14 the same way.

15 But the key question is what's relationship
16 between what we ask of the health insurance plan and what
17 we're willing to pay them. I doubt if that question has
18 ever been asked. It was asked in the old days because we
19 thought we knew what we were doing and we had evidence of
20 it, and we knew when we were getting our money's worth and
21 when we weren't getting our money's worth, and we didn't
22 always react in quite the same way or appropriate ways to

1 reward it. But we did. And there was a lot of oversight
2 over that whole process. But that's still the critical
3 question.

4 The first one of those has always been improved
5 service, care coordination, quality, whatever you want to
6 call it. The assumption has been that -- however you might
7 look at them, the HMOs, or the health insurance plans as
8 they've become -- that you were buying something for the
9 beneficiaries that they couldn't necessarily get out of the
10 current medical care delivery system.

11 And the evidence was they were getting it at 95
12 percent of the average cost.

13 The second thing was that to deal with the average
14 community cost of delivering Medicare services. This is a
15 debate we had in the competitive bidding commission. The
16 idea of a competitive bid was to find out in competition
17 between health plans what is the real cost of delivering a
18 basic set of Medicare services in Kansas City or Phoenix or
19 Minneapolis or wherever it may be. That was the idea of it.

20 That is a policy point that probably only the
21 private sector can help you get at.

22 The third one is to lower beneficiary cost. The

1 evidence is where it works it lowers beneficiary costs. The
2 evidence in this one is it lowers beneficiary cost if you
3 give them more money and then they use it sort of like a
4 Medigap plan or something like that. But the question is
5 always which is the best way to lower beneficiary costs?

6 If you would lower beneficiary class with subsidy,
7 a \$65 billion subsidy, you might say there's a better way to
8 do it.

9 The fourth one is improved benefit structure. I
10 think there's evidence that in this current approach there's
11 improved benefit structures. But I remember about the
12 original benefit structures of the original demonstrations
13 was people in my community could buy one health plan with
14 added benefits for \$14.95 a month and no paperwork. They
15 flocked to it. That is a benefit structure that appeals to
16 the Medicare eligible.

17 But that appeal then means that something else has
18 to change in order to make it work. That's physician
19 behavior, admission practices and hospitals, a lot of things
20 like that.

21 So if you put all those four things together, and
22 in the old days you could do that in some parts of the

1 country for 95 percent of traditional Medicare, I have to
2 ask myself the question why can't you do it for 100 percent?
3 The evidence came, and I can't say that this is the case now
4 but it's at least worth some congressional oversight. The
5 evidence came to us when we were doing the competitive
6 bidding demonstration that the kind of health plans that
7 were doing private Medicare in the 1980s are not the same
8 health plans today. That's part of the program that
9 everybody is going to have to deal with.

10 In this case, there was no question that the
11 predecessor to the lobbying organization was out to kill the
12 competitive bidding demonstration. They followed us.
13 Whatever community we selected they found a Republican
14 senator. In Missouri, Kansas City, it was Kit Bond. In
15 Arizona it was John Kyl. They found somebody to sponsor a
16 resolution of some kind to kill all of this sort of thing.

17 I only say that to reflect my own set of
18 experiences over time which lead me to the conclusion only
19 that it really is imperative that we, the Congress in
20 particular, ask the question about what are we getting for
21 our money? And then from that you can get a specific policy
22 goal. We may want to say all we want is extra benefits.

1 And we may want to say all we want is extra cost-sharing or
2 maybe we want...

3 But the evidence is most people need some kind of
4 coordinated care, improved health care. The HMO, by the
5 data here, gives it to them at a cost lower than traditional
6 Medicare still does. I don't know where those HMOs are
7 located. It still does.

8 John, certainly with all due respect to you, the
9 idea that this is what beneficiaries want when they choose a
10 PPO or they chose something else and so forth is not the
11 measure by which I would be able to make a recommendation in
12 this commission or if I were still in the United States
13 Senate or something like that. Because it is unlikely that
14 a lot of beneficiaries are aware of the fact of what they're
15 getting for their money, even though it's taxpayer
16 subsidized money or whatever you might call it.

17 And it is the responsibility of policymakers to
18 deal with what's behind those expenditures. And I think
19 that is a responsibility that at least has not been well
20 discharged since 2003.

21 MR. HACKBARTH: Nancy, -Ann, I know you need to
22 leave. Why don't you go.

1 MS. DePARLE: Thanks, and actually I want to build
2 on what some of what Dave just said.

3 I think he's asking the right question, which is
4 are we getting our money's worth? I agree there hasn't been
5 enough oversight of this program in the last few years since
6 it's been implemented.

7 But as I look at the data that we do have, I would
8 say that for me the answer is yes, for many of the local
9 coordinated care plans or CCPs, what you and I would think
10 of as the traditional HMOs. The reason I say that is
11 because I think, from what I've seen, they are providing
12 coordination of care, hospitalists, preventive care, a much
13 more intensive package of benefits and clinical coordination
14 -- Jay's plan is one of them -- than you can get in the
15 traditional Medicare program.

16 We spend 90 percent of our time in this commission
17 talking about the ways in which the traditional fee-for-
18 service Medicare program doesn't do these things and what
19 can we do to make them happen.

20 It may just be, and I'm preaching to the converted
21 here, but it may just be, I think we would all agree, that
22 that costs a little more money. That may be part of why it

1 costs a little bit more money for these coordinated care
2 plans to provide those things.

3 On the question of some of the other types of
4 plans, some of the newer types of plans, we haven't seen the
5 data. What I have seen so far doesn't convince me, at
6 least, that private fee-for-service offers those same
7 benefits. I'm intrigued with -- John and I have talked
8 about this over the past few months -- I'm intrigued with
9 some of the things he's seen that they've been able to do
10 without much real authority, as you say, to help drive down
11 inappropriate utilization, which is bad for beneficiaries
12 and bad for the Medicare program.

13 So maybe I'm making a judgment too early there,
14 but at least with respect to the traditional coordinated
15 care plans, I think they have shown their value. And you've
16 heard me say many times that one reason I'm a fan of them is
17 because they can do things that traditional Medicare has not
18 been able to do, either because it hasn't had the
19 administrative wherewithal or the political support or
20 whatever to do.

21 So for all those reasons, that's where I would
22 come out on that question. But I do think it's the right

1 question to ask.

2 I would just say I hope we continue to focus on
3 that question. You hearken back to 1997 and our competitive
4 pricing demonstration, and I think there are three members
5 of this commission who were nice enough to take my phone
6 call and agree to serve on that, and spent hundreds of hours
7 in something that turned out perhaps not to be -- well,
8 certainly not to be much fun, and perhaps not to be so
9 useful.

10 But it also reminds him of what we went through
11 during that period. I would just say, if you'll recall, as
12 I remember it, the goal in the BBA with respect to HMOs was
13 really to expand them, in part because they offered benefits
14 such as prescription drugs that were not available in all
15 areas of the country.

16 To be sure, there was a lot of discussion of why
17 did they get paid more in Miami than Minneapolis? Or why
18 are payments so different. But there was overall a desire
19 to expand the availability of that care in 1997.

20 And what happened was exactly the opposite. I
21 don't think anyone anticipated this, but it was a very
22 disruptive, wrenching experience for the Agency, for

1 Congress, for beneficiaries to go through. Millions of
2 beneficiaries lost their care plan or were disrupted in some
3 way. Many of them lost faith in the Medicare Advantage
4 program, the Medicare+Choice program as it was then called.
5 And I'm sure the plans that participated in and had to
6 withdraw from some areas lost some of their brand with those
7 beneficiaries.

8 No one intended that. So I just would say here it
9 seems like there is a very deliberate approach to let's
10 reduce down to 100 percent of fee-for-service. And while
11 philosophically certainly I can support that idea, I just
12 hope that -- as I think is on the table -- that if we go in
13 that direction that we do it very mindfully of all of the
14 unanticipated consequences that can flow from even what was
15 10 years ago a well intentioned proposal to do something
16 very different that ended up having that consequence.

17 DR. REISCHAUER: I guess as the third veteran of
18 that commission, I have to add my two cents worth here.

19 As Dave said, the original intent of the private
20 plans was to offer Americans a different delivery system,
21 one that was thought to be more efficient, provide higher
22 quality care, that possibly could generate some savings that

1 could be redirected towards added benefits or lower cost
2 sharing.

3 And with respect to the coordinated care plans,
4 one can make that argument no matter where you set the
5 benchmark. It's much harder to make that argument with
6 respect to fee-for-service, private fee-for-service, because
7 it's offering, in a sense, the exact same product. And
8 unlike the coordinated care plans, really nothing is being
9 asked of it and, in fact, it's getting a huge advantage
10 relative to them in that it can use the administrative
11 market power of Medicare in its pricing with providers.
12 Unlike the other Medicare Advantage plans, it isn't asked to
13 submit the same sort of quality data.

14 I was interested, John, in what you said because
15 you implied that, notwithstanding no requirement for you to
16 provide services that might improve quality, might in a
17 virtual way coordinate care, you're doing that.

18 So my question would be well that's great and
19 shouldn't we begin asking you for the quality data?

20 DR. MILSTEIN: Okay.

21 DR. REISCHAUER: Okay.

22 DR. CROSSON: I have to say I wasn't particularly

1 looking forward to this report. I was actually hoping it
2 would be scheduled at the May meeting. Oh that's right,
3 there's no May meeting.

4 [Laughter.]

5 DR. CROSSON: But having read it, I thought it did
6 a very good job of touching on a set of key issues here and
7 we've already started talking about them.

8 One is, of course, the question of equity between
9 Medicare Advantage and fee-for-service and what we really
10 mean by that and how fast that equity should be achieved.

11 The second thing that's treated, I think, well in
12 the paper is the fact that doing it and certainly doing it
13 too quickly creates the risk of disrupting the relationship
14 between the plans, including mine, and the beneficiaries.
15 And also it well raises the concern about the potentially
16 differential impact on certain vulnerable populations,
17 including low-income beneficiaries.

18 But it also raises the fourth consideration, which
19 I think Bob just brought up, and that's an issue of equity
20 among MA plan types. I think those are the four issues that
21 we have to deal with.

22 I have my own thoughts about which of these

1 options make the most sense but I'm not sure this is
2 necessarily the time to do that. What I hope that we do is
3 that we develop more information for the Commission on each
4 one of those four issues and then we work our way through
5 them and decide along the way whether we think we can or
6 should come up with a point recommendation, getting back to
7 this same issue again, on these four points or whether our
8 job is to create a set of pros and cons in very clear
9 language for the Congress to make the determination.

10 It will be interesting to see which way we go. My
11 guess is that in the end we're going to end up with issues
12 that are so value laden on at least three of these that we
13 may end up presenting, and hopefully very clearly, the pros
14 and cons for the policymakers to decide.

15 MS. HANSEN: Actually, I think especially Bob and
16 Jay have covered what I was interested in, in the area of
17 the equitable accountability for plans that get the private
18 fee-for-service element.

19 The other point I wanted to underscore, Glenn,
20 that you brought up was the premium support aspect of it
21 relative to the beneficiary, their paying on top of and not
22 all getting the benefit from it. If we're going to have to

1 have them make up, it's the beneficiary that has to pay some
2 more.

3 I know implied in that that some of perhaps the
4 tools of coordination that are being developed that will
5 eventually benefit everybody. But right now I think the
6 beneficiary might be placed in a position to do some added
7 premium support.

8 But I also know that I come through to say that I
9 do believe in the equity side, but I do want to agree that
10 there are many benefits right now that here go to the people
11 who are the lower income, that they do get some benefit from
12 it. So the graduation of this and the intentionality of how
13 we do this will be real important.

14 And finally, I just would like to say that if, in
15 fact, the care coordination stuff does come out of the
16 private fee-for-service, then I think that stands to get
17 elevated and looked at because that is, at the end of it,
18 what is really crucial on the chronic disease management
19 side.

20 DR. WOLTER: The thing that concerned me about
21 this last time we discussed it was the issue of trying to
22 create equity with a fee-for-service plan that, in other

1 context, we all agree is very inequitable in terms of the
2 large amount of payment variation around the country in that
3 system. And so I really worry that we're kind of getting
4 back to that again and we may end up with a situation, if we
5 follow this path, where we, in essence, allow the plans to
6 play in the areas where the utilization and the payment
7 rates are already higher than we wish they were. And that's
8 great, because maybe they will have some impact in those
9 areas.

10 But it wouldn't be the same as saying let's have a
11 strategy where taken in aggregate we would like these plans
12 all together to deliver care at lower than the average fee-
13 for-service cost across the country. And let's do what Bob
14 was implying. Let's really start strengthening what we're
15 requiring back in terms of information about congestive
16 heart failure admission rates or other things that could
17 very likely be linked to lower annual expenditures. And
18 that would be something I could get very excited about.

19 But to link this back to county level fee-for-
20 service rates when that is currently such an irrational
21 situation, just doesn't feel very good.

22 DR. SCANLON: Given all that we've heard about the

1 equity across plans, I think this is almost a footnote.

2 But I believe our recommendations would be
3 strengthened if we thought about -- if we stopped
4 considering Medicare Advantage as a single homogeneous
5 entity, and to make potentially differential
6 recommendations. The glide path to equity doesn't have to
7 be the same for all the plan types.

8 In doing that, you might create an option for
9 plans to be able to convert to a different type if they want
10 to be on a slower glide path.

11 But consistent with all we've said about value
12 purchasing, if we're not getting anything additional why do
13 we want to prop something up longer at some kind of higher
14 level?

15 The second kind of differentiation I think we
16 would consider is how much above fee-for-service are we
17 willing to tolerate before we want to move quickly? These
18 options here, they're not all equal in terms of how they're
19 going to impact different areas. You might want to consider
20 combining these options and having a cap on how much above
21 fee-for-service that one is willing to go, which will affect
22 some areas. But then other areas you might want to do up

1 blend and move from a blended position.

2 I think working through some of these options
3 would be an important thing to do.

4 MR. MULLER: Along the theme of the last few
5 comments, and going back to Bob's recitation of some of the
6 intent of this 10 years ago, it almost struck me that in
7 managed care you were, as a beneficiary, putting yourself
8 into a coordinated care plan. You would do that maybe for
9 lower copayments, maybe increasing at that time for better
10 benefits. That was a fair trade to go into.

11 I do have a concern of when I see the 66 percent
12 growth in private fee-for-service and 2 percent in
13 coordinated care, in some ways if you can get that kind of
14 random walk down medicine street and get extra benefits, I'm
15 surprised that everybody didn't convert to private fee-for-
16 service. If you can get extra benefits, any rational person
17 would say I want that. It doesn't cost me anything, so
18 everybody in the Medicare plan should go to private fee-for-
19 service and get the extra benefits. In some ways you could
20 keep going in that direction.

21 My concern is that if we're going to offer extra
22 benefits to people, why don't we just offer them here? What

1 says this population should get them? If we want extra
2 benefits, we should think about how we want to target them.

3 If we want to target them towards people who get
4 coordination, then we should give more encouragement to the
5 coordination plans. They're obviously coming in at an
6 economic level that we find attractive by being less than
7 fee-for-service, whereas others are coming in at 120
8 percent.

9 If we're really concerned about offering
10 incentives to coordination, why just do it through private
11 fee-for-service? Why don't we offer it to primary care
12 physicians? We've discussed that at other times. We've had
13 some discussion about how one actually puts coordination
14 payments into an E&M schedule and whether the ACP has been
15 recommending medical homes and forth.

16 Without going through all that again, there are
17 other ways of getting coordinated benefits in the fee-for-
18 service plans through primary care and even specialty
19 physicians. You don't have to go to a 22 percent premium.

20 This strikes me that we're paying an awful lot for
21 the same system and the argument that people benefit from
22 it, there are other ways to target benefits more selectively

1 towards people who want to benefit.

2 So I'm with Bill, in a sense borrowing from him.
3 I think we have different recommendations around the
4 different plans. If the care coordination plans are meeting
5 what we want them to do, I'm very distressed the growth is 2
6 percent and 66 percent in an area that basically mimics a
7 system that we spend, somebody said, 95 percent of our time
8 criticizing.

9 So I'm very concerned that we're willing to pay 20
10 percent extra for a system that we don't like and we don't
11 have enough movement towards a system we do like with only 2
12 percent growth.

13 MR. HACKBARTH: Let me just pick up on Ralph's
14 comment.

15 Our immediate impulse, I think almost across the
16 board, is well on timing you want to do gradual because we
17 don't want to hurt the beneficiaries. And that was the gist
18 of what we said a couple of years ago when we talked about
19 getting to 100 percent over time.

20 But I've had, personally, second thoughts about
21 that with regard to private fee-for-service. In fact, I
22 think time may make things worse. Indeed, in time it may

1 become politically impossible to deal with the issue.

2 As the number of people enrolled in private fee-
3 for-service grows, drawn in by free benefits, financed not
4 through the efficiency of the plans but through the
5 generosity of the taxpayers and other Medicare
6 beneficiaries, it becomes every day more difficult for
7 members of Congress to say I'm going to take this away.

8 So the idea of a glide path down may just be
9 wishful ivory tower thinking about at least this particular
10 sector of the Medicare Advantage program.

11 With regard to the targeting issue, I basically
12 agree with Ralph. If Congress wants to provide more
13 benefits to low income beneficiaries, we know how to do
14 that. We know how to do it at a lower cost.

15 So why, when Medicare faces long-run
16 sustainability issues, should we be choosing to use vehicles
17 that are known to be more expensive? Let's connect the dots
18 here in the various statements that we make and not just
19 talk in chapter one about long-run sustainability and then
20 go on and accept policies that threaten to make that much
21 worse.

22 Again over time, if we allow this to continue and

1 hundreds of thousands of new people go into that open door,
2 drawn by free stuff, we're in the process of taking areas
3 that have been lower cost for Medicare and pulling them up.

4 I'm very sympathetic with the geographic equity
5 issues but to be real blunt about it, for our long-term
6 sustainability problem, we've got to take the high areas and
7 level down. It is not a strategy to take the low areas and
8 level up. And yet, I think that's what we're doing through
9 the back door with Medicare Advantage right now.

10 DR. WOLTER: I think, Glenn, the question I'm
11 throwing out is the strategy just to return to current
12 county level fee-for-service going to get us some attention
13 to the high geographic areas where the payment is out of
14 whack? I'm worried that we are creating strategies to do
15 that. That's all.

16 MR. HACKBARTH: And you're absolutely right,
17 Medicare Advantage won't do that. And that's why I
18 personally thought that the discussion in the SGR report
19 about geographically-based limits that press down on the
20 high-cost areas and put the greatest pressure on those that
21 contribute most of the problem, that's how you deal with
22 that geographic inequity. You can't resolve it through

1 Medicare Advantage. You've got to do it through traditional
2 fee-for-service.

3 It's a choice. We agree on the goal but we've got
4 to use a tool that's appropriate to the task.

5 MR. MULLER: You don't get there by making the
6 floors higher than the system you don't like. It's totally
7 perverse.

8 MR. HACKBARTH: We're behind. Any other comments?

9 Thank you.

10 Next is SNF refinement.

11 DR. MILLER: Just before we get started, I want to
12 make sure a couple of things. The public should know that
13 Carol Carter was slated to make this presentation and she
14 has had some family emergency. And so Sarah Thomas, who's
15 the Deputy Director here, has agreed to step in and take the
16 presentation. I'd like to thank Sarah for that.

17 And for the commissioners, it may mean we might
18 have to follow up on a couple of your questions. And please
19 take care of Sarah, because I need Sarah.

20 [Laughter.]

21 MR. HACKBARTH: This is a rare opportunity to
22 heckle Sarah. We don't get this.

1 MS. THOMAS: Do you want me to go ahead and start,
2 since we're behind?

3 We have talked for maybe two or three years about
4 some of the problems in the SNF prospective payment system.
5 I think the two key issues that I just want to remind
6 everybody about before we get into the meat of the
7 conversation is that even though the cost for these services
8 called non-therapy ancillaries, which are respiratory
9 therapy, drugs and IV drugs, and I'm sure there's a longer
10 list of things? Even though the costs were built into the
11 PPS, the case-mix system doesn't pay more when a patient
12 needs more of these services.

13 So what we've heard from a series of reports that
14 were done by the OIG and from our own site visits is that
15 there's really a disincentive for SNFs to take patients who
16 are expected to use a lot of these non-therapy ancillary
17 services. In fact, we've heard about over time some of the
18 SNFs getting out of the business in furnishing it, not
19 taking patients, and then they end up back in the hospital.

20 The other theme that we've earned over the years
21 is that there is an incentive in the system, sort of the
22 opposite from the non-therapy ancillaries, that you get paid

1 more, the SNF gets paid more to do more therapy. This would
2 be occupational therapy, physical therapy, and speech
3 language pathology. So it's the opposite problem as the
4 non-therapy ancillary problem.

5 What I'm going to do is I'm going to talk about
6 some work that CMS recently put out in a report to talk
7 about possible reform options which would deal with both of
8 those two issues I just mentioned, and also take into
9 consideration an outlier policy for this payment system.
10 And then what I'm going to do is shift the focus of the
11 presentation to Dr. Korbin Liu from the Urban Institute, and
12 he's going to talk about work that he's going to do for us
13 in the coming set of months. This is intended for
14 publication in the June report, although we think that we're
15 going to be actually driving recommendations in a longer-
16 term time frame.

17 And when we come to the end of the presentation
18 I'm going to ask you to help give us some feedback on how to
19 narrow the scope or broaden the scope to include some
20 broader issues about the payment system. So that's what I'm
21 going to turn to you guys for at the end.

22 CMS funded extensive research to explore

1 alternative ways to more accurately pay for SNF care. Urban
2 Institute actually did much of that work. Although CMS made
3 some refinements to the PPS in 2006, we've stated that these
4 changes did not go far enough in revising the payment
5 system.

6 Just to remind everybody about how this payment
7 system works, SNFs are paid a daily rate which is adjusted
8 for case-mix using the Resource Utilization Group
9 classification system. This is a patient assessment tool
10 that comes off of something called the Minimum Data Set or
11 the MDS. Payments go up or down depending on patient
12 characteristics and their use of services such as therapy.
13 Information is gathered from that MDS.

14 In order to qualify for a SNF stay, patients must
15 have had a prior hospital stay.

16 This summarizes work that is published in the CMS
17 paper on what they did to look at options to improve the
18 payment for non-therapy ancillary services. CMS has
19 actually acknowledged that the RUG-based system is only a
20 modest predictor of the variation in non-therapy ancillary
21 use and actually spent a lot of time in its report and
22 outside to developing a refinement.

1 These are basically the summary of two models that
2 were promising. One would start with the current RUG system
3 and it's a system that would be called the RUG 58 + Service
4 Index Model. The other model that they looked at was called
5 the New Profiles Non-Therapy Ancillary model. Under either
6 of these options a new component would be added to the PPS
7 that would calculate a separate payment for non-therapy
8 ancillary services. So there would be then instead of three
9 parts of the payment system, there would be four.

10 The RUG 58 + Service Index Model starts with RUGs
11 and adds other variables that come from the existing patient
12 assessment tool, the MDS. The New Profiles model, by
13 contrast, actually starts with a classification system that
14 was developed by the University of Colorado Health Sciences
15 Center and it actually adds information from the previous
16 hospital stay. So everybody's had one of those, so you can
17 pull some information from that, as well.

18 The current payment system explains about 10
19 percent of the variation in non-therapy ancillary services.
20 If you look at that row with the amount of variation and
21 cost explains, you can see that both of these models do two
22 times better than the current system at explaining the

1 variation in non-therapy ancillary costs. The last line
2 summarizes the data collection. For the RUG 58 + SIM model,
3 you actually would just use additional variables from the
4 MDS. And then from the New Profiles model, you pull some
5 information from the hospital stay. In neither case would
6 you need to create a new data stream. You may need to pull
7 some data from some existing places.

8 The second chart here is the summary of the
9 different models that CMS looked at to deal with this
10 therapy issue. Right now the payment system basically is
11 like a fee schedule. It pays more the more therapy is
12 provided. Both of these models would, instead of being
13 based on that sort of a system, they would build a
14 prediction of the amount of therapy that a patient would be
15 expected to use and pay that amount prospectively. The two
16 models, first is the New Profiles, and it actually pulls
17 data from the prior hospital stay like the New Profiles for
18 Non-Therapy Ancillaries model. And then the DRG model
19 actually just uses the DRG from the prior hospital stay.

20 The current system, which matches pretty well to
21 service use, has performance -- I think the explanation is
22 in the 30 percent range, 39 percent of the variation. You

1 can see that for these two models they don't explain costs
2 as well. And actually I believe the DRG model -- both of
3 these models actually did a better job at explaining the
4 variation in speech language pathology costs.

5 In terms of data required, again these would draw
6 from the prior hospital stay. It would not require new data
7 collection. It might require existing data to be rerouted
8 to be added into the classification system.

9 These are some questions I'm going to return to
10 you guys at the end, but let me just give you a sort of a
11 heads-up on one of the things that we'd like you to give us
12 some feedback on.

13 Before we even start delving into the system one
14 thing we might want to ask is whether we're comfortable with
15 the current system being based around a per day payment or
16 whether we might want to consider a per stay kind of model.
17 The advantages to a per stay model is it's a larger bundle
18 of services. On the other hand, the disadvantage is that
19 there's maybe a risk that SNFs might start shortening stays
20 inappropriately.

21 The other issue we're going to tee up at the end
22 is the extent to which you would want us to explore these

1 predictive-type therapy models or whether you'd want us to
2 focus on some other issues.

3 Let me also take you through some of the outlier
4 policy issues. These are basically to encourage providers
5 to -- it protects them against spending extraordinarily high
6 amounts on particular patients. It may protect some SNFs
7 from taking on certain cases that they might worry might end
8 up as being high cost.

9 Generally outlier policies look at the total cost
10 of patients, not a particular category of costs. But
11 because non-therapy ancillary services are a specific
12 concern in the PPS, CMS's researchers actually looked at
13 creating an outlier policy particularly for non-therapy
14 ancillary service costs.

15 What they found is that total cost and non-therapy
16 ancillary cost outlier policies would actually help the
17 financial condition of particular groups of SNFs. That is
18 hospital-based facilities, government-owned facilities,
19 small facilities, and facilities with high Medicare shares.
20 On average, the financial condition of freestanding
21 facilities was pretty much unaffected by a non-therapy
22 ancillary cost policy but would be lower under a total cost

1 outlier policy

2 Here's some data on the distribution of costs in
3 these two types of facilities, freestanding and hospital-
4 based. I'm using this to illustrate why hospital-based
5 facilities would benefit more from outlier policies than
6 freestanding SNFs.

7 If you look at the median costs, the differences
8 aren't particularly dramatic, particularly for non-therapy
9 ancillary costs. What you can see is that at the extremes
10 there really is a quite substantial difference in the cost
11 for these two types of facilities. Of course, an outlier
12 policy which is targeted towards paying for these extremely
13 costly case would help. You can see why it would help the
14 hospital-based facilities.

15 One question to think about is if you see that
16 there's something that needs to be fixed in the payment
17 system, perhaps an outlier policy isn't the best way to do
18 it. Ideally if you see that there's something
19 systematically wrong, you might want to fix that with a
20 systematic adjustment to the payment. But it is something
21 that you might even want to consider as a short-term
22 adjustment while that fix is being created and implemented.

1 So that's something we'll return to at the end.

2 Now I'm going to turn it over to Dr. Liu to talk
3 about work he has planned to do for us.

4 DR. LIU: Thanks, Sarah.

5 One of the first things we did in the past year
6 was actually help MedPAC develop a new analysis file. A lot
7 of our research that was done for CMS was based on a 2001
8 file. So we created a brand new 2003 file of SNF stays.

9 The data that went into this particular analysis
10 file included the Minimum Data Set information on individual
11 assessments for the SNF patients, claims from the SNF stays
12 themselves, and claims from the prior hospital stay. So
13 you've got three major sources of information on patients.

14 So being good researchers with a brand new file,
15 we felt as a first step it would be important to reexamine
16 some of the predictors and models that we had found to be
17 very interesting and to be associated with various cost
18 centers. So that would be one of the logical first things
19 for us to be doing.

20 The second bullet under the new file says IV
21 therapy and respiratory therapy. I wanted to highlight
22 those two variables because in our prior research we found

1 those two to be particularly good predictors of non-therapy
2 ancillary costs. We did, between the University of Colorado
3 and the Urban Institute, we did quite a bit of data mining
4 which is to look at all available information that we had on
5 patients. These two really popped up.

6 The way that's phrased, it's IV
7 therapy/respiratory therapy based on both claims and MDS
8 interaction. One of the things we discovered in our prior
9 research was that when you only pulled out IV therapy or
10 respiratory therapy indicators from the MDS, they didn't
11 turn out to be as powerful predictors of non-therapy
12 ancillary costs as one might expect. One would expect that
13 primarily because of a lot of anecdotal information we had,
14 and I'll get back to that in a second.

15 It turns out the way the question is phrased in
16 the assessment, it's phrased something along the lines of in
17 the past 14 days did you receive IV therapy? Now a lot of
18 these assessments are based on the first five days in a
19 skilled nursing facility. So that 14 days actually covers a
20 lot of use in a prior hospital stay. So between the two,
21 it's confounded in terms of how powerful that variable might
22 be for a SNF stay.

1 That's why, as a way to get around that, we
2 interacted the MDS indicator of IV therapy or respiratory
3 therapy with the actual SNF claims, which indicates that it
4 be done at the SNF level. So once we did that interaction,
5 those two variables just popped up as incredibly powerful.

6 Anecdotally, I had done a study on post-acute care
7 -- this is in 2000 before a lot of the post-acute care PPSs
8 were implemented. And we talked to stakeholders, including
9 associations and the nursing home industry and so forth.
10 And everybody said boy, IV medication and other IV therapy
11 are extremely expensive these days and they're not built
12 into the payment system. Respiratory therapy the same way.

13 We also found, looking at cost report revenue
14 centers, that after the PPS was implemented a lot of the
15 freestanding skilled nursing facilities stopped billing for
16 respiratory therapy and it was not reflecting in the cost
17 reports themselves.

18 So again apparently because the respiratory
19 therapy and IV therapy are very expensive services, or could
20 be, they are very good predictors of costs. And we will
21 come back to that.

22 After looking at the database and re-examining the

1 predictors and models that we had developed, there are
2 various new avenues actually that I think that we want to
3 explode that we didn't really spend a lot of time on in the
4 past few years. In our initial conversations with MedPAC
5 staff, we came up with a nice list of new things to explore.
6 I wanted just to highlight a few of them.

7 One is this question of per diem versus per stay.
8 Most of our prior research focused on per diem as the
9 dependent variable. We did examine per stay on a very
10 cursory basis but I think there's a lot more that could be
11 done there.

12 Length of stay adjustment. We did not use length
13 of stay during a SNF stay as a possible factor in predicting
14 costs. I think the notion is that in the early parts of the
15 stay your costs are likely to be higher than the latter
16 parts of the stay.

17 So we do have this variable. This is a variable
18 we plan to take a look at and see how that does in
19 connection with predicting various types of costs in the
20 SNF.

21 Another impetus for looking at this is we
22 discovered that the inpatient psychiatric hospital PPS now

1 does include a length of stay adjustment. So this provides
2 a sort of a precedent, in a sense, for looking at it.

3 Another new avenue that we were thinking about
4 exploring was simply looking at those high cost cases
5 themselves and finding out, rather than trying to use a lot
6 of variables to predict costs, but just to actually look at
7 the ones with high cost and see who they are.

8 I think a good example of this particular exercise
9 would be like HIV patients. We sort of know intuitively
10 they're going to be expensive, they're going to have high
11 NTA costs, and they do.

12 Another factor when you're considering whether to
13 include HIV in any kind of classification model is that
14 there's only 1,000 cases nationally. So that goes against
15 the likelihood of trying to incorporate that particular cell
16 in a classification system. But again this is more of a
17 data analysis exercise.

18 A fourth one I'd just like to mention is that we
19 thought it might be productive to look at nursing costs and
20 facility level case-mix. It's facility level because the
21 nursing cost variables are available only on a facility
22 basis from routinely collected administrative information.

1 Unlike the non-therapy ancillary, the rehab therapy
2 variables, which are available on a per person basis through
3 the claims, the nursing cost variable has to be teased out
4 of the cost report which, by definition, makes it a facility
5 level dependent variable.

6 We'd would like to explore how Medicare case-mix
7 might be related to nursing costs on a facility level.

8 After exploring these new avenues, we'd would like
9 to return again to creating or examining the building blocks
10 that can be combined perhaps in various combinations in new
11 SNF PPS options. We had developed some building blocks.
12 They were very preliminary and I think we're at the point
13 now where we might be able to refine a lot of these.

14 Number one listed there is non-therapy ancillary.
15 It's perceived to be the most important service component by
16 a lot of folks. So we will examine the building blocks we
17 have and see if we can modify them with perhaps length of
18 stay adjusters and things of that sort.

19 The predictive therapy models, we have a
20 predictive therapy model. The New Profiles is a good
21 example there. In the New Profiles model we had actually
22 two components. One was PT/OT combined and one was speech

1 by itself. One of the things we plan to do going forward is
2 to combine all three of those therapies into a single model.
3 They were also created using a lot of variables and we want
4 to slim down the number of variables there.

5 The third one is DRGs. We've developed some
6 models using DRGs and these are DRGs based on the hospital
7 DRG. In one of Sarah's earlier tables, the R-squares were
8 not particularly high for the DRG models. But I've got to
9 tell you that in the DRG models we used only two sets of
10 variables. We used only the DRG and then we used functional
11 status variables from the SNF say.

12 We wanted to keep this one as clinical as possible
13 so those variables in the DRG models we used are not very
14 gameable.

15 MR. HACKBARTH: Korbin, we're running behind
16 schedule. So if you could take it up a couple of levels in
17 terms of specificity and not go into as much detail, that
18 would help.

19 DR. LIU: Will do.

20 We developed some outlier payment options and they
21 were for NTA and also for total cost and we'll revisit some
22 of those primarily in combination, I think, with some of the

1 classification models.

2 Then as we begin putting some of these building
3 blocks together, there are a lot of things we want to
4 consider. The sources of data, because of the complexity
5 and perhaps burden of pulling data from too many different
6 sources, the number of variables that go into creation of
7 these classification models, and we want to keep the payment
8 cells as small as possible for simplicity purposes.

9 There's going to be a trade-off in any of these
10 combinations. One is the statistical variance explanation
11 power, and that trade-off may be at the expense of burden
12 for both providers and for CMS to administer these programs.

13 And then we'll look at the incentives.

14 I think the last thing I want to do today is to
15 show you an example of -- this is an NTA model. It's based
16 on three variables. It's based on that IV/med variable that
17 I had mentioned earlier, it's based on the respiratory
18 therapy variable that I mentioned earlier, and the third is
19 the RUG classification. This is an NTA model that has an R-
20 square of about 20 percent. It uses three variables. The
21 reference here is that the NTA average cost is \$63. So what
22 you end up with in this model is six cells, six payment

1 cells.

2 The first one is a case where there is no IV and
3 there's no respiratory, and the person is classified in one
4 of the rehab classification groups. That payment is \$39
5 relative to the \$63 average. That's because you don't have
6 either IV, you don't have respiratory, and these are primary
7 therapy patients.

8 So at the other extreme, number six, are people,
9 cases with both IV meds and respiratory therapy. And they
10 have an average cost of \$247. So you've got both extremes.

11 The last point on this chart is that if you look
12 at the cases with neither IV nor respiratory, like cell
13 number one, cell number three, that's almost 90 percent of
14 your cases. So about 90 percent of your cases are below or
15 at the average.

16 I think I'll stop right there.

17 MS. THOMAS: We're going to wind up. These are
18 some suggestions of things you might want to talk about,
19 whether you want us to go beyond thinking about ways to
20 refine the per day system and even think about per stay.
21 Think about this question of predictive therapy model versus
22 one that pays more the more you do. And about an outlier

1 policy.

2 You're also, of course, free to ask questions
3 about anything that Korbin or I presented.

4 MR. HACKBARTH: Sarah, could I asked about the
5 history a little bit? We have a per day system now. In
6 general, we seem to prefer bigger bundles rather than
7 smaller. Could you just describe why, when the current
8 system was put in place, the decision was made to go with
9 per day versus per stay? Was it because of the weakness of
10 the case-mix adjustment?

11 MS. THOMAS: I guess what I remember, and maybe
12 Bill has the answer. I think it's because the MDS is
13 oriented towards per day, right, from the long-term care
14 side?

15 DR. SCANLON: Actually I was at GAO and we were
16 advocating the per day system. I think the primary system
17 is because in a SNF your Medicare stay does not mean that
18 you leave the SNF. You can be staying in the same bed and
19 continue on as either a private pay or a Medicaid patient.

20 And that, in some respects, created a great deal
21 of uncertainty about the amount of under provision of
22 Medicare covered days that might occur under a per stay

1 model.

2 I don't know how much that has changed. We certainly
3 have had changes in the nursing home sector in terms of a
4 lot more use of assisted living facilities. But we still
5 may have a lot of people that are continuing on as nursing
6 home residents, being paid from other sources. That was the
7 primary thing, I think, that was driving it.

8 MS. THOMAS: One of the things that Dana points
9 out to me was that there was a desire back at the time to
10 develop a system that would be able to work with both
11 Medicaid and Medicare. So I was kind of on the right track
12 with that answer, that it be compatible with the MDS system.

13 MR. HACKBARTH: Questions? Comments?

14 DR. SCANLON: Two quick comments. One, I think
15 the problem we have is we're working with bad data. When
16 you had your lower R-square on your therapy models, I think
17 we have to remember that the therapy use that we're looking
18 at is therapy use that's been distorted by the incentives
19 created by a system that maybe encourages over provision. I
20 don't think we have a gold standard in terms of what are the
21 therapy levels that we should be targeting and therefore can
22 predict.

1 The fact that the existing system predicted more
2 is not a surprise. It's not clear how bad your model was.

3 The other thing I would say is that the outlier
4 policy, with respect to total cost that you describe, sounds
5 like a reward for inefficiency more than anything else.

6 With respect to non-therapy ancillary though, an
7 outlier policy which in some ways could be considered a
8 carve-out policy, might be a way of dealing with the fact
9 that in a number of instances we're talking about things are
10 done relatively rarely and that we're not going to ever be
11 able to predict them for the small caseloads that many
12 skilled nursing facilities have. And the best way to deal
13 with them is on an outlier basis.

14 At the same time, we want to be very sure that
15 we're picking things that aren't gameable so that we know
16 that there is a real medical need for these kinds of
17 services.

18 MR. HACKBARTH: Explain, Bill, why you said that
19 the outlier policy sounded like a payment for inefficiency?
20 Why is this different than the hospital outlier policy?

21 DR. SCANLON: For one, we're paying on a per day
22 basis here. It's going to drive the differences in terms of

1 the costs. We don't have a sense of how the nursing costs
2 vary because we don't measure that. If that's not captured
3 in the rate already. we don't have a measure of that. The
4 things that are going to vary are the non-therapy
5 ancillaries or the length of stay.

6 Sarah, in talking about which facilities would be
7 affected most by an outlier policy for high cost, it was
8 hospital-based, governmental, and I would think that maybe
9 the ones that are --

10 MS. THOMAS: High Medicare share and small.

11 DR. SCANLON: Right. So it's ones where you can
12 think of it more from an efficiency level than sort of the
13 patients or the residents need as driving those higher
14 costs.

15 MS. HANSEN: Just a comment. Korbin, you're
16 familiar with all of the PACE sites. I just wonder whether
17 again, because they haven't had the incentive to do any
18 gaming as such, the ability just to look at their
19 utilization patterns. It's not going to be the big dataset
20 but it does give you some patterns of utilization for
21 therapy.

22 DR. LIU: Glad to.

1 DR. KANE: Weren't we talking, when we were
2 talking about hospital readmission rates, that there may be
3 things that go on in the hospital stay that create problems
4 in the post-acute setting? I don't know if this is just a
5 wild goose chase but would that predict -- would it be
6 possible to look at, I guess 16 percent of hospital
7 discharges are two SNFs. Would it be possible to sort out -
8 - are there things that happen in that stay that predict the
9 greater needs of a visit in the SNF?

10 At some point, I'd like to see the SNF and the
11 hospital bundled but I don't know if that make sense. But
12 meanwhile, what does the hospital stay tell us besides just
13 the DRG that might help predict what goes on in the SNF?

14 DR. LIU: I guess one of the things -- the
15 hospital -- the information about the hospital stay really
16 is intriguing, conceptually intriguing, because it really is
17 what kicks off the SNF stay. And so when we were looking at
18 the data from the hospital stay, we were very intrigued
19 about what was taking place in the hospital that might be
20 associated with SNF costs, for example. It gets a little
21 bit fuzzy because you can't tell, on the one hand you think
22 more therapy done in a hospital, there might be more therapy

1 done in the SNF. On the other hand, maybe there's an offset
2 instead. So if there was more done in the hospital there
3 would be less needed in the SNF. So it's very complicated
4 but I think it's a very interesting relationship.

5 We could look at the hospital stay, spend a little
6 more time looking at those characteristics.

7 DR. KANE: Some of the things we were talking
8 about was things like adverse events in the hospital having
9 a post-acute effect. So some of the untoward things. So I
10 don't know if that's possible to dig up but I think that
11 would help us think more about how linked those two should
12 be and whether the SNF is actually getting penalized if it's
13 only paid X when it received a patient from a hospital that
14 had been damaged more than they should have been.

15 MR. HACKBARTH: Any others? Okay, thank you very
16 much. Thank you. Korbin.

17 And last for today is findings on hospital-based
18 SNF.

19 Craig got the seat of honor.

20 MR. LISK: I am going today present results of an
21 analysis that we conducted to take a closer look at
22 hospital-based SNFs. To remind you, hospital-based SNFs, as

1 you know, have very low margins, as reported in our March
2 report, minus 85 percent in 2005 compared to freestanding
3 SNFs who had a margin of 13 percent. We want to understand
4 better the financial situation of hospital-based SNFs and
5 how they may differ from freestanding SNFs.

6 We also wanted to see if we could classify
7 hospital-based SNFs into different SNFs models. Are they
8 homogeneous or not? We plan to include this analysis in
9 this year's June report along with some of the stuff in the
10 previous discussion, as well.

11 The basic outline today, I'm going to briefly
12 review our case study, results that we had. That is
13 actually now available on our website, on hospital-based
14 SNFs. We're going to look at a comparison of freestanding
15 SNFs and how they compare, hospital-based SNFs compare with
16 freestanding SNFs, and look at the different models of SNFs.
17 These later two analyses are new analyses.

18 On the case study, this past year we conducted a
19 site visit of several different markets with hospital-based
20 SNFs, and we found that hospitals closed their SNFs because
21 of financial losses, a more profitable or better use of the
22 space such as a need for more acute care beds, the

1 difficulty in staffing particularly with RNs, and some point
2 also to some regulatory issues, state regulatory certificate
3 of need issues.

4 Hospitals retained SNFs because of savings on
5 acute care from shorter inpatient stays, easier or quicker
6 access to post-acute care and, in particular in some rural
7 areas, for access to SNF services in the community, and
8 continuity of care particularly for physicians to have
9 easier access to their patients.

10 We heard and saw about three different models of
11 hospital-based SNFs, and I'm going to go back into these
12 when we get to the table on that so I can save a bit of time
13 here.

14 I want to first describe some basic
15 characteristics of Medicare patients who use post-acute care
16 services, this isn't just those who use SNF services, but
17 these are some basic characteristics of patients who use
18 post-acute care. What we find is within and across DRGs
19 that patients who use post-acute care services tend to have
20 longer acute-care inpatient hospital stays, they have higher
21 severity of illness scores measured by the APR-DRGs. In
22 turn, because they have these characteristics, they also

1 have what we would say on a case level lower inpatient
2 margins compared to cases that don't use SNFs within DRGs.

3 So how do hospital-based SNFs fit into
4 marketplace? Well, they represent a small share of the
5 facilities, just 8 percent, and they account for 17 percent
6 of the SNF cases and 9 percent of patient days.

7 As this is a per diem payment system, payments
8 track pretty close to patient days. Payments account for
9 about 10 percent in hospital-based SNFs.

10 Hospital-based SNFs differ from freestanding SNFs
11 in a number of ways. They are smaller, 26 beds on average
12 compared to 98 for freestanding. Hospital-based SNFs have a
13 higher proportion of Medicare patients. They also have
14 shorter stays on average compared to freestanding SNFs, half
15 of what they are in freestanding SNFs. Staffing is also
16 higher in hospital-based SNFs, and from research that Korbin
17 Liu had done in a previous study, also found that skill mix
18 of the staff was higher in the hospital-based compared to
19 freestanding. Higher as they had more RNs and LPNs than
20 others.

21 Of course, as I mentioned at the beginning, the
22 Medicare's SNF margins are very different between the

1 hospital-based and the freestanding facilities.

2 So how do the patients differ? This table shows
3 differences in patient characteristics of patients in
4 hospital-based and freestanding SNFs. Beneficiaries in
5 hospital-based SNFs are slightly younger. Their severity of
6 illness as measured by the APR-DRGs for the inpatient stay
7 is also lower. But their share of hospital days that are
8 spent in an ICU is greater, 27 percent of their inpatient
9 days compared to 23 percent of the patients who were
10 admitted to a freestanding SNF.

11 A higher proportion of hospital-based cases also
12 come from MDC8, which is for musculoskeletal conditions such
13 as major joint replacements. This MDC has a lot of rehab
14 patients and that's why we looked at that. So that's a very
15 big difference.

16 Hospital-based SNFs are also less likely to take
17 patients who come to the hospital from a nursing home. You
18 see 2.4 percent of those patients came from the nursing home
19 into the hospital then to the SNF, compared to 5 percent for
20 freestanding facilities.

21 If we look within and across DRGs, we find in
22 general that hospital inpatient stays are slightly shorter

1 for patients discharged to hospital-based SNFs compared to
2 patients discharged to freestanding SNFs. For major joint
3 procedures, strokes and major small and large bowel
4 procedures the difference though is a little bit greater, a
5 day or more.

6 We find the inpatient case level hospital margins
7 to be similar for these two cases and the severity of
8 illness scores for APR-DRGs to be slightly lower for the
9 hospital-based SNF patients, although there are some DRGs
10 where it is higher.

11 This next slide shows the percent of cases that
12 are discharged to different post-acute care settings from
13 hospitals with SNFs and hospitals without SNFs. Hospitals
14 with SNFs tend to use SNFs more and other post-acute
15 settings less. Hospitals with SNFs discharge 17 percent of
16 their patients to a skilled nursing facility compared to 14
17 percent of hospitals that did not have a skilled nursing
18 facility.

19 Interestingly, hospitals use their own SNF for
20 only about a third of the patients using these services, on
21 average.

22 While SNF use is higher, use of home health,

1 inpatient rehabilitation and long-term care hospitals is
2 slightly lower. And overall a slightly larger proportion of
3 patients in hospitals with SNFs use post-acute care services
4 compared to hospitals that don't have a SNF.

5 Beneficiaries discharged from hospital-based SNFs
6 use a second post-acute care provider more often than
7 beneficiaries that are discharged to a freestanding SNF. In
8 your handouts it should say freestanding SNFs in that third
9 column.

10 This slide shows what percent of SNF patients use
11 a second post-acute care provider immediately after leaving
12 the skilled nursing facility. What we find is that 9
13 percent of the patients are discharged from the hospital-
14 based SNF to another SNF, compared to freestanding SNFs
15 where it's 1.7 percent.

16 And 25 percent are discharged using home health
17 care compared to 12 percent of patients discharged from
18 freestanding SNFs. And 2 percent use inpatient
19 rehabilitation facilities versus a very small percent from
20 freestanding facilities.

21 Freestanding facilities do have a larger
22 proportion of their cases that go back to the hospital

1 compared to hospital-based SNFs and some of that could be
2 due to patient characteristics and other capabilities of the
3 hospital-based SNF and the closeness to the hospital in the
4 hospital-based SNF.

5 But overall, a higher proportion of freestanding
6 SNF patients are discharged home directly from the SNF stay
7 as compared with hospital-based SNF patients.

8 So in looking at resource use of hospital-based
9 SNFs, we cannot consider just what happens during their SNF
10 stay, but we also need to consider what happens after. And
11 that has implications for a case level payment system versus
12 a per diem payment system in our considerations.

13 Looking at financial performance of hospitals with
14 and without SNFs, we see lower overall Medicare margins in
15 hospitals with SNFs compared to hospitals without. But this
16 0.9 difference in 2005 is the smallest we have observed
17 since the SNF PPS went into effect.

18 We also see the inpatient margin for hospital-
19 based SNFs is slightly higher, a possible indication that
20 the hospitals are benefitting on the inpatient costs from
21 having the skilled nursing facility.

22 So let's look at how costs differ between

1 hospital-based SNFs and freestanding SNFs. This table shows
2 average per diem routine and the different types of
3 ancillary costs for hospital-based and freestanding SNFs.
4 Routine costs reflect room, board, and nursing costs. As
5 you can see, routine costs are much higher in hospital-based
6 SNFs as compared to freestanding SNFs.

7 If we look at ancillary costs, therapy costs are
8 similar but the other ancillary services, often referred to
9 as the non-therapy ancillaries, we see much larger
10 differences in the costs between the two types of
11 facilities. For example, in supplies it's \$18 compared to
12 \$5 on average per day.

13 The higher cost may be the result of easier access
14 to ancillary services in hospital-based facilities or it
15 could be due to differences in patient characteristics. But
16 we heard from our site visit there is a desire from doctors
17 who treat people in hospital-based SNFs to treat patients as
18 if they are in the hospital.

19 MR. HACKBARTH: Craig, can I ask you about this
20 one before you leave?

21 Take supplies and it says \$18 for hospital-based
22 versus \$5 for freestanding. In that \$18, does that include

1 overhead allocations?

2 MR. LISK: Yes. These, in both cases, reflective
3 overhead allocations in here. Yes. I should have mentioned
4 that.

5 So what do we find when we look at direct costs?
6 We covered this a little bit at the January meeting.
7 Hospital payments don't cover post-acute patient's IPPS
8 costs, including overhead. The average payment-to-cost
9 ration was 0.82 for patients discharged to hospital-based
10 SNFs for inpatient acute care. But on average, hospitals
11 cover their direct IPPS costs, that is costs excluding
12 capital and overhead, of the patients discharged to the SNF.
13

14 As might be suggested from the extremely negative
15 hospital-based margin, hospital-based SNF payments don't
16 cover either the fully allocated costs of SNF care or even
17 the direct cost of the SNF care. But if we consider total
18 payments, hospital plus hospital-based SNF, they come very
19 close to covering total direct costs. That's the cost
20 excluding the overhead or what we think of as a variable
21 cost of care of the patient stay in the hospital. The
22 payment to direct cost ratio is 0.99 for these cases.

1 One point I want to add to this is, in how we're
2 calculating our variable costs, we're calculating on an
3 average cost basis. So on a true marginal cost basis, we
4 are overestimating probably the true variable cost here.

5 I want to now move on and briefly discuss how the
6 hospital-based SNFs fit into the different models that we
7 saw on our site visits. There's the long-term care model,
8 which these patients look very much like the people going to
9 freestanding facilities on average. There's the
10 rehabilitation model, which concentrates their patients on
11 joints and other types of cases requiring large amounts of
12 therapy. And there's a complex model which focuses on
13 medically complex patients, and these are sometimes referred
14 to as transitional care units. These patients often look
15 like hospital patients just continuing their stays.

16 About 15 percent of facilities fit into the long-
17 term care model, 47 percent into the rehab model, and 17
18 percent into the complex care model. About 20 percent don't
19 cleanly fit into either of these different models. I can
20 get into that a little bit more if you want.

21 This next slide gives us a comparison of how these
22 different facilities compare across these different models

1 on characteristics, facility inpatient characteristics. As
2 you can see, most of the characteristics, freestanding SNFs
3 and long-term care model, the hospital-based SNFs look very
4 similar across the different characteristics. The
5 rehabilitation model has a large share of cases in
6 musculoskeletal conditions, which we would expect. And it
7 has shorter stays and higher staffing than the long-term
8 care model.

9 The complex care model has the shortest SNF stays,
10 the highest staffing, and the highest share of Medicare
11 patients, and a very high share of patient days that were
12 spent in the acute care site in the ICU, 32 percent. they
13 also have the largest proportion of patients continuing SNF
14 care to another facility, 14 percent. And 27 percent
15 continue care in home health.

16 This use of SNFs in home health is actually
17 similar to what we see for patients who were discharged from
18 hospitals that don't have a SNF that are discharged from the
19 hospital without a SNF.

20 The rehab also, if we look at severity of illness
21 -- that's not on the table -- the rehab group has the lowest
22 severity of illness on average.

1 This next slide shows how costs differ for these
2 three different models of hospital-based SNFs. As you can
3 see, costs per day are lowest in the long-term care model
4 and they're highest in facilities we identified as the
5 complex care model.

6 The same is true for direct costs, which we also
7 have on this slide. The last line shows the ratio of
8 payments to direct costs for hospital and hospital-based SNF
9 services combined. We see here that hospitals with a long-
10 term care model SNF more than cover the direct costs of
11 care. The ratio for the traditional model and the complex
12 medical model are below one but not too far below.

13 Given our method of calculating direct costs where
14 we have routine ancillary services on an average cost
15 basement basis less overhead, this estimate of direct costs
16 is likely overstated and thus the ratios are likely higher
17 than what are shown below, shown on the slide.

18 There have been significant concerns raised by you
19 and the industry about hospital-based SNFs. This analysis
20 was meant to explore more in depth the differences and
21 similarities between these facilities. On the one hand, we
22 find that hospitals with the SNF discharge patients more

1 often to skilled nursing facilities than hospitals without
2 them and that their SNF care is more frequently followed by
3 care in a second post-acute care setting compared with
4 freestanding SNFs. We therefore need to consider this when
5 we compare episode costs for patients using different types
6 of skilled nursing facilities. Post-acute care for many
7 patients, therefore, does not end with discharge from the
8 skilled nursing facility.

9 We also find that on average hospital-based SNFs
10 have much higher routine and non-therapy ancillary costs per
11 day than freestanding facilities. Some of this may be due
12 to easier access of ancillary services in the hospital
13 setting or a hospitalcentric approach to providing care, but
14 some may be due to differences in the complexity of patients
15 not measured by the current payment system.

16 MS. BURKE: Craig, could you go back two steps and
17 just remind me. Do I recall that in the paper earlier you
18 noted that a larger majority of non-hospital-based SNF
19 patients came out of nursing homes?

20 MR. LISK: Yes.

21 MS. BURKE: So the fact that -- presumably, they
22 would go back to a nursing home?

1 MR. LISK: Yes. About 7 percent of patients
2 discharged from a freestanding nursing home go to being a
3 long-term care resident and 5 percent from hospital-based.

4 MS. BURKE: I'm just trying to sort out among
5 these issues which you could anticipate or not. The fact
6 that hospital-based discharges would go to a facility
7 wouldn't be terribly surprising by comparison because, in
8 fact, in many cases the non-hospital-based, in fact, are
9 discharged back to nursing homes?

10 MR. LISK: Yes, but basically what I was trying to
11 say is that about 47 percent of patients from a freestanding
12 nursing home go home directly from the nursing home, whereas
13 40 percent after their hospital-based stay go home without
14 any post-acute care. So there's a difference of more post-
15 acute care use with even the patients who are using the
16 hospital-based SNF. There's more use of a second post-acute
17 care provider after, even accounting for the fact that some
18 of those people are going back to a nursing home.

19 MS. BURKE: Thank you.

20 MR. LISK: Hospital-based SNFs also have higher
21 staffing and provide easier access to beneficiaries
22 physicians to see and monitor the patients in the post-acute

1 care setting, promoting continuity of care. But we don't
2 know whether we really have quality of care differences here
3 or not that we find worth the difference in the cost.

4 We also find that hospital-based facilities are
5 not homogeneous. There are different models of care and
6 their role in providing post-acute care services appears to
7 potentially differ. The long-term care model looks very
8 much like the freestanding SNFs with long days. And the
9 patients in the complex care model look very much like the
10 extended stay patients that, in other hospitals that don't
11 have SNFs, may very well be staying as longer stay patients
12 in the hospital.

13 Finally, we also find that hospitals come close
14 to covering the direct costs of hospital and SNF services
15 combined. At a minimum, this is what we need to do is at
16 least be covering their variable costs if we're wanting to
17 make sure that they have adequate payments for covering
18 that.

19 Adjusting for severity --

20 MR. MULLER: That's inpatient costs only; right?

21 MR. LISK: No, that's inpatient and SNF costs.

22 MR. MULLER: But not outpatient and all that other

1 stuff?

2 MR. LISK: No.

3 Adjusting for severity should improve the
4 inpatient profitability of patients and reforms in the SNF
5 PPS may also improve the financial situation for this
6 portion of care, as well.

7 So some of the things the Commission has on the
8 table in terms of what we're considering may improve the
9 financial situation here that we see here and improve these
10 numbers on the bottom line there.

11 I'd be happy to answer any questions you have. I
12 know it's late and we can continue this discussion another
13 time, too.

14 MR. HACKBARTH: Do you plan to look at Medicare
15 case costs, and so look at the total cost inpatient
16 hospital, hospital-base SNF, plus whatever follows that
17 versus models that don't have the hospital-based SNF in the
18 middle and went straight to freestanding?

19 MR. LISK: We theoretically could do that if
20 there's desire to do that.

21 MR. HACKBARTH: Do you think it would be
22 worthwhile looking at that?

1 MR. LISK: It gets more complex when we're trying
2 to get the costs of all of the different settings together
3 but I think it could be worth doing if we were trying to
4 consider bundled payments.

5 MS. THOMAS: Glenn, did you mean payments or
6 costs?

7 MR. HACKBARTH: Obviously, there are two different
8 ways you can look at it. What combination costs Medicare
9 the most, and then you could look at it from an efficiency
10 standpoint which combination has the lowest cost of care. I
11 don't know if the stories would be the same or different.

12 DR. MILLER: I think one of the issues is that you
13 still have this problem of not being able -- we do think
14 that different types of patients go to these different --
15 have the hospital-based SNF in the middle of their episode
16 and still don't have a particularly good way of adjusting
17 for the differences in the characteristics.

18 Part of this effort was to talk about the hospital
19 and the hospital-based SNF because that's been an issue that
20 has come up each time we've done payment adequacy and people
21 have gone back and forth on it, to at least try and isolate
22 -- let me put it this way.

1 If you look at the data just in a margin sense,
2 it's like why is anyone doing this? I think what Craig is
3 getting at is if you look behind it and on a patient care
4 basis and the different models they're using, there may be
5 an argument from a financial perspective for the hospital to
6 keep these around.

7 You could assemble the data that you've asked for,
8 Glenn. I would be a little concerned though that we know
9 that there's some sorting going on in those two different
10 episodes and how we can actually adjust. Because we all
11 think that the SNF RUG adjuster is not a good enough case-
12 mix adjuster.

13 MS. BURKE: And we really can't, or can we, judge
14 whether there are qualitative issues? For example, you note
15 specifically, Craig, that there is a higher ratio of RNs and
16 LPNs in the service mix in terms of the facilities that are
17 hospital-based.

18 Query whether -- I think Jennie and I would argue
19 at least historically we've always believed that RNs, in
20 fact, have a qualitative impact in terms of the nature of
21 the service. Query whether, in fact, we know that on more
22 than sort of our own instinctive reactions.

1 MR. MULLER: There are studies of that in
2 hospitals.

3 MS. BURKE: I know there is on the hospitals. But
4 the question is here it has a demonstrable impact in terms
5 of the cost. Query whether we think it has any qualitative
6 impact.

7 MR. LISK: It may have an effect on hospital
8 readmissions, for instance, whereas certain nursing homes,
9 they don't necessarily have to have an RN 24 hours I don't
10 think. That might have an impact where someone could --
11 somebody was a problem in the middle of the night and they
12 send to the ER instead of someone there might be able to
13 manage it, an RN might be able to manage it in some nursing
14 homes. I don't know how often that's the case.

15 I think part of the ratio issue on the nursing
16 home staffing is possibly just due to the differences in
17 size, too, is the hospital-based units are smaller and if
18 each one has one RN in each shift, by definition they're
19 going to have a higher staffing ratio.

20 Also on the hospital-based SNFs, they may be able
21 to float someone over if they don't even have an RN in the
22 middle of the night, they may be able to float someone over

1 from the hospital to take care of that situation, in that
2 situation.

3 MS. HANSEN: Just as artifact I don't know whether
4 the California experience is somewhat different because
5 there are actually registered nurse staffing ratios, as
6 well, that are built-in to the hospital that have gone on
7 now for at least two-and-a-half years. And so the hospital
8 nursing homes there will be staffed differently. So that
9 will be another thing to take a look at.

10 MS. THOMAS: You remember we had Andy Kramer from
11 the University of Colorado come in. We actually have some
12 contract work going in the background where he's looking at
13 his two quality measures, readmissions and whether people go
14 home to the community, and trying to look at those patterns
15 of differences between those two.

16 It's always going to be somewhat confounded by
17 differences in cases and convenience, too. If you're in the
18 hospital maybe you don't need to be admitted to the
19 hospital, if you know what I'm saying.

20 But we're going to take a look at his draft report
21 and hope to bring it to you even as soon as next month.

22 MR. MULLER: Craig, I'm a little puzzled by pages

1 seven and eight where the severity -- obviously it's a crude
2 measure on page eight of level three or four is roughly the
3 same yet the length of stay is half.

4 Is that just a function you think of their being
5 more rehab patients?

6 MR. LISK: This is, of course, -- the severity --

7 MR. MULLER: Slide eight. They're roughly the
8 same.

9 MR. LISK: Right. This is for the hospital side
10 of the patient. And so the severity is lower but the ICU
11 days is higher. So you kind of have that -- one is lower
12 and one is higher, if you think about the ICU as another
13 measure of severity of the patient.

14 DR. MILLER: Ralph, you said something about
15 rehab?

16 MR. MULLER: On a later slide. But I'm saying
17 that -- I would say that if you take that as a measure of
18 the severity of the patient coming in, 42 versus 46 on this
19 slide and 27 -- I'd say they're roughly the same measure of
20 severity. Yet the length of stay is half.

21 That just puzzles me. I don't know the answer to
22 that. You generally think if the severity is the same that

1 you think the length of stay --

2 MR. LISK: I think the length of stay is half is
3 partly reflected that many of these patients are going on to
4 use other post-acute care afterwards whereas in the
5 freestanding SNF they're not.

6 And then some of the ones who were longer stay in
7 the freestanding SNF may be continuing on and more likely to
8 be nursing home patients. So it's kind of that combination
9 of things that are going on.

10 DR. MILLER: The reason that I was asking is
11 because I thought you were also picking up on the fact that
12 they are MDC8, which we haven't drilled down far enough but
13 that could be rehab.

14 MR. MULLER: That was the second part of that.

15 MR. HACKBARTH: Others? Okay, thank you, Craig.

16 We will now have a brief public comment period.

17 The ground rules are...

18 MR. PRECHT: I'll identify myself and be quick.

19 I'm Paul Precht. I'm the Policy Coordinator for
20 the Medicare Rights Center.

21 over the last years, we've been dealing a lot with
22 the fallout of very aggressive and sometimes deceptive

1 marketing of private fee-for-service plans. And in
2 particular, dual eligibles who are able to change each month
3 have been targeted by some very aggressive brokers.

4 So what we're hoping is that in the course of your
5 work on Medicare Advantage that you look at a couple of
6 questions. One, whether private fee-for-service plans,
7 which provide very little if any coordinated care, are an
8 appropriate home for dual eligibles, many of whom have
9 multiple chronic conditions. And also whether the private
10 fee-for-service model, whose chief benefit is to provide
11 reduced cost sharing, is of benefit to a dual eligible who
12 already has zero cost sharing by virtue of being in
13 Medicaid.

14 I'll call your attention to a plan that's now
15 being marketed by WellCare. It's the Duet Plan. It
16 provides -- the cost sharing structure is virtually
17 identical to original Medicare, \$10 off the inpatient
18 deductible but other than that it's 20 percent for the
19 doctor, et cetera.

20 It's targeted to dual eligibles and it's marketed
21 as a zero copay plan. But the zero copayment is entirely
22 due to the fact that the target market has Medicaid.

1 So the question is what value does this provide to
2 the Medicare program?

3 And that raises the second point, which is private
4 fee-for-service plans are exempt from the kind of bid review
5 that other Medicare Advantage plans. CMS is barred by law
6 from looking at the supplemental benefits and that's why we
7 have things like the Duet Plan. We also have plans like
8 Sterling Option II that charges 20 percent for Part B drugs
9 and there's no out-of-pocket limit.

10 So what are our counselors supposed to say to
11 somebody that's locked into a plan like that except don't
12 get cancer?

13 So we're hoping as you look at private fee-for-
14 service plans that one of your recommendations might be that
15 they not be exempt from this type of bid review, and that
16 you look also at whether it's feasible to have a mandate for
17 an out-of-pocket limit.

18 Thanks very much.

19 MS. WILBUR: I'm Valerie Wilbur with the National
20 Health Policy Group, and my organization represents the
21 Special Needs Plans Alliance. And I wanted to make two
22 comments on the section of the report dealing with SNPs.

1 The first section had to do with the questions
2 that your staff for asking. The two questions that I wanted
3 to address were should Congress and CMS expect more of SNPs?

4 I think if you look at what they've said already
5 that the answer is yes. If you look at the legislation for
6 SNPs, one of the primary reasons for establishing them was
7 to provide a platform for all these specialty demonstrations
8 that were going to be expiring soon to have a home to
9 transition into MA plans. If you look at the report
10 language, it talks about encouraging replication of those
11 models for people with comorbid conditions, frail elderly,
12 other Medicare beneficiaries that have special needs.

13 If you talk to staff on the hill, they're all
14 asking are the, in fact, meeting the intent of Congress by
15 doing something special?

16 If you look at CMS's expectations and their SNP
17 applications for 2008, they're much more detailed in their
18 requirements for documentation about what SNPs are going to
19 do to take care of frail elderly, adult disabled, people
20 with multiple comorbidities and people at the end of life.
21 They're asking are the duals having Medicaid contracts so
22 that there's an opportunity for coordination? And if

1 they're doing Medicaid contracts are they, in fact,
2 capitated?

3 I would suggest that the additional detail in the
4 CMS application would suggest that CMS does expect something
5 different.

6 The second issue I wanted to address was the point
7 about whether they should be extended. I would suggest it's
8 premature to make a decision that they shouldn't be extended
9 because of the 470 SNPs online this year, 200 are new this
10 year. So it's a little bit soon to decide whether they
11 worked or whether they didn't work.

12 If you look at the experience of what I would call
13 the legacy demos that many of the SNPs are coming from
14 transitions, like Minnesota, Wisconsin and Texas, there's
15 very good evidence of reduced emergency room use, nursing
16 home days, inpatient hospital use. So they look promising.
17 We don't have the data available yet.

18 Even the report that comes to Congress at the end
19 of the year is going to be more about profiles -- what do
20 they look like, what are they doing -- not outcomes because
21 the HOS, HEDIS and CAHPS data aren't available to CMS for
22 the report that will come up in December.

1 The second point I wanted to make is I was really
2 happy that people were talking about relative payment equity
3 across the different MA plans. I would encourage MedPAC to
4 look at relative payment equity in relation to SNPs, but
5 SNPS that are serving the high-risk population. I know that
6 all SNPs aren't targeting the highest of the high-risk
7 population. But the most recent research we have that looks
8 at payment equity across the different plans that was done
9 in 2003 or 2004 for CMS that Greg Pope did, showed that for
10 the highest cost 20 percent high-cost population for
11 Medicare, that the HCC methodology they put in place was
12 going to continue to underpay by about 14 percent.

13 Even CMS acknowledges the HCC does way better than
14 the old AAPCC model in the middle. They say it's perfect in
15 the middle. But even CMS acknowledges that on the low end
16 and the high end there continues to be payment inequity
17 relative to fee-for-service.

18 So when we submitted our comments to CMS, we asked
19 them to look at a couple of things. The top 20 percent,
20 what's the relationship between that population and people
21 with frailty, disability, comorbidities, late stage
22 conditions? Because nobody's ever really reported on that.

1 And the second thing we asked them to look at is
2 please look at the relative payment equity of the HCC
3 adjuster, the pharmacy adjuster, and the dual adjuster
4 relative to various stages of frailty, disability,
5 comorbidity and condition.

6 I think if we look at those things, we're going to
7 get a sense that the SNPs that are really targeting the high
8 risk aren't overpaid by 10 percent, as your report indicated
9 for CCPs in general, but in fact they're underpaid relative
10 to fee-for-service.

11 I think at this point in time we see great promise
12 for these plans. It's too late to pull the plug on them,
13 but we know for sure that they need to be paid equitably if
14 they're going to meet the promise that some of the demos
15 have. So it would be great if MedPAC could look at some of
16 those issues.

17 Thank you very much.

18 MR. HACKBARTH: Okay, we are adjourned until 9:00
19 a.m. tomorrow.

20 [Whereupon, at 5:52 p.m., the meeting was
21 recessed, to reconvene at 9:00 a.m. on Friday, March 9,
22 2007.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, March 9, 2007
9:00 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
MITRA BEHROOZI
JOHN M. BERTKO
SHEILA P. BURKE
RONALD D. CASTELLANOS, M.D.
FRANCIS J. CROSSON, M.D.
NANCY-ANN DePARLE
DAVID F. DURENBERGER
JENNIE CHIN HANSEN
DOUGLAS HOLTZ-EAKIN, Ph.D.
NANCY KANE, D.B.A.
ARNOLD MILSTEIN, M.D.
RALPH W. MULLER
WILLIAM J. SCANLON, Ph.D.
NICHOLAS J. WOLTER, M.D.

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

2 MR. HACKBARTH: Today we begin with a mandated
3 report on the wage index reform. As I recall, this is due
4 in June.

5 MR. GLASS: Glenn, if you like practice expense,
6 you're going to love the wage index. It's another one of
7 those technical factors that moves a lot of money around the
8 system. In fact, a recent article was called the Wage Index
9 Factor: Your Medicare Reimbursement Driver. In fact, it can
10 change hospital base payments from \$4,100 to \$6800.

11 So it's not only of interest to providers, it's of
12 interest to Congress. And as you said, the Congress has
13 mandated that we report on the wage index by the end of June
14 this year. What that means to us is we only have today's
15 meeting and the April meeting to discuss possible
16 recommendations.

17 If you choose to make recommendation, CMS has to
18 take them into consideration as it prepares the FY 2009
19 proposed rule for the inpatient prospective payment system
20 for hospitals and that should come out in April of 2008,
21 which is about a year from now.

1 When CMS puts out that rule, it's supposed to
2 consider that list of things you see up on the slide there,
3 many of which we've discussed in the past and they're in the
4 paper handed out to you before the meeting.

5 Today I'm going to briefly review the current
6 method and its limitations. Jeff will then explain the new
7 approach and its characteristics, and I will then compare
8 the CMS Index to our new index and present some possible
9 directions for recommendations.

10 Just briefly, the current approach uses data from
11 hospital cost reports, uses wage and benefit data in
12 particular. It then uses those data to calculate an average
13 wage for the market area. The market area are metropolitan
14 statistical areas, which are usually a central city and
15 surrounding counties, and the statewide rural area, which is
16 all counties in a state which are not in an MSA.

17 That area's average wage is then compared to a
18 national average wage and that gives you the wage index.
19 There's a separate adjustment along the way for occupational
20 mix, and reclassifications and other exceptions to the wage
21 index change the calculated index for about a third of the
22 hospitals.

1 Some of the limitations in the current approach is
2 data are from hospital cost reports, not all employee areas
3 in the market. And that can be idiosyncratic to the
4 hospitals that are reporting, particularly if there are very
5 few hospitals in the market. We'll give some examples of
6 how that works out later.

7 Also, the concept should be to estimate input
8 prices to modified PPS payments. Instead, this using
9 hospital data is conceptually a back door to cost
10 reimbursement system. Hospitals that control costs get paid
11 less. Those that increase costs get paid more by the wage
12 index calculation. And that creates an incentive to report
13 higher costs.

14 Another objection is that the market areas may be
15 too large. The central county in an MSA may be a somewhat
16 different labor market than the outlying counties and large
17 changes in the index values between labor areas could be an
18 indicator that the market area itself is too large.

19 The adjustment for the occupational mix is
20 difficult to make. It was discussed for years and finally a
21 court case forced them to adjust for so-called 100 percent
22 occupational mix, but it requires a separate survey and the

1 somewhat elaborate methodology and not everyone is very
2 satisfied with that.

3 If you look at the result, the resulting wage
4 index is fairly volatile from year to year and it has many
5 exceptions that have accreted over the years into the
6 system. And they're probably all symptoms of underlying
7 issues that people weren't happy with so they created an
8 exception.

9 Let's take an example of what results from the
10 current system. The state of Connecticut, this is the pre-
11 reclassification hospital wage index. The state of
12 Connecticut has four MSAs, and that green area up in the
13 corner is in the state-wide rural area. The green area is
14 the statewide rural area. Note it does not have the most
15 wage index. The lowest wage index is that blue area in the
16 middle, which is the Hartford MSA. The orange MSA over
17 there, Bridgeport-Stamford-Norwalk, is the highest. You'll
18 note that all of these are above one, which is rare. Most
19 areas of the country are not above one.

20 You'll note the red colored there, the highest
21 wage index bucket, isn't there yet.

22 This is just the pre-reclassification hospital

1 wage index. What did they actually end up with?

2 If we look at the wage index that hospitals
3 actually received, it turns out that most hospitals in
4 Connecticut are exceptions. Each dot here is a hospital and
5 the color of the dot shows its actual post-reclassification
6 wage index. Only five of the 32 hospitals stayed with their
7 original wage index. The two rurals up in the corner, the
8 two yellow in New London MSA, and there's one in New Haven
9 that stays the same color. All the rest are reclassified.
10 That is they get a wage index that is higher than their own
11 area's wage index.

12 The 12 hospitals in the blue area are lifted up by
13 the rural value and become green dots. This is the so-
14 called rural floor provision. 15 get some other exception,
15 including some getting reclassified to the New York City
16 MSA, which accounts for the red dots over in the lower left-
17 hand corner.

18 We should note that for budget neutral
19 reclassifications, which are most of them, other hospitals
20 have to pay. For a hospital here to go from 1.1 to 1.2,
21 every other hospital in the nation has to go down a bit,
22 including those where the wage index as well below one.

1 In this state, the exception is the rule, which is
2 one of the reasons we think the new approach may be
3 warranted.

4 In a somewhat related issue, if you're a SNF or
5 another provider, you're probably paid under the pre-
6 reclassification wage index. So if you're in that blue area
7 you'd get that pre-reclassification wage index even the
8 hospital next to you, or even possible the same hospital if
9 you're a hospital-based provider, is getting a different
10 wage index, a higher wage index. So people have raised that
11 as something that they don't think is very fair.

12 Also, the data that these are coming from are
13 somewhat limited. We looked at a number of MSAs. And a
14 large MSA, such as the New York City MSA, average hospital
15 wages vary from \$27 to \$57 but all these hospitals get the
16 same wage index. It could be that the market is just too
17 large and that we're really looking at different labor
18 markets. Or it could be that there are large areas in the
19 reported data or in the occupational mix adjustment. We
20 really can't tell which.

21 In a medium MSA like York, Pennsylvania there are
22 only three data points and there's not much confidence in

1 the mean value. If you look at a confidence interval, it
2 goes from \$19 to \$30, which is about the range of data
3 points that are reported. About half of the MSAs have three
4 or fewer reporting hospitals.

5 In the York MSA one of the hospitals reclassifies
6 out because it has a higher average wage. What that means
7 is the two hospitals that are left have to compete with it
8 for workers and they have a lower wage index than the one
9 that reclassifies out. So the question is is that fair to
10 the other two hospitals? And by the way, it once again
11 rewards hospitals for reporting higher costs.

12 Finally in a one hospital MSA, there's really not
13 any assurance that what gets reported is that the underlying
14 labor costs. Or it could be very idiosyncratic to that
15 particular hospital.

16 MR. HACKBARTH: How many one hospital MSAs are
17 there?

18 MR. GLASS: We actually have that number.

19 DR. STENSLAND: 58 MSAs have one hospital. That's
20 about 2 percent of the hospitals.

21 MR. GLASS: So if there's a new labor agreement or
22 they start contracting out some workers, that number could

1 change very rapidly and without any change to the underlying
2 labor cost.

3 Because of these limitations, the large number of
4 exceptions, and other issues we've discussed in the past,
5 we've explored whether there was a better way to determine
6 wage indexes. And Jeff will now describe our new approach.

7 DR. STENSLAND: Before I start describing the
8 approach, I want to thank BLS for assisting us with
9 obtaining the data needed for these computations. They've
10 been very helpful as we work our way through the difficult
11 task of accurately reflecting an area's input prices.

12 The new approach has two key factors. First, the
13 new wage index is designed to reflect input prices in the
14 market, not necessarily each individual hospital's costs.

15 Second, the new methodology limits errors that can
16 be caused by imperfect data. We know that both the
17 current CMS cost report data and the BLS data are not
18 perfect. The current CMS system gathers data on the average
19 compensation paid at a hospital. This is simply total
20 compensation over total hours. The BLS gathers more refined
21 data. It gathers data on each occupation and each wage of
22 each individual employee. The BLS unit of analysis is each

1 nurse, each LPN, et cetera.

2 In addition, the BLS collects data from all
3 employers of health care-type workers, not just hospital
4 employees. So the average RN salary reported by the BLS
5 would be a blend of the salaries of individual RNs at the
6 hospital, the SNF, and doctors practices. But having a
7 larger sample of respondents in the survey, the BLS data
8 will be less affected by one errant value.

9 One limitation in the BLS data is it only includes
10 wages. It ignores benefits. To correct for that we
11 obtained data on the ratio of wages to benefit from hospital
12 cost reports. We then created a wage index that reflects
13 the relative costs of total compensation, BLS less wages
14 plus estimated benefits in each MSA and each statewide rural
15 area.

16 A large MSA or statewide rural area may be too big
17 to be considered a single labor market area. On the other
18 hand, each county may be considered too small to be a self-
19 contained labor market. Therefore, we created a blended
20 wage index that is based at least 50 percent on MSA level
21 data from the BLS with the remaining weight being county
22 level data. The MSA level data comes from the BLS and the

1 county level data comes from the Census. Because we blend
2 MSA level data with county level data, each county ends up
3 having its own wage index under the new system. The wage
4 indexes within an MSA or within a statewide rural area are
5 all within 5 percent of the mean. We limit how much the
6 county data can move the average wage.

7 We also acknowledge that the county borders are
8 not the same thing as labor market borders. Hence, the data
9 are imperfect. To prevent a hospital on one side of a
10 county border from having a significantly lower wage index
11 from its competitor across the border, we smooth the wage
12 indexes. In the end, every hospital wage index is at least
13 90 percent of its highest neighbor's wage index.

14 Visually we can look at the impact of smoothing as
15 follows: this is the pre-reclassification wage index for
16 Minneapolis MSA in Minnesota, and the Rochester MSA in
17 Minnesota, and the rural areas of Minnesota. Red represents
18 the highest wage index, white is a medium wage index. If
19 there's any blue-gray areas, that's the lowest wage index.

20 You'll notice that there's a sharp drop-off as you
21 move outside that Minneapolis MSA and outside the Rochester
22 MSA.

1 The new system will remove these county level
2 cliffs, as we can see on the next slide.

3 Now we note that there's always a pink county
4 between a high wage red counties and the low wage white
5 counties. We also notice that the center of the Minneapolis
6 MSA is paid a higher wage. From a practical standpoint what
7 that means is it says the data is telling us that the center
8 city hospitals have to pay their workers an extra \$5
9 dollars, \$10, \$15 a day to compensate them in for the
10 commute into the center of the city. That's a difference
11 between this system and the other system, which ignores
12 those commuting costs and assumes that the wage is the same
13 throughout the MSA.

14 As I mentioned before, we smooth the wage index
15 because we acknowledge the data are not perfect and we want
16 to make sure that no hospital has a wage index that's
17 significantly lower than its competitors.

18 Now let's look at how the system smooths
19 differences across the borders of two rural states.

20 This is the CMS pre-reclassification wage index
21 for the Dakotas. Having driven, on one of our site visits,
22 from a hospital in South Dakota to Bismarck, North Dakota, I

1 found it odd that the wage index for rural North Dakota and
2 for Bismarck were both more than 10 percent below the wage
3 index for rural South Dakota.

4 It's important to note that the Bismarck wage
5 index is determined by only two hospitals and the rural
6 North Dakota wage index was determined with information from
7 only seven PPS hospitals. The small sample of observations
8 could affect how accurately the CMS wage indexes for the
9 Dakotas reflect differences in underlying input costs.
10 There could be some other factors also.

11 Now let's look at the new system. Under the
12 proposed or alternative system, we see that the rural North
13 Dakota and rural South Dakota now have very similar wage
14 indexes. The cliff along the border is gone. In addition,
15 we see that Bismarck's wage index has risen up almost to the
16 level of Fargo. There's also a smoothing along the border
17 between Minnesota and the Dakotas.

18 One benefit of the BLS data is it's based on a
19 larger sample of employers. It includes not only PPS
20 hospitals but also critical access hospitals, SNFs, doctors'
21 offices. By having a larger sample of data we reduce the
22 effect that low wages from one or two hospitals will have on

1 the wage index. The wage index is determined more by the
2 conditions of the market and less by the behavior of
3 individual hospitals.

4 One goal of the wage index is stability. We don't
5 want a hospital's wage index bouncing up one year only to
6 bounce down the next. Our primary results suggest that the
7 BLS-based approach is more stable. This could be due to
8 having a larger sample frame, all employers not just
9 hospitals, and due to having the survey based on a blend of
10 different surveys taken over a three-year period.

11 We will be investigating this issue further and
12 we'll report more on the details of volatility at the next
13 month's meeting.

14 One additional issue is which wage index will
15 result in Medicare payments more closely matching Medicare
16 costs? To test this we use a multivariate regression model.
17 The result is that the CMS wage index fits costs slightly
18 better than the new wage index. The model explains 84
19 percent of the variation in hospital costs using the CMS
20 wage index and 82 percent using that new wage index.

21 This small difference should not be surprising.
22 Under the current system hospitals that can afford to

1 increase their wages get paid a higher wage index and in
2 some cases can even reclassify into higher wage index areas.
3 Currently, high wage hospitals can often reclassify. Low
4 wage hospitals in the same county or even the same city
5 often cannot reclassify.

6 In contrast, under the new system, all hospitals
7 in the same town would receive the same wage index and all
8 hospitals in the same county would receive the same wage
9 index.

10 Recall that CMS starts with the average wage paid
11 by a hospital. CMS does not know the degree to which those
12 wages are based on say technicians in the cath lab or to
13 what extent those hourly wages are based on housekeeping
14 salaries. To approximate and partially correct for this
15 lack of detailed data, CMS uses a separate occupational mix
16 survey to address that wage index for differences in the
17 type of nurses employed by the hospital but the adjustment
18 is only for nurse wages.

19 The new approach, using BLS data, does not need an
20 occupational mix adjustment because it starts with more
21 refined data. The BLS collects data on each individual
22 employee. To compute the wage index we then weight the

1 relative wages of each type of employed by that occupation's
2 share of overall hospital payrolls. Because we use a fixed
3 national weight and occupation-specific wages there is no
4 need for an occupational mix adjustment.

5 Currently the other PPS providers, such as SNFs,
6 home health, they use the pre-reclassification version of
7 the hospital wage index. They don't have their own wage
8 indexes. Under the BLS/Census approach, we could readily
9 tailor separate wage indexes for each sector. The sector's
10 wage indexes would be computed using the same underlying BLS
11 and Census data. The only difference would be how we weight
12 the various occupations that make up the index. For
13 example, SNFs would receive a higher weight on LPNs and a
14 lower weight on RNs while hospitals would receive a higher
15 weight on RNs and a lower weight on LPNs to reflect their
16 mix of employees.

17 Over the next two weeks, we will be investigating
18 whether there would be enough difference in the SNF, home
19 health, and hospital wage index to justify these three
20 different wage indexes.

21 Now David will discuss who would win and who would
22 lose under the transition to a new wage index system.

1 MR. GLASS: The basic result of this is that more
2 hospitals would gain than lose moving to the new wage index
3 from the CMS hospital wage index. The CMS wage index we're
4 using is the post-reclassification index not including the
5 508 adjustments that are not budget neutral and expire at
6 the end of 2007.

7 You can see that about 860 hospitals gain from 1
8 to 5 percent while about 800 lose that much. Over 500
9 hospitals gain from 5 to 10 percent and slightly over 400
10 lose that amount. And finally, over 200 gain over 10
11 percent while under 200 lose.

12 Because a fair number of hospitals would see
13 fairly major shifts in the index values, we might want to
14 phase in this kind of change. Many of the hospitals that
15 lose are those that have reclassified and the gainers are
16 ones that could not reclassify.

17 Another way to look at the result is what does the
18 resulting distribution look like? Here we're looking at the
19 distribution where red is the CMS Index and yellow the
20 BLS/Census index. You can see that the new approach has
21 fewer hospitals in the lowest two bars and in the very
22 highest bar. So it has fewer extreme wage index values.

1 More hospitals end up in the central part of the
2 distribution and it smooths out, which makes it more
3 analytically attractive -- to us, at least. Under both
4 systems the average wage index is just below one, hospital
5 weighted.

6 Even though we see these differences you have to
7 remember that these indexes are still highly correlated.
8 The correlation is over 90 percent.

9 In summary, the advantages of the new approaches:
10 the data represents the entire market, as Jeff has said, it
11 has a better chance of telling us what the underlying labor
12 input costs really are. It's less volatile over time,
13 automatically adjusts for occupational mix. There are
14 smaller differences across borders, which should reduce the
15 need for exceptions and hopefully reduce it to zero. It can
16 be tailored to other types of providers and give them each
17 their own wage index instead of using the pre-
18 reclassification index. Less data burden on hospitals and
19 less sensitive to imprecision in reported wages. The
20 disadvantages explain slightly less of the variation in
21 hospital costs, as Jeff said, and some phase-in period would
22 probably be needed when transitioning.

1 Because the Congress asked for the report by the
2 end of June, we've included two draft recommendation this
3 month for your consideration. The first reads as follows
4 the Congress should direct the Secretary to compute a
5 hospital wage index that uses wage data from all employers
6 and industry-specific occupational weights.

7 We want to make the point that it should be a
8 broad survey of underlying wage levels rather than hospital
9 specific, more of an input price and less of a cost
10 reimbursement system, more appropriate for a prospective
11 payment system to use, and the fixed weight specified to
12 eliminate the occupational mix problem. This would get rid
13 of reclassifications, simplify life and hopefully make
14 things more predictable for the providers.

15 The rest of this should presumably be in the text
16 rather than in the recommendation.

17 We've addressed this recommendation to the
18 Congress because we think that a change in law is needed
19 rather than CMS accomplishing this through regulation alone.
20 The law now says that the Secretary should update the factor
21 on the basis of a survey conducted by the Secretary of the
22 wages and wage related costs of hospitals in the United

1 States. So it was pretty prescriptive.

2 Another approach could be just to make the
3 language less prescriptive and leave it up to the Secretary
4 how to do the wage index and then we can make our
5 recommendation directly to the Secretary, saying do this
6 sort of thing.

7 If you make any recommendation, CMS has to
8 consider it when they're developing their proposed rule for
9 FY 2009.

10 DR. MILLER: David, another thing to think about,
11 particularly in this one, just before we go to the next
12 recommendation which is a little bit more mechanical, is
13 whether you would want to include a strong statement with
14 the recommendation that to end the exceptions process. I
15 mean, part of the objective here is through all of the new
16 data methods and then the smoothing is to get rid of that
17 process. So it's something that you should be thinking
18 about when we discuss this recommendation.

19 MR. GLASS: Thank you, that's a good point.

20 The second one is really just we don't want to
21 create any bad incentives so the recommendation is as a
22 condition of participation in Medicare, the Secretary should

1 require that hospitals and other providers submitting cost
2 reports participated in any BLS-sponsored wage survey when
3 requested to by BLS.

4 Again, we just don't want to create an incentive
5 for people not to answer the survey if they have low wages.

6 We'd be happy to answer any questions you have and
7 look forward to your discussion of the recommendations.

8 MR. HACKBARTH: Can I just ask one question? This
9 is very good work and it has a lot of appealing
10 characteristics. It makes sense. The barriers here, I
11 fear, are not analytic but rather political because of the
12 redistribution of payments involved.

13 Just a question about the concept of calculating
14 the index based on broader employment and not just
15 employment by hospitals. That's very appealing to me. But
16 I wonder in the case of RNs, in particular, whether the job
17 is really quite different between being an RN in a medical
18 practice or a skilled nursing facility or home health
19 agency, as opposed to in an inner-city teaching hospital or
20 public hospital, and whether that's really combining jobs
21 that are quite different and appropriately paid for on
22 different pay scales.

1 Is that something that you've thought about?

2 DR. STENSLAND: That is a limitation of this
3 system and it's a limitation to the extent that the relative
4 share of the nurses in each market differ. So for example,
5 maybe the nurses in a physician office get paid a little
6 less than the nurse in the hospital. But as long as there's
7 that same proportion of physician office nurses and hospital
8 nurses in each market it's okay, it will work out. But
9 there would be a little distortion if, for example, you have
10 a county and all the nurses work in physician offices and
11 there's a lot of physicians offices and SNFs, for some
12 reason, in that county and not hospital. But I think that's
13 a fairly rare occurrences.

14 MR. HACKBARTH: Is there a way to test the
15 validity of that assumption, that it sort of works out
16 because the proportions are fairly constant? To me that's
17 one job category that sort of leaps out where you might be
18 blending things that are dissimilar.

19 DR. STENSLAND: We can work on that.

20 MR. HACKBARTH: We don't need to dwell on it right
21 now.

22 DR. CROSSON: I had somewhat a similar question

1 and it has to do with the fact that the new system, which I
2 agree seems very elegant, takes out the occupational mix
3 adjustment.

4 So the question is, getting to winners and losers,
5 is there a classification or type of hospital that we know
6 has a much higher mix adjustment that would then end up
7 generically being in the loser category? Or is the
8 occupational mix adjustment sort of just a random
9 phenomenon?

10 MR. GLASS: Actually, I think what some people
11 have objected to with the occupational mix adjustment
12 they're using is it that if you have, say you're in
13 California and you have to have a certain ratio of nurses to
14 patients, I guess. And they therefore employ more RNs and
15 fewer LPNs, for example, than hospitals in other places.
16 The occupational mix adjustment actually penalizes that
17 hospital, the one they have in the current system. So
18 California hospitals actually get taken down by the current
19 occupational mix adjustment. Ours would not do that.

20 DR. CROSSON: I wasn't being a regionalist
21 particularly in asking the question.

22 MR. GLASS: I just thought it might be of

1 interest.

2 DR. CROSSON: Actually it is, and thank you. It's
3 helping me think about this issue more acutely.

4 I was wondering beyond that, beyond geography,
5 want do we know about the occupational mix in various types
6 of hospitals? For example, is there a different
7 occupational mix in academic medical centers than in
8 community hospitals?

9 MR. GLASS: There may well be. What the proposed
10 system says is we don't need to worry about that because
11 we're trying to understand what are the underlying labor
12 costs, what are the labor input costs in each market? So we
13 don't have to worry about that so much.

14 DR. STENSLAND: For example, we're taking a
15 weighted average. So we're taking 43 percent of the RN wage
16 in each market, plus 2 percent of pharmacist wage in each
17 market, plus such and such. So the occupational mix we're
18 holding constant across all the markets. So the only thing
19 that moves it up and down is whether the RN wage varies up
20 or down in the different market, whether the pharmacist wage
21 varies up and down in the different markets.

22 Under the current system they say oh, you have a

1 wage of \$35 an hour on average. That's partially because
2 you have a lot more RNs and LPNs than is average. So we
3 think it's not that the underlying wages are so much higher
4 in your area. We think it's just that you have a lot of
5 RNs. So we're going to adjust that \$35 downward to account
6 for that occupational mix.

7 MR. HACKBARTH: Me try to help here. I think I
8 understand what Jay's coming from. He's sort of coming at
9 it from the other direction. That in fact, we ought to be
10 paying more to institutions that have more complicated high
11 level mix of occupations. The way we want to do that is
12 through the case-mix adjustment, as opposed to through the
13 wage index. We want the wage index to be neutral on
14 occupational mix. And then if an institution has a lot of
15 complicated cases, that number is multiplied, if you will,
16 by the case-mix adjustment to increase payment.

17 Right now we have it double counted. We have an
18 occupational mix factor in the wage index, which means that
19 potentially we're distorting that.

20 I'll just stop there.

21 DR. KANE: [off mike] There are more experienced
22 nurses in the ICU. If you have to attract more experienced

1 nurses that would --

2 DR. REISCHAUER: The case-mix, there are two
3 elements to it. You might have to do more stuff and you
4 might have to have a different mix of labor. I think you're
5 catching half of it but not the other half.

6 DR. SCANLON: Why aren't you catching both parts,
7 because you take out the wage portion before you calculate
8 the case-mix adjustment?

9 DR. REISCHAUER: But if you do ---

10 DR. SCANLON: That's what you're supposed to do.
11 That's what they do. They standardize costs and then they
12 calculate that DRG weight. And so if you do that, you
13 should be reflecting both a different mix of labor that's
14 required for a particular case, as well as the stuff that
15 goes with different cases.

16 MR. MULLER: [inaudible.]

17 DR. SCANLON: I don't understand the difference
18 between the occupational adjustment in the current method
19 and this one, because both of them are basically weighting
20 by occupation. So to me they're equivalent. It's not that
21 one is -- and California loses in both. Sorry, Jay.

22 DR. MILLER: That was the way I was going to try

1 and come at this. Under the current system you can get
2 rewarded, or at least your wage index value will be higher
3 just because you're employing a higher skill mix, even
4 though the wages are not necessarily different from area to
5 area. The recent requirement that they have to adjust for
6 occupational mix is trying to take that phenomenon out.

7 The proposal that we have here, in a sense,
8 already does that. It's not so much that it's -- it already
9 accomplishes what the survey and what the changes that
10 they're required now to make in the wage index is supposed
11 to accomplish.

12 MR. GLASS: It is actually a good thing, if you
13 start with the current system, to try to occupationally mix
14 adjust it. That would be a good thing to do. What we're
15 saying is that it's a very difficult thing to do and the
16 charm of this approach is that you avoid that whole question
17 by starting with a fixed weighting across the nation.

18 DR. STENSLAND: The same thing with the ICU days.
19 In theory, as Glenn was saying, if somebody has the kind of
20 -- maybe they're on a ventilator and they have that kind of
21 DRG, then that DRG weight should reflect the fact that they
22 have more ICU days.

1 [Simultaneous discussion.]

2 DR. KANE: I know there's a differential for
3 working -- there's a differential. You have to pay a nurse
4 a higher amount to work in a highly critical care
5 environment than you do to work in a nursing home. So the
6 RN wage is differential based on where they work. And I
7 think it might also reflect their level of experience of the
8 RN. So when you're doing the wage survey, are there
9 differentials for the nurse's wage based on the site of
10 care?

11 DR. STENSLAND: It's not for the nurse's wage, but
12 that should be reflected in the costs of the ICU and then
13 reflected in the cost-to-charge ratio of ICU, and then
14 reflected in the weight for the DRG.

15 MR. MULLER: That weight is calculated nationally;
16 right? It's not a hospital-specific weight.

17 So with our recommendations and CMS's
18 implementation of it, we do have the cost-to-charge
19 weighting of the DRG. But it's not as if the California
20 hospital gets their weight different than a New York
21 hospital. That calculates a hence national weight for
22 cancer or heart disease and so forth; right?

1 MR. HACKBARTH: And you wouldn't want a hospital-
2 specific weight.

3 MR. MULLER: I understand that. I'm just making
4 the point that the weighting does not capture the kind of
5 occupational mix dialogue we're having here.

6 Now we may decide we're indifferent to
7 occupational mix, but I'm just trying to tease out whether,
8 in fact, the argument both in the paper and the way you
9 stated it, that the case-mix index captures the differences
10 by having let's say either more RNs because California and
11 some states require staffing ratios. Or the common one is
12 by and large cancer nurses have to be paid more than OB
13 nurses because it's harder work, et cetera, and so forth.
14 Does it capture that or not?

15 MR. HACKBARTH: The weights are national and so it
16 doesn't reflect the difference in California's regulatory
17 requirements that might affect the cost structure in
18 California versus another state for the same patient. No
19 question about that.

20 MS. THOMAS: There's also the IME adjustment
21 which, to the extent some of these hospitals have higher
22 cost structures to reflect, more complicated stuff they do,

1 we're capturing that and more in the adjustment. It's not
2 perfect. These are not always teaching hospitals, but many
3 of them are.

4 MR. HACKBARTH: So it doesn't capture state-by-
5 state variation in regulatory requirements or institution by
6 institution differences. But I'd argue that you wouldn't
7 want a system that would do that. And so you want a wage
8 index that is neutral to occupational mix, as opposed to
9 going through the current process of trying to take it out
10 once it's in. This is a more elegant approach that avoids
11 it at the front end and you adjust for differences in the
12 intensity of resources required for different types of cases
13 through the case-mix adjustment, not through the wage index
14 system.

15 MS. BEHROOZI: Just on this point, but also in
16 terms of leading into the question. First of all, thanks.
17 This explained a lot of stuff that I think I wasn't the only
18 one who had a little trouble with a while ago.

19 But in terms of all of these individual questions
20 that people are asking about what the impact is of any one
21 of the pieces, what I had wanted to ask was is there a way
22 to create a profile of the winners and losers by the nature

1 of the institution they are? We're sort presuming this
2 could have an impact on teaching hospitals or this can have
3 an impact on community hospitals or hospitals in a certain
4 geographic area or state. Can you sort of plot that out?

5 I realize that there are more winners than losers,
6 but can we get what the characteristics are of the winners
7 and the losers?

8 DR. STENSLAND: There's no exact pools. We can
9 say in general the places that tend to win under this were
10 places that weren't benefitting under reclass and maybe had
11 a fairly low wage index, they tend to be winners here.
12 People that benefitted a lot under reclass, maybe you were
13 say on the border of an MSA, you were just outside of there,
14 and then you were able to reclass into this MSA, and you
15 didn't just get the wages for around this part, you got the
16 same wages as the people in the center of the MSA. So
17 sometimes you got a big bump-up, 15 percent or more through
18 your reclass. They tend to lose under this scenario.

19 MS. BEHROOZI: Right. It sounds like the ones who
20 figured out how to play the game better under the old roles
21 won't be as favored under the new rules, just by what you've
22 described now. But I think if we could go down, drill down

1 a level in terms of the characteristics.

2 Let me just ask a question that I don't know if it
3 was answered somewhere already. Is physician employment
4 counted in the occupational data?

5 DR. STENSLAND: No. And that's, I think, one
6 advantage. In the current system, physicians can be counted
7 in the wage index to the extent of their time that is not
8 involved in teaching or patient care. But they're supposed
9 to set up a contract with the physician and say how much of
10 your time is, just in general, hospital administration? How
11 much is in teaching? How much is in patient care? I think
12 that's often been a hassle and a problem in terms of
13 accuracy of the data.

14 MS. BEHROOZI: That also could go to some of those
15 characteristics of institutions. Poorer community hospitals
16 tend to employ physicians more than teaching hospitals or
17 whatever, I think. That's my impression. So if that's not
18 a factor, then that wouldn't have a disproportionate effect
19 on poorer community hospitals. But I think that's the kind
20 of characteristics that maybe people are concerned about,
21 whether there's a certain type of hospital that's impacted
22 more.

1 DR. STENSLAND: I think there's a lot of hospitals
2 that don't reported any physician wages on the current cost
3 report system. Because again if the doctor is maybe
4 employed by the hospital but they're spending all their time
5 on patient care or patient care and teaching, then they're
6 not supposed to include any of those wages in the current
7 wage index anyways.

8 So doctors are pretty much almost out of both the
9 wage index. 90 percent of the hospitals report less than 1
10 percent of their salaries going to physicians. I think most
11 present zero because their doctors aren't in administration,
12 they're just patient care or teaching.

13 MR. GLASS: I think we can prepare a kind of
14 impact chart, urban and rural and how many go up and how
15 many go down sort of thing.

16 DR. STENSLAND: The suburbs will generally lose.
17 Just because I talked about the commuting affect, the
18 current system doesn't account for any commuting costs. So
19 Manhattan gets paid the same as New Jersey suburbs. In this
20 system, New Jersey suburbs would get paid less than
21 Manhattan because the data indicates to us that the
22 hospitals are having to pay a little more to get people to

1 commute into Manhattan than to stay in Jersey and work.

2 MS. BEHROOZI: Also, thank you very much for
3 including the benefit data, which I had raised in an earlier
4 meeting, because that's such an important component,
5 particularly in some MSAs or counties or whatever, relative
6 to others.

7 I had a question about whether that needed to be
8 specifically noted in the recommendation with respect to the
9 legislation that we'd be recommending, because it doesn't
10 appear there specifically. Since it would come from a
11 different source, the hospital cost data, I think it
12 probably ought to be noted in particular that, in addition
13 to the BLS data and the Census wage data, that the cost
14 report data on benefits ought to be in there.

15 I don't know how hard this is to do and I don't
16 mean to torture you with this, but again just going to all
17 the different question that people have about impacts of
18 things, even starting with Glenn's question about how much
19 using BLS data ignores the differences in different
20 settings, RNs in hospitals versus other settings. I
21 wondered if you could --

22 MR. GLASS: I don't think you want to say it

1 ignores the differences. It simply averages the wages from
2 all the different --

3 MS. BEHROOZI: Smooths the difference.

4 Whether you could break out the impact of each of
5 the different facets of the analysis because there are
6 different ways of achieving the same goals in terms of, for
7 example minimizing volatility. BLS data is collected over a
8 longer period time. You could look at hospital cost data
9 over a longer period of time. You could do a rolling three-
10 year average or that kind of thing.

11 So if there's a way to break out each of the steps
12 that you take essentially, to see what the impact is, to see
13 again if that has a specific impact that we might want to
14 consider, if it raises issues that we might want to address.

15

16 MR. GLASS: We can try.

17 DR. STENSLAND: Maybe if you have any specific
18 ones maybe you could communicate with us or Mark, just
19 because there's kind of an endless number of permutations we
20 could do in this. And so we'll try to focus on some of the
21 few ones that people are most concerned about.

22 DR. SCANLON: I think we're dealing with a very

1 important problem with the PPS design. The labor market
2 definitions were, in essence, too crude. And you've really
3 made significant progress there in terms of improving
4 things.

5 I guess I'm concerned because -- and some of our
6 earlier discussion illustrates this -- the reclassification
7 history is a tortured one, to say the least. We didn't get
8 to all the reclassification options in one fell swoop. We
9 got there through a series of plaintive cries of we're
10 different and we need to be treated differently.

11 Probably the most memorable hearing I ever
12 attended was where the first panel of witnesses was 17
13 members of Congress explaining why their hospitals needed to
14 be treated differently. So I think we need to be concerned
15 about that we're different aspect again, because we can have
16 a rational system, and this certainly improves greatly on
17 the old system, but we're going to hear -- as we've heard
18 today -- isn't this different? Isn't that different? That
19 kind of thing.

20 A concern I have is moving completely to the BLS
21 data and giving the hospital's information a much smaller
22 role here. I'm wondering if -- I guess I might prefer using

1 your methods of calculation but actually collecting the data
2 from hospitals. If the BLS survey is simple enough for
3 employers to fill out for free who are being paid nothing by
4 the federal government, isn't it something that hospitals
5 could provide you comparable information as a condition of
6 Medicare participation? Since they're actually being
7 rewarded for their Medicare participation?

8 That still leaves us with the problem of the small
9 number of hospitals in certain areas, and I think we need to
10 think of a way to deal with that.

11 In terms of some of the other problems, the
12 volatility, the BLS data is dealing with volatility both by
13 the large sample and by smoothing over several years. We
14 could think about something like that for hospitals, as
15 well.

16 It would remove one of the arguments about how we
17 are different because I think we could anticipate not too
18 far down the road was wait a minute, these are data for all
19 employers, hospitals are different, we're particularly
20 different in our community. Those things, unfortunately,
21 resonate and we do get reclassification options built into
22 law that change things.

1 Again, if this survey is simple enough, it's not
2 beyond the pale to say SNFs and home health agencies should
3 also fill it out so that we could have data that are
4 specific to them as well to make the adjustments in the
5 index for their area. That seems appropriate.

6 DR. MILLER: Can I ask one thing? Isn't that what
7 goes on in the BLS data? They go out and they survey the
8 hospital, home health agencies, and ask them what their
9 paying their labor. It's just not every --

10 DR. KANE: What's the response rate?

11 DR. MILLER: Under recommendation two, they would.

12 MR. GLASS: It was over 70-some, 76 percent, or
13 something.

14 DR. MILLER: Bill, I'm trying to get to the
15 implications of your question. I may have missed it but I
16 thought you were saying shouldn't we ask the hospitals to
17 fill out the BLS --

18 DR. SCANLON: The difference, as I understand it
19 from the paper, in the BLS what we're talking about is a
20 sample of employers. So we don't have the universe of
21 hospitals, we wouldn't have the universe of home health
22 agencies or SNFs. And on top of it, it's voluntary, you

1 don't have to fill it out. I don't know what the selection
2 bias is, if there is any, but there may be some.

3 You raised in the paper the issue that the IG has
4 looked at the data that is being supplied by hospitals
5 currently to CMS and found some deficiencies. I guess I
6 would hypothesize that if you look at the BLS data with the
7 same type of audit approach, you would find problems that
8 were as significant if not greater because there's more of
9 an obligation with Medicare. The whole concern about when
10 you send something into CMS, are you liable in any way for
11 providing false information?

12 Given all of these things, I'm thinking that if
13 CMS is sponsoring the data collection, we may have better
14 compliance both in terms of participation as well as the
15 quality of the data.

16 We don't have the physician office, necessarily,
17 or other employers of nurses or other types of personnel to
18 match in here. But again, I think that actually could end
19 up being a handicap as much as an asset in terms of the
20 arguments down the road of why we need to do something
21 different. That's what's worrying me, since we've had this
22 history of making all these exceptions.

1 DR. HOLTZ-EAKIN: I have lots of comments but I
2 think that's exactly the wrong thing to do. Point number
3 one is that the BLS data are, in fact, very high-quality
4 data. They're not perfect but these are the data that are
5 underneath things like the Consumer Price Index. The Jobs
6 Report came out today that's going to have average hourly
7 earnings. This is what these data are. They are vetted for
8 their quality on a regular basis. I don't think we should
9 be suspect about that. Like all data, they could be better.

10 The second is that the goal is to isolate that
11 part of the cost of doing business that comes with a piece
12 of geography. Like my life is harder because I'm in here.

13 And so you want to take and find all the employers
14 in a labor market because they're all participating in that
15 piece of geography. You want all of the ages of workers.
16 You want all their education and training. You want all of
17 their occupations that experience and take out all of that
18 stuff that you can and find out what's just left because
19 you've got to drive into New York City. That's an expensive
20 place to do business.

21 So you don't want to just do hospitals or SNFs or
22 anybody. You want everything that you can. So I would

1 argue that this is a dramatic step in the right direction
2 because it expands greatly the amount of information that
3 comes into identifying the cost of doing business in a
4 location.

5 It's not a reimbursement model. It's just trying
6 to identify costs of doing business due to geography. This
7 is much better at doing that than the predecessor. There's
8 no question.

9 My question is twofold. Number one, could you go
10 over why it has to be a statutory change again? To be blunt
11 about the politics, we know that there are these winners and
12 losers. The exceptions didn't come out of nowhere and the
13 reclassifications didn't either. So if you put this thing
14 back into the Congressional field, you're going to open it
15 up to that. So why can't CMS simply say here's a better
16 wage index.

17 MR. GLASS: Let me just read you this. This is
18 from Section 1395(w)(w)(d)(3)(e) of the --

19 DR. HOLTZ-EAKIN: I read it but I forgot it.

20 MR. GLASS: Basically it says the Secretary shall
21 update the factor under the preceding sentence on the basis
22 of a survey conducted by the Secretary and updated as

1 appropriate of the wages and wage related cost of subsection
2 D hospitals in the United States.

3 And then not less than once every three years the
4 Secretary, through such survey or otherwise, shall measure
5 the earnings and paid hours of employment by occupational
6 category and shall exclude data with respect to the wage and
7 wage-related cost incurred in furnishing skilled nursing
8 facility services.

9 So it's just really proscriptive.

10 DR. HOLTZ-EAKIN: It sounds like it to me.

11 My last question is is there a precedent outside
12 of this group anywhere of requiring someone to participate
13 in the BLS survey? There's a long history of making sure
14 these surveys are of high enough quality but I'm unaware of
15 anything like this anywhere else.

16 DR. STENSLAND: I think that that isn't, and the
17 people we've talked to at the BLS aren't completely against
18 it but they're not completely comfortable with it either.
19 You can talk about whether you want is, but maybe before you
20 actually vote we could get some specific statement from the
21 BLS and their opinion of this.

22 DR. REISCHAUER: I'm with Doug on the first issue

1 about what's appropriate. Could you tell us just a little
2 bit about the BLS versus the Census information? Where is
3 the Census information from? Which survey are we talking
4 about?

5 MR. GLASS: The Census information that we were
6 using is from the decennial long form census.

7 DR. REISCHAUER: That's what I thought.

8 MR. GLASS: The American Community Survey is
9 taking the place of the long form and so instead of being
10 done every 10 years it's done continuously and would provide
11 data, at least for large conglomerations, fairly regularly.
12 In other words, I think if it's a large county we'd get
13 numbers from the American Community Survey every year or two
14 and the smaller counties would be less.

15 DR. REISCHAUER: And again, you're merging several
16 years together to get -- but we have some areas more
17 contemporaneous than others.

18 MR. GLASS: Right, under the American Community
19 Survey process, yes. But all of it would be more current
20 than once every 10 years.

21 DR. REISCHAUER: And the BLS? Is it continuous?

22 MR. GLASS: Every six months they do a survey of

1 200,000 establishments. And they put together three years
2 of data or 1.2 million establishments.

3 DR. REISCHAUER: Thank you.

4 On Mitra's point, we always a show winners and
5 losers, numbers of hospitals. And that can mean 50 beds or
6 600 beds. You really don't get much of a feel for what
7 we're talking about here. It would be nice to see that
8 chart weighted by beds or something, and you'd have more of
9 a feel. The break that I'd like to see would be
10 reclassified versus non-reclassified. Because if what we're
11 doing is whacking most of the people who are hurt are the
12 reclassifieds, I'd have less sympathy for whatever anguish
13 they might express.

14 MR. GLASS: Because our wage index is budget
15 neutral by design to the current wage index, if you weight
16 it by discharges it will essentially be no effect over all.
17 If you weight by discharges the effect overall will be zero
18 because it's budget neutral to the current wage index.

19 DR. MILLER: What you're driving at is that, if I
20 understand it, is that you may have people who are large
21 winners or large losers. And you want to know not just the
22 number of hospitals but the numbers of either beds,

1 admissions, dollars involved in it. And I think we can work
2 to that.

3 MR. MULLER: The high number of reclassifications,
4 especially you show this in the Connecticut example -- I
5 don't know what the number is nationally, but it tells you
6 there's a lot of incentive to reclass.

7 So I'm trying to differentiate in the
8 recommendation here how much of the winners and losers of
9 the redistribution comes from presumptively the
10 reclassification process versus the smoothing process.

11 Right now I think one of the reasons people try to
12 reclass obviously, if there's such a cliff between what you
13 get on this side of the border and that side of the border,
14 you try to figure out how to be part of that.

15 So the way I understood your Minnesota and Dakotas
16 examples is we're going to have some smoothing in regions so
17 that there's more than a flow of labor markets -- I don't
18 know if that's the right phrase -- as opposed to kind of a
19 cliff.

20 So how much of the change they we're proposing
21 here comes from the ending of reclasses is versus the
22 smoothing of labor markets? I have three or four questions

1 but can you give me a sense of that? Is it largely from the
2 ending of the reclasses or more from the smoothing process?

3 DR. STENSLAND: I think it's probably larger from
4 ending the reclasses. The smoothing only moves around half
5 of 1 percent of the money because we get to the county level
6 and then we just smooth a little bit. So there's some
7 counties in California where it has a fair amount of effect
8 because you have some high wages in the Bay Area and the
9 neighboring counties have to get up to -- so there's not a
10 cliff.

11 MR. MULLER: So the assumption is, in a sense, as
12 Doug and others have said, if there's strong gains to be
13 made from reclassing, human nature will demand
14 reclassification. So you're assuming that by having more
15 smoothing there's less incentive to reclass?

16 DR. STENSLAND: To think of it like in the D.C.
17 area, right now if you're in rural Virginia, if you reclass,
18 you reclass into the same thing as Washington D.C. Central.
19 But under this new system, even if you recommended that
20 reclasses end and then maybe if Congress didn't exactly
21 follow the recommendation and there continued to be
22 reclasses, I think it would be easier for them to argue that

1 the reclass shouldn't be to the D.C. MSA but it should be
2 the county that's adjacent to you that has just a little bit
3 higher wage index.

4 MR. MULLER: So it's also having a tighter
5 specification of the labor market. For example, in the New
6 York example you gave where hospitals paying \$27 or \$57 were
7 in the same wage classification. So you're saying we would
8 have that kind of gradation, like I think you said anybody
9 in your Minneapolis example, where you wouldn't take the \$27
10 hospital and the \$57 hospital and put them into the same
11 grouping.

12 DR. STENSLAND: They may be in the same grouping.
13 Now that \$27/\$57 part of that could be that the market area is
14 wrong. But I think a lot of that could be just the reported
15 wages are wrong or the occupational mix isn't getting
16 everything straightened out. Because it adjusts for nurses
17 but it doesn't adjust for your cath lab employees versus
18 your housekeeping. It doesn't know what that is. So
19 there's a lot of room for error in the CMS data.

20 MR. MULLER: So we just have smaller labor pools
21 in this recommendation, which helps to add -- it allows for
22 more gradation rather than having the kind of lumpiness of

1 the gradation.

2 MR. GLASS: Right, the county level would
3 essentially smooth it out all by itself.

4 MR. MULLER: I assume that the -- are we assuming
5 that the critical access and other hospitals are outside the
6 system in that recommendation? Is there a cost-base?

7 MR. GLASS: Their wage data would be in the system
8 because the BLS collects it.

9 MR. MULLER: The payment level --

10 MR. GLASS: Their payments are cost-based.

11 DR. STENSLAND: Except for we have a home health
12 agency or a SNF. If they have a home health agency or a
13 SNF, their home health and SNF payments would still be
14 affected by changes in the wage index, because those are not
15 cost-based.

16 MR. MULLER: Let's go back to the question that
17 was raised by Mitra and Bill and others, which is how
18 appropriately the DRG case weightings captured the
19 differences. I always defer to our economists here to our
20 right, in terms of labor theory about how to think about
21 these things.

22 So what we're saying is we don't want to really

1 correct for occupational mix within this system. We want to
2 do that within the DRG system. That's what we're saying;
3 right?

4 But to go back to the question of whether it's the
5 California nursing ratios or intensive care units have more
6 nurses than OB units and so forth, we think that is
7 adequately captured by the DRG case-mix system? The fact
8 that there's a different occupational mix in different
9 medical errors should be captured, we think, fairly well by
10 the DRG system?

11 DR. STENSLAND: I think maybe CABG person in the
12 ICU versus the uncomplicated pneumonia person in the regular
13 bed, that will be captured in the DRG case weight. But I
14 don't think the California effect is captured.

15 MR. MULLER: That one we know is not captured
16 well, so let's use another example. Please go ahead.

17 DR. STENSLAND: I just think the California, if
18 you require by law that they have higher number of RNs and
19 they have a higher number of RNs say for that cancer patient
20 with the same condition as the number of RNs in New York
21 City for a cancer patient with that same condition, this
22 wouldn't account for that. We wouldn't give California a

1 higher wage because the state legislature has decided to
2 mandate higher staffing ratios.

3 MR. MULLER: In a sense, in that kind of example
4 where it's a geographic requirement, in a sense all of the
5 labor market in California are under the same requirement so
6 there's not a differential advantage or a differential
7 disadvantage.

8 MR. HACKBARTH: Before we leave that point, it
9 does not address the California situation. And I would
10 argue that you don't want to address the California
11 situation. That if you go down the path of saying we are
12 going to adjust the Medicare payment levels for regulatory
13 policies, differences in regulatory policies in every state,
14 you've got to do the minimum wage, you've got to do probably
15 a very long list. You've gone from a national payment
16 system to a state payment system or even maybe a substate
17 payment system.

18 MR. MULLER: I understand, but the one I'm
19 concerned about, and I think some of the other commissioners
20 are concerned about, and I think we're answering that we
21 capture it through the case-mix index, is in the hospital-
22 based reporting if routinely around the country it is much

1 more difficult to attract nurses to cancer units because
2 it's hard work, people burn out, et cetera, and so forth,
3 compared to -- not that anything is easy but just for the
4 sake of argument less difficult areas of the hospital, this
5 does not capture that in that sense because it basically
6 says a nurse is a nurse is a nurse. And the fact that you
7 may have to pay 10 percent or 20 percent more for cancer.

8 MR. HACKBARTH: The current system doesn't address
9 that either.

10 MR. MULLER: I thought it does by being hospital-
11 based. So if the hospital reports, by having big cancer
12 programs, routinely higher average wages am I wrong in
13 saying therefore we would have --

14 DR. MILLER: Can I say this just a little bit
15 differently? Let me try it this way. Jeff, just make sure
16 that this is right.

17 This is one thing that the current system does
18 without the occupational mix adjustment if you don't adjust.
19 What it means is if Jeff and I are running two different
20 hospitals and we are paying the same wages for any given
21 employee and he chooses, for whatever reason, chooses a
22 higher occupational mix, his wages go up and mine go down

1 even though, in this very stylized example, we're paying the
2 same wage rates for each type of employee, he chose more of
3 these employees, his wage goes up, nine goes down.

4 MR. HACKBARTH: Take it one step further in the
5 hypothetical example. Assume they have the same case-mix,
6 they're treating the same type of patients and they're
7 paying the same wages per employee. The current system
8 rewards the hospital that chooses the higher cost mix of
9 labor.

10 Well, it doesn't quite do that. It gets factored
11 into the overall calculation of the wage index. So it's not
12 even that targeted. The current system is not getting the
13 money to the right places.

14 MR. MULLER: Let me summarize where we are. We're
15 saying that, hopefully, by having more smaller labor markets
16 and more of a blend from the very high cost labor markets
17 there would be less temptation to reclass. And even if
18 there is, there isn't as big a drop from one to the next,
19 not as much of a cliff between one labor market and the
20 next. Therefore, that would also hopefully be an incentive
21 to have fewer reclassifications.

22 Now I think most people are concerned, when you

1 see that kind of Connecticut map where the exception is the
2 rule. You say to yourself what kind of system, in fact, is
3 being conducted?

4 Is Connecticut an outlier in the sense that such a
5 high proportion of hospitals reclass? Or is that the norm?

6 MR. GLASS: Over a third of the hospitals either
7 reclass or have some other exception nationwide. So
8 Connecticut is an extreme example.

9 MR. MULLER: Thank you.

10 MS. HANSEN: I think we've covered a number of
11 them but I do want to -- in capturing the complexity of the
12 roles that are played in different settings. But I'd like
13 to kind of extend that a little further to describe whatever
14 is available for both the skilled and home health agencies a
15 little bit more.

16 And part of it is right now I think of the 2.9
17 million nurses, which is the largest health care workforce
18 relative to this hospitals and health care, just over 60
19 percent right now are in acute settings. But with the other
20 40 percent are in other settings that are not as easily
21 captured, especially in home care.

22 But I just wonder if we could kind of start

1 tracking that a little bit because I think there will be
2 some shifting that's trending and planning to occur. And
3 maybe a source of some of this might come from the American
4 Nurses Association, just because this is such a large body
5 of the wage factor for health care.

6 So I really would appreciate that.

7 Thank you.

8 DR. KANE: I think this is a huge improvement over
9 the existing system, and I think the wage information should
10 come from outside the industry itself or it is basically
11 cost-based reimbursement. And that system wasn't perfect.
12 It didn't recognize a lot of the things we have concerns
13 about then. So we're just saying let's perfect the part of
14 it that we can.

15 So I'm very supportive of the general trend
16 towards using data external to the industry you're trying to
17 set a wage index for to get the wage index going.

18 I guess my only question, sort of two. Does the
19 BLS data let you see what the reported wage data is by the
20 hospital sector versus the skilled nursing? Can it break it
21 out by the type of employer? So that you see that it looks
22 like the hospitals do have to pay, on average, a 10 percent

1 premium relative to the others that you could build that if
2 you had to?

3 DR. STENSLAND: We can see that at the national
4 level but we can't see it on an MSA by MSA level. They keep
5 that confidential so that we can't figure exactly who is
6 reporting what.

7 DR. KANE: But maybe that's one way to deal with
8 the fact that the concern that maybe hospitals have to pay
9 more because the work is more intense than the home health
10 agency. If at the national level it's consistently 10
11 percent more or something that you just bump up the -- I
12 don't know if that makes any difference or not.

13 MR. GLASS: If you do that nationwide --

14 DR. KANE: Then it comes out the same anyway.
15 Right. I just figured that out. So you can't adjust it
16 down at the MSA.

17 On the occupational mix, trying to get at it the
18 same way. On the occupational mix, is there just one
19 classification for nurses? Or are there multiple? Like
20 critical care nurse.

21 DR. STENSLAND: It's just RNs, LPNs, nurses aides,
22 and then there's some various technician categories. But it

1 doesn't get into the RN differences.

2 The stuff that Ralph was talking about other
3 people have brought up as a DRG refinement issue. On top of
4 the DRG refinement we did, they said maybe there should be
5 some DRG refinement for nursing intensity of different DRGs,
6 rather than just the same room and board rate across all of
7 these different DRGs. So I think that problem might really
8 belong in a different discussion, maybe in further DRG
9 refinement.

10 DR. KANE: Overall I think it's a great advance
11 over what is.

12 DR. SCANLON: On the recommendation, I think that
13 it's important to incorporate the methodology change, as
14 well as the data issue. Because the methodology change is a
15 very important part of fixing what was a bad definition of
16 labor markets.

17 MR. HACKBARTH: Any reaction to that?

18 DR. STENSLAND: We can do that. Just note that
19 the counties -- the labor markets will be subdivided into
20 counties or something of that nature.

21 MR. MULLER: [off mike] In some sense you want
22 smoothing rather than the cliff.

1 MR. GLASS: It's there in the smaller print. I
2 guess we can just elevate the size.

3 DR. SCANLON: In a recommendation we may not have
4 a specific parameter like 10 percent, but the idea of
5 smoothing is, I think, the important concept.

6 DR. MILLER: Just to be clear for all of you and
7 anyone in the public, the 10 percent is -- there's no magic
8 to that number. It's just sort of how much tolerance and
9 room you want between two settings. We did this for
10 purposes of an exercise to go through and show you how it
11 works. But we're not saying that's the parameter.

12 MR. MULLER: Just in the Connecticut map, because
13 we have it up there, we were showing 30 percent differences
14 in terms of the existing definition, the existing state?

15 MR. GLASS: The highest being 1.3 and the lowest
16 being 1.0, yes.

17 MR. MULLER: Which in part tells me there are kind
18 of intrastate variations that are probably as great as the
19 interregional variations. And therefore there will still be
20 some temptation to go for exceptions based on local
21 conditions. Maybe this smoothing will take care of it.

22 MR. GLASS: If you remember on this map, the state

1 problem tends to get blended away, also.

2 DR. REISCHAUER: North Dakota is in the United
3 States but South Dakota is not?

4 MR. GLASS: But just barely.

5 DR. MILLER: That's one of the impacts of this.
6 We forgot to mention that.

7 [Laughter.]

8 MS. DePARLE: That might help the Trust Fund, too.

9 On this smooth process and the questions that
10 Ralph raised and others have raised about the counties
11 around the higher counties, I do think one great advantage
12 of the direction we're moving is it just seems fairer to
13 have it be smoother and less of a cliff. And having faced
14 many -- having been responsible for many of these exceptions
15 up here, or faced them down, I met with so many members of
16 Congress who really just had a hard time explaining to their
17 constituents why it was fair, when they were so close.

18 So I think if it's smoother or a more gradual
19 slope, it will be easier for them to withstand those
20 complaints. That's a word that hasn't been used today, I
21 think. But I do think it just strikes one as fairer.

22 MR. HACKBARTH: Any others? Bill, do you want to

1 correct my misstatement about who wins under the
2 occupational mix thing?

3 DR. SCANLON: Because this is on an average basis,
4 it's the low-cost hospital, the low-wage hospital that
5 actually gains because it's the average that's used to do
6 this.

7 Again, this is all a relative index. It's not
8 absolute wages. So even if hospitals are paying more than
9 others, it's a question of comparing one market to another
10 that's the critical thing in terms of the payment system.

11 MR. HACKBARTH: So the reason I think it's worth
12 closing with that, the ideal situation is to be a low cost
13 hospital that is in with hospitals that have a high
14 occupational mix before adjustment. And that's one of the
15 reclassification incentives. If you can get into that area
16 where --

17 MR. MULLER: Can we charge for that halo effect?

18 MR. HACKBARTH: Good work. Thank you very much.
19 Our next topic is interaction between Part B and
20 Part D.

21 DR. SOKOLOVSKY: Good morning.

22 Medicare prescription drug benefit is administered

1 through pharmacy benefit managers and health plans in a
2 manner similar to drug benefits available in the commercial
3 market. Most outpatient drugs are provided through retail
4 or mail order pharmacies.

5 When drugs are provided in settings or under
6 conditions that do not fix this model, patients, physicians,
7 plans, and pharmacies can all experience difficulties
8 navigating the system. Today I'm going to report on one
9 such situation, the situation of overlapping coverage of
10 drugs under Part B and Part D.

11 Stakeholders have repeatedly told us that
12 determining whether a given drug should be covered by one or
13 the other part of the program has been a headache for them.
14 Commissioners may want to consider some recommendations to
15 resolve some of the issues caused by the issue of overlapped
16 drug coverage.

17 When Medicare was implemented, the Congress
18 designed Part B to resemble typical ambulatory medical
19 benefits provided by private insurers at the time.
20 Physicians provided most drugs covered under Part B in their
21 offices as part of a medical service. The Congress
22 gradually expanded the type of drugs eligible for Part B

1 coverage. For example, as some older chemotherapy drugs
2 became available in oral form the Congress decided to cover
3 oral chemotherapy and anti-emetic drugs that were exact
4 replacements for covered infusible drugs under Part B. The
5 Congress also extended coverage to some vaccines,
6 immunosuppressive drugs used following a Medicare covered
7 organ transplant, blood products, and drugs used with
8 durable medical equipment. Retail and mail order pharmacies
9 dispense some of these drugs but physicians continue to
10 provide most Part B drugs.

11 With the addition of Part D, Medicare
12 beneficiaries now have access to coverage for most
13 outpatient drugs dispensed by pharmacies. In the course of
14 research for our report to the Congress on the effect of
15 Medicare payment changes for Part B drugs interviewees
16 reported instances where overlap in drug coverage caused
17 many problems for them.

18 To examine this issue, we've been working with
19 NORC and Georgetown University researchers to interview
20 representatives of drug plans, pharmacists, and beneficiary
21 advocates. Since plans are not allowed by law to cover
22 drugs under Part D that should be covered under Part B,

1 decisions about overlap drugs can delay beneficiary access
2 and increase costs and administrative burdens for plans and
3 pharmacies.

4 In this presentation I will talk about the
5 conditions under which the same drug can be covered by both
6 parts of the program and possible solutions to the problems.

7 Most drugs are clearly covered by one or the other
8 program, but in some instances pharmacies find that
9 additional information is needed to determine which programs
10 should cover a particular drug. Let me give you just two
11 examples.

12 First, drug coverage can depend upon patient
13 diagnosis. As you all know, drugs can be used to treat many
14 different conditions. For example, physicians use
15 immunosuppressive drugs like prednisone and methotrexate to
16 treat many conditions. If a physician prescribed them
17 following a Medicare covered organ transplant, the drugs are
18 covered under Part B. These same drugs are covered under
19 Part D for all other indications.

20 The second example, drug coverage can depend upon
21 when a patient had a particular medical procedure or
22 treatment that required additional medication. This issue

1 is similar to the first one, but applies to drugs that are
2 covered for the same indication. For example, most oral
3 anti-emetics that are dispensed within 48 hours of a
4 chemotherapy session are covered under Part B. After that
5 time period, they would be covered under Part D by PDPs even
6 though they're still being used to treat nausea caused by
7 chemotherapy. I'd be happy to address any of the other
8 issues or conditions under question.

9 As many as 6,000 individual drug products can be
10 covered by either one of the programs, depending upon
11 circumstances. By law again, PDPs cannot cover a drug under
12 Part D if it should be covered under another part of the
13 program.

14 In 2005, before the drug benefit was implemented,
15 CMS advised plans to place drugs that might be covered under
16 either program on a prior authorization list. This means
17 that the plans have to gather additional information about
18 why the drug is being prescribed or where the beneficiary
19 lives before they can approve the drug. When this happens,
20 the prescription just can't be dispensed immediately at the
21 pharmacy. The pharmacy must contact the plan, frequently
22 the physician must provide information to the plan, and the

1 beneficiary cannot get their medication until the prior
2 authorization is resolved. This also results in increased
3 costs for pharmacists, physicians, and the plans.

4 I should note that in a study we did in 2005 about
5 how prior authorization works in commercial plans, many plan
6 representatives told us that they were very careful about
7 what drugs they put on a prior authorization list because
8 sometimes the cost of staffing a call center to resolve
9 prior authorizations could be more expensive than any money
10 they might save by not dispensing drugs that didn't meet
11 their requirements.

12 In 2006 CMS made some decisions that allowed plans
13 to make quicker coverage determinations. The Agency said
14 that plans could accept physician diagnosis codes on
15 prescriptions as enough information to determine which
16 program should cover a drug. They also decided that no drug
17 that was dispensed at a pharmacy could be considered a
18 physician administered drug. So if a prescription appeared
19 at the pharmacy the plans could assume that such drugs would
20 be covered under Part D.

21 In addition, many plans began to use information
22 collected from an initial prescription to automate the

1 process for refills. For example, if a PDP learned that a
2 patient was taking immunosuppressive drugs because they had
3 a Medicare covered organ transplant, the plan would know
4 that future prescriptions for immunosuppressants were
5 covered under Part B. Plans also include codes in their
6 information systems to track if a beneficiary is living in a
7 long-term care facility.

8 However, problems remain. Pharmacists note that
9 plan processes for determining whether a drug should be Part
10 B or Part D are quite variable. Plans are most likely to
11 ask physicians for diagnosis information but some plans also
12 request information on the indications for a drug, they want
13 a faxed statement from the physician, or proof of denial
14 from Part B. Some plans allow pharmacists to ask physicians
15 about their patient's diagnosis. Others require that
16 physicians complete written authorization forms.

17 If a physician writes the needed information on
18 the prescription, plans can provide immediate authorization.
19 However, to date few physicians have begun to do this.
20 Physicians that prescribe a high-volume of drugs that could
21 be covered under one or the other program, for example
22 rheumatologists, are most likely to include diagnosis on the

1 prescription but other doctors are much less likely to do
2 it. In addition, some physicians are very reluctant to
3 include diagnosis on a prescription because of their
4 concerns about patient privacy.

5 Although the use of codes to determine whether the
6 beneficiaries live in long-term care facilities has helped,
7 stakeholders told us that the use and accuracy of codes to
8 indicate that a patient lives in a facility vary
9 considerably. However, let me come back again to the fact
10 that the problem we heard most about was the situation where
11 it's just not possible to tell at the pharmacy why an
12 overlap drug is being prescribed.

13 This leads to the following draft recommendation:
14 the Congress should direct CMS to identify certain overlap
15 drugs and direct plans to always cover them under Part D.
16 These identified drugs should be low-cost and covered under
17 Part D most of the time.

18 As I said earlier, inexpensive drugs, like
19 prednisone and methotrexate, are prescribed for many
20 conditions. They are covered by Part B only for the one
21 situation where they are used following a Medicare covered
22 transplant. The cost of these drugs is well below \$2 and it

1 is estimated that PDPs end up covering them more than 90
2 percent of the time. Plans, pharmacists, and physicians
3 will spend much more money and use more time and resources
4 meeting prior authorization requirements to determine why
5 the drug is being prescribed than it would cost plans to
6 cover the drugs routinely.

7 And if the drug is held up at the pharmacy while
8 plans collect more information, beneficiaries can be delayed
9 getting access to their drugs.

10 Some plans told us that they have directed
11 pharmacies to override the prior authorization and just
12 cover them routinely but they are also concerned about their
13 liability under any future audit. Fundamentally, what we
14 want with this draft recommendation would be for CMS to
15 draft a regulation about which drugs should be covered under
16 Part D using these criteria. In order for CMS to do this,
17 Congress has to change the law to modify the sections that
18 say that Part B can't ever cover a drug that might be
19 covered under another part of the program.

20 Stakeholder groups for both plans and pharmacists
21 support this solution to the problem.

22 This recommendation is based on a year's

1 experience with Part D which suggests that some drugs should
2 always be covered under one program. Similarly, many
3 experts agree that vaccines fit much better under Part B,
4 since they are typically given by physicians and physicians
5 have no direct relationship with PDPs. If you like, I could
6 come back to you in April with a modification to this
7 recommendation that would place all covered vaccines under
8 Part B.

9 Another problem that we heard about is that claims
10 are processed very differently under both programs.
11 Pharmacists told us that claim adjudication under Part D is
12 much simpler for them. Plan decisions are generally made
13 instantly. Under Part B pharmacists must dispense the drug,
14 submit a claim, and then wait to see if it will be covered.
15 Carriers may take a couple of weeks to make a determination.
16 If the claim is denied, the pharmacist must then submit the
17 claim to the beneficiary's PDP, if they have one.

18 In addition, pharmacists report problems
19 coordinating with both programs. A PDP may produce an
20 online message as a denial of a claim while the carrier
21 wants a written form, a paper denial, before they will
22 process the claim under Part B. In all these cases, while

1 coverage under Part B or Part D is being determined, plans
2 are not allowed, again under law, to approve transition drug
3 supplies. That is, the plan can't pay for a small supply of
4 the drug under Part D until a prior authorization is
5 resolved. In some cases, beneficiaries may have to wait
6 until coverage is decided before they can get their drugs.

7 Again, the law doesn't allow plans to approve
8 transition supplies for overlap drugs while the prior
9 authorization is ongoing. One beneficiary advocate pointed
10 out to us that prior authorization processes are not bound
11 by the same timetables that apply to appeals. So
12 beneficiaries can wait some time before they get their
13 drugs. We were told by many pharmacists that they are
14 providing emergency supplies but sometimes they have to
15 absorb the cost of coverage if coverage is denied and the
16 beneficiary cannot pay out of pocket.

17 So draft recommendation two says that Congress
18 should allow plans to cover a transitional supply of overlap
19 drugs under Part D, with certain limitations, until a
20 coverage determination is made. The limitations would be
21 that the transition supply should be time-limited and it
22 should not override the plan's formulary.

1 This recommendation would improve access for
2 beneficiaries and reduce risks for pharmacists.

3 Pharmacy and PBM trade associations again both
4 support this approach. Again the law would have to be
5 amended in order for plans to be able to provide coverage
6 for a drug that might be covered under Part B.

7 I wanted to bring to your attention one other
8 issue, and that's brown-bagging. Although we were told by
9 some physicians that they are sending patients to pharmacies
10 to purchase drugs under Part D in order to administer them
11 in the physician's office, which is something called brown-
12 bagging, interviewees did not describe this as a widespread
13 practice. Some specialty groups reported that their members
14 were engaging in brown-bagging for a few drugs that they
15 couldn't purchase at the Medicare payment rate. A number of
16 pharmacists reported that they knew about the practice and
17 had asked physicians who were doing it to order the drugs in
18 advance because they were not medications that they
19 routinely stocked. And also, they tried to arrange for
20 patients to pick up the drugs on their way to the
21 physician's office so that the drug wouldn't be improperly
22 stored.

1 No plan representative that we spoke to reported
2 brown-bagging as a problem, although plans may not have any
3 way of knowing whether the patients are going to self-
4 administer a drug or take it to their doctor's office.

5 While some physicians were experimenting with this
6 practice, others raised several concerns. Doctors did not
7 want to put the patient in charge of maintaining the proper
8 storage requirements for a particular drug that had to be
9 kept at a certain temperature or have other specific storage
10 requirements. In addition, many pharmacists, as I said,
11 don't regularly stocked these drugs and so waiting for them
12 to get the drug could create problems with a patient's
13 medical treatment schedule. Part D claims data, when it's
14 available, could help us to understand more about how
15 widespread this practice is.

16 Just to sum up, overlap drugs can delay
17 beneficiary access to medication and increase costs and
18 administrative burden for physicians, plans, and pharmacies.
19 CMS and plans have taken actions to ease the problems but
20 some issues remain. The most common problem, again, remains
21 determining coverage for drugs that are used to treat
22 multiple conditions.

1 So we would like Commission feedback on this
2 topic, and also especially to discuss the draft
3 recommendations.

4 DR. CASTELLANOS: Joan, I think that you dealt
5 with a difficult problem very nicely.

6 I guess one of the concerns I have, I think it's
7 just an omission on your part. You mentioned in the report
8 that you interviewed health plans, pharmacists and
9 beneficiaries. I don't see where you interviewed
10 physicians. I think physicians are a very important part.

11 The second point is I'm not sure if you're aware
12 but the AMA has established a group specifically looking at
13 this.

14 And the third issue, you may want to contact CMS.
15 There are two people in CMS that deal with this almost
16 exclusively, a fellow named Bill Rogers, Dr. Rogers, who is
17 head of PRIT. He's probably the most experienced person
18 dealing with this.

19 This problem has been in existence now for about
20 two years. Fortunately, most of the problems have been
21 "worked out" as you would expect. I think you may want to
22 look at getting some physician input and the AMA input and

1 CMS input.

2 DR. SOKOLOVSKY: I just want to say that, although
3 for this particular project we didn't interviewed
4 physicians, it was the interviews with physicians for the
5 last report that brought up this problem.

6 DR. CASTELLANOS: Those are the last two reports.

7 DR. SOKOLOVSKY: They are the ones that brought it
8 to our attention.

9 DR. CASTELLANOS: I fully recognize that, that you
10 did a great job with those two previous reports. But I'm
11 not sure if you asked physicians in the context of the
12 problems they're having between these two programs.

13 DR. MILLER: Joan, you did do your consultation
14 with CMS? I guess I want to reinforce, I think it was some
15 of the problems raised by the physicians that brought this
16 to the table. And then we're going through the rest of the
17 actors in a process to try and isolate what each of their
18 views are.

19 DR. CASTELLANOS: Mark, I'm not getting
20 argumentative, but Bill Rogers is a personal friend of mine.
21 And he's the one that's the key person on this in CMS. When
22 I spoke to him this week, he said he hadn't been contacted.

1 DR. SOKOLOVSKY: That's true and I will certainly
2 reach out to him. I had informal conversations with other
3 people at CMS but not him.

4 MR. HACKBARTH: The other thing is that I thought
5 what I heard you say is that the origin of this was actually
6 physicians. And the other people that you've talked to in
7 CMS and plan representatives and beneficiary
8 representatives, this is an area where there's agreement.

9 DR. SOKOLOVSKY: Strangely enough.

10 MR. HACKBARTH: One of those happy occasions. I
11 think that's worth underlining.

12 MR. BERTKO: Joan, just a couple of places where
13 you may have be intending to add this but I'll mention it.
14 There is a connection here just into the administrative
15 mechanics of bids and formulary approval and everything.
16 Number one, we've had several instances of changes being
17 made after the bids are in. So the timing on this -- there
18 might be some cost impact. I can see from your responses
19 that you reported from plans the administrative savings
20 might, in fact, offset some of these lower cost things. But
21 it would be nice to know that.

22 I know the formulary approval process is really

1 important to us and to CMS. And again, having that done
2 kind of in a normal fashion as opposed to late in the year
3 would be pretty useful.

4 MS. HANSEN: Joan, this is really eye-opening to
5 see the whole range of issues, so I really appreciate your
6 doing the report. I have a question and then I have a
7 comment.

8 The question was about the vaccines possibly going
9 into Part B. Are we talking about all vaccines, including
10 flu vaccines?

11 DR. SOKOLOVSKY: Medicare right now covers flu
12 vaccine and a number of other preventive vaccines, but it
13 doesn't cover other vaccines just for prevention and new
14 vaccines coming along. So this would be a process of --
15 right now if it's just for prevention the previous process
16 has been that the law actually has to change to get to be
17 covered under Part B.

18 We could, and I have not had time to fully work
19 this out, I was trying to get your reaction first, but there
20 is an advisory group that advises CDC about preventive
21 vaccines. And they divide not only the new vaccines as they
22 come along, not just in general, but by age of the people

1 who should get it, by their risk group, by gender, by a
2 bunch of other things. We could have a process where if a
3 new preventive vaccine -- and the one that people are
4 talking about is for shingles -- comes along and they
5 believe it should be covered for the Medicare population,
6 then it could be covered without needing a change in law for
7 it to be covered.

8 MS. HANSEN: This is probably really a specific
9 one just so that I can understand. Let's say a flu vaccine
10 that right now is generic, let alone the shingles vaccine in
11 the future. Many of these are given in supermarkets. So
12 does this change effect that at all?

13 DR. SOKOLOVSKY: No, generally speaking, the
14 entities that provide these vaccines at supermarkets or
15 drugstores have a Medicare billing number and are able to
16 and do bill through Part B.

17 MS. HANSEN: Thank you.

18 And then the comment that I have is this is just
19 fascinating. I was just looking at a report from OECD and
20 when we compare our administrative costs relative to all
21 these other countries, ours is like 85 percent higher than
22 others. And so when I hear all of this going on relative to

1 kind of the synchronization of B and D, it's so clear the
2 issues that have to get done in order to make this happen.

3 But then I bring it back to the beneficiary and
4 the impact on the beneficiary, in many cases waiting a
5 little bit, some of these things are not as vital. But some
6 of these cancer drugs. If this gets addressed in some of
7 the recommendation, that's great.

8 But I just wonder if -- I don't know that this is
9 almost too operational -- but to be able to ask in this
10 effort that some kind of synchrony occur with much more
11 real-time data. And this underscores the need for a health
12 information infrastructure.

13 But this whole approval process type of thing,
14 diagnosis/no diagnosis, is just such a painful process to
15 hear about that is pretty straightforward despite the HIPAA
16 issues of privacy. But to be able for a beneficiary to get
17 a medication, whether it's an urgent for certain medications
18 or a reasonable time for others, I just wonder if we can
19 build in, either to the chapter in terms of the context or
20 anything that would be appropriate -- and I'm not sure that
21 is appropriate -- in the recommendation itself to just
22 underscore that this affects quality and access ultimately

1 here.

2 I know, and it makes sense that the pharma and the
3 plans are happier because there's greater synchrony. I
4 really would like to make sure that the beneficiary impact
5 looms large in the course of it, because the administrative
6 structures are better. But how does that really affect the
7 whole purpose of this ability to get medications?

8 Thank you.

9 DR. SCANLON: Certainly, it seems that central to
10 all of this is the need to determine whether it's going to
11 be B or D that's going to cover this, and the prior
12 authorization processes are critical to that. And while I
13 guess you could think of issues that apply to all plans, it
14 sounded like from your presentation that there's also
15 variability in terms of how well this is working.

16 I think from that perspective, concerns about
17 prior authorization have extended beyond the drugs that
18 might be covered under B, as well as D. The two different
19 thoughts: one is how is CMS monitoring the prior
20 authorization experience in terms of getting information?
21 And then, even a further step would be to share that
22 information so that people understand how well plans perform

1 in this area?

2 The second, you mentioned that there are no
3 standards for prior authorization in terms of a timetable.
4 The question would be whether or not there should be
5 standards for prior authorization, that we should have some
6 kind of an expectation that the process will be completed
7 within a particular time frame.

8 I know that there's been some voluntary efforts in
9 terms of trying to standardize this, and the question is
10 whether there should be more direction from CMS in terms of
11 trying to standardize this to make it easier for physicians
12 and beneficiaries and pharmacists to be able to deal with
13 it.

14 DR. CASTELLANOS: Just a point of information.
15 Jennie, you asked about which vaccines are covered under
16 Part B and D. Under Part B, the influenza, pneumonia and
17 hepatitis B are covered. All other vaccines are under Part
18 D.

19 DR. KANE: Following up a little on what Bill just
20 said. On the database that the consumers use, the
21 Medicare.gov, where you pick your drug plan, are there
22 required elements or can there be required elements that

1 they have to fill out around how fast it takes them to do a
2 prior authorization? In terms of informing the beneficiary
3 at the time they make the choice of plan, can we make a
4 recommendation that this kind of information has to be
5 disclosed?

6 DR. SCANLON: I actually think that would be
7 ideal, that there were standards of performance of plans
8 that you shared this information, just as in Home Health all
9 Compare or Nursing Home Compare, or Hospital Compare we have
10 found measures to say this is how well this provider is
11 performing. We would potentially want to do the same thing
12 with Part D plans.

13 But right now it's just basically the description
14 of the benefit, the formulary, et cetera.

15 DR. MILLER: Sounds like you have an interest in
16 us trying to work something up like that for the next
17 meeting.

18 DR. KANE: Say what we think should be on that
19 website that the consumers use to choose the plan, beyond
20 just the formulary. There should be more service attribute
21 type information.

22 DR. SOKOLOVSKY: It will say on the formulary

1 whether a particular drug requires prior authorization. You
2 do get that.

3 DR. KANE: But we don't know how fast the prior
4 authorization takes. We don't know frustrating it is, how
5 many forms. I think there needs to be some sort of
6 beneficiary input or survey required that shows up on
7 satisfaction with the administrative processes.

8 DR. REISCHAUER: I think that might be very
9 complicated and not tell you very much because you're going
10 to have an average with a distribution around it and it
11 might differ geographically and everything else.

12 DR. KANE: Isn't that true of all consumer --

13 DR. REISCHAUER: I think setting a regulation
14 about a maximum time is really a much better way to go.

15 DR. SCANLON: But I think we should be moving in
16 the direction that Nancy is talking about, which is what are
17 meaningful measures of plan performance that we can put on
18 to the website to share with consumers.

19 DR. REISCHAUER: That's a bigger topic which we
20 don't want to just add on to this.

21 MR. HACKBARTH: I agree with the direction as
22 being potentially important. But what I would urge is that

1 we not just focus on one thing and say this ought to be
2 included, that we step back and look at this more
3 systematically. In particular, after we have some
4 experience with the program and we've got a sense now, here
5 are some really big items that we ought to set about to
6 advise beneficiaries on.

7 MR. BERTKO: Glenn, let me only add at this point,
8 J.D. Powers has surveyed PDPs in a number of states and some
9 of this may already be available. So why redo it if it's
10 out there?

11 MS. THOMAS: A couple of years ago we actually did
12 a chapter that even included a table describing dimensions
13 of performance measures for plans. We can certainly, in the
14 chapter, reference that and bring it back to you guys to
15 refresh your memories on what we said there.

16 MR. HACKBARTH: In fact, that's the framework that
17 I was thinking of. And our hope is that over time we will
18 start to get some data that would allow us to look at
19 various dimensions of performance, as I recall. And then we
20 could really think systematically about what sort of
21 information you may want to provide.

22 DR. MILSTEIN: One of the reasons that American

1 administrative costs are as high as they are, not just for
2 this program but for all programs, is because all these
3 programs often engage in what I'll call the false economy of
4 reducing information requirements associated with payment
5 with the idea that that is somehow less of a burden. But
6 the consequences of that are to generate more burden
7 downstream.

8 I would hope that one of the things we might want
9 to consider, though maybe not resolve today, is whether or
10 not this is a moment in the evolution of the Medicare
11 program where we might want to consider recommending a
12 policy that no prescription is coverable under any program
13 within Medicare unless it's paired with the diagnosis for
14 which that prescription is written.

15 It requires more deliberation but I just think
16 we're far past the time. There are disadvantages, but the
17 disadvantages of not doing it, I think, are greater.

18 MR. HACKBARTH: Okay. Any other comments before
19 we move on?

20 Thank you, Joan.

21 Our last session for this meeting is on Part D and
22 long-term care pharmacies.

1 DR. SCHMIDT: We're also going to touch on a set
2 of issues related to Part D that policymakers perhaps didn't
3 anticipate as much when they were putting the drug benefit
4 into law. Specifically, right now I'm talking about how
5 Part D is affecting the way drugs are delivered to
6 beneficiaries in long-term care settings.

7 Residents of long-term care facilities are
8 typically frail. They often have multiple comorbidities,
9 and often cognitive difficulties as well. Naturally an
10 important policy goal is that the changes brought about by
11 Part D not adversely affect their care.

12 Today I'm happy to have with us David Stevenson
13 and Haiden Huskamp. Joe Newhouse is also part of this
14 project team but is not able to be here today.

15 MedPAC contracted with them, the Harvard Medical
16 School Department of Health Care Policy, to interview
17 stakeholders to get their take on how Part D's introduction
18 is affecting things.

19 I want to start out by laying out what we think
20 are some key issues with respect to delivering drugs in the
21 long-term care setting. We're going to go through more
22 detailed slides and then come back to this later and I

1 wanted to give you a sense ahead of time of what we think
2 are some key issues.

3 Nursing facilities are highly regulated and much
4 of that regulation focuses on getting the right medications
5 to the right patient in a timely manner. In part, because
6 these are medically complex patients, resident of nursing
7 facilities take many drugs. And as a result they're also at
8 higher risk for adverse drug events. There are lots of
9 adverse drug events in long-term care settings. But there
10 are also some questions about the quality and
11 appropriateness of drug use in nursing facilities that
12 predate Part D. For example dosing levels for certain
13 psychoactive medicines or questions about the management of
14 patients on anticoagulants.

15 Within this context, as we move into Part D we
16 need to monitor whether the new program is affecting the
17 care of these patients.

18 CMS's marketing guidelines for Part D prohibit
19 providers, including nursing facilities, from steering
20 patients toward specific plans because of potentials for
21 conflict of interest. For example, a nursing facility might
22 find it more convenient to have every resident in one

1 particular specific Part D plan, but that might not
2 necessarily be in the best interest of each of those
3 patients. At the same time stakeholders are telling us that
4 there's considerable administrative burden from having to
5 interact with multiple Part D plans.

6 One interesting aspect of delivering Part D in a
7 long-term care setting is that there are two sets of
8 formularies and two sets of rebates involved, one for the
9 Part D plan itself and one for long-term care pharmacies.
10 Historically, long-term care pharmacies have used revenues
11 from rebates to provides certain required services to
12 nursing facilities without charging much more than the cost
13 of the drug ingredients and dispensing. CMS is concerned
14 that long-term care pharmacies -- they're concerned about
15 them receiving these separate rebates from drug
16 manufacturers and the Agency thinks this could raise
17 Medicare program spending. We'll tell you why in a few
18 slides.

19 If those rebates go away, it could have
20 implications for both the long-term care pharmacy industry
21 as well as other payers, potentially even Medicaid.

22 An overarching issue throughout all of this is

1 that some stakeholders believe that Part D's approach of
2 using competing private plans isn't a good fit for the long-
3 term care sector. CMS and some other stakeholders believe
4 that Part D's approach can work and, in their view, past
5 ways of doing business weren't necessarily the best.

6 I want to emphasize from the start that we are not
7 talking about patients who have a SNF stay who are covered
8 under Part A. We're talking about people who have a longer-
9 term stay and often require personal care, custodial care,
10 that sort of thing.

11 There are on the order of 2 million Medicare
12 beneficiaries in long-term care facilities according to
13 survey data. I'm not going to go over the stats that are in
14 your mailing materials about their demographics other than
15 to say these are medically complex patients oftentimes.
16 They're fragile because they have multiple comorbidities.

17 There may be, as a result, less consensus among
18 providers on how exactly to treat these patients. They're
19 disproportionately among the oldest old. A few of them
20 still have spouses alive. There's often high levels of
21 difficulty with activities of daily living, obviously which
22 is why there's a loss of independence. And there's often

1 high of cognitive impairment. Many of these individuals
2 are very low income and, as a result, more than half of them
3 are dually eligible for Medicaid. They also use a lot more
4 prescription drugs than beneficiaries who live in the
5 community, on the average six to 10 prescriptions per month
6 compared to about two to four.

7 They also use some categories of medicines more
8 frequently in this setting. Some of these are identified as
9 being particularly high risk for adverse drug events related
10 to medication errors. I'm thinking of things like
11 antipsychotics, anticoagulants, diuretics and anti-
12 epileptics.

13 There is a very different distribution system for
14 nursing facility residents for the distribution of their
15 drugs than for beneficiaries who fill scripts at retail and
16 mail order pharmacies. The long-term care facilities can
17 use retail pharmacies, but instead most of them use very
18 specialized long-term care pharmacies. These long-term care
19 pharmacies dispense to the nursing homes and then to
20 residents in a very highly specific and regulated way.
21 These regulations are a result of laws that were passed
22 primarily in the late 1980s and early 1990s that came about

1 over concerns about medication errors, quality of care, and
2 safety.

3 Long-term care pharmacies use their own
4 formularies. They have to dispense in a different way from
5 retail pharmacies because of state laws and regulations.
6 For example, they have to repackage drugs into unit doses,
7 these little blister packs. They often have to do
8 compounding in preparation of IV drugs. They have to be
9 available to deliver drugs 24 hours a day. They also have
10 to provide the services of consultant pharmacists who keep
11 electronic dispensing histories of each patient and conduct
12 monthly drug regimen reviews that are required of nursing
13 homes under conditions of participation for Medicaid.

14 Now we're going to walk through how this
15 distribution system worked prior to Part D and then, in the
16 following slide I'll show you how it's changed.

17 We're using an example of a dual eligible but keep
18 in mind that there are other types of residents at nursing
19 facilities who either had retiree drug coverage or paid out
20 of pocket.

21 We start out in the same sort of manner as for the
22 retail distribution system. Manufacturers and wholesalers

1 deliver drugs to pharmacies. But again, instead of retail
2 pharmacies, most long-term care facilities use these long-
3 term care pharmacies. Long-term care pharmacies dispense to
4 nursing homes and then to residents.

5 The physicians who write prescriptions for nursing
6 home residents can be either a facility's physician, such as
7 its medical director, or doctors who are in the community.
8 Nursing facility staff and the consulting pharmacist check
9 to see if the drug is on the long-term care formulary and
10 they shepherd the process with their prescriber for
11 documenting medical necessity and so on. Under current
12 regulations if a consultant pharmacist makes a
13 recommendation for a therapeutic substitution, the attending
14 physician has to consider that and respond to that.

15 Like PBMs long-term care pharmacies negotiate with
16 manufacturers for rebates. If a long-term care pharmacy is
17 able to move drug utilization of the nursing facility
18 residents towards a manufacturer's specific drug, then the
19 manufacturer typically pays a rebate. Given how care is
20 delivered in nursing facilities and the role of these
21 consulting pharmacists, long-term care pharmacies are likely
22 to have a higher rate of formulary compliance than PBMs that

1 are operating in a more retail setting.

2 Prior to Part D, Medicaid paid nursing homes for
3 the room, board, and personal care services of dually
4 eligible residents plus a separate fee-for-service payment
5 to the long-term care pharmacy. But the fees paid to the
6 long-term care pharmacies largely were just for covering the
7 drug ingredient and the dispensing services. Much of the
8 costs of the other services, such as those for the
9 consultant pharmacist, were thought to have been financed
10 through the rebates from drug manufacturers.

11 As of January 1, 2006 Medicaid no longer was the
12 primary payer for drug coverage for duals.

13 Now we have the world after Part D. Instead now
14 Medicare is paying monthly payments to a private plan that
15 provides Part D coverage to the beneficiary. Since we're
16 talking about a dual eligible in this case, Medicare is also
17 paying their monthly premium and cost sharing.

18 Just like with retail pharmacies, from this
19 monthly payment that Medicare is making to the plan, the
20 plan in turn must make a payment to the long-term care
21 pharmacy for the prescriptions it fills, subject to the
22 contract terms between them.

1 As we've talked about before, Part D plans use
2 formularies to manage the drug benefit and to encourage
3 their members to use certain brand-name drugs rather than
4 others by putting them on preferred tiers. In return, the
5 drug manufacturers typically pay a rebate.

6 So a situation that is unique to delivering drugs
7 in the long-term care sector is that there are two different
8 entities, both covering the same enrollee, that have
9 separate formularies and are each receiving separate rebates
10 from drug manufacturers, again the Part D plan and the long-
11 term care pharmacy.

12 Remember that CMS auto-assigns duals, including
13 those who are in long-term care settings, into plans that
14 qualify. That is, they have premiums that are at or below
15 certain regional premium thresholds that differ around the
16 country. Each region has a dozen or more plans with
17 premiums that are low enough to qualify for these auto-
18 enrollees. So CMS is randomly assigning duals to them, no
19 matter whether the plan's formulary covers the mix of drugs
20 that resident is taking currently.

21 Other nursing facility residents who aren't duals
22 decide whether or not they want to enroll. The end result

1 of that is that any given nursing facility has residents
2 enrolled among several different plans.

3 CMS's marketing guidelines prohibit providers,
4 including nursing facilities, doctors, and long-term care
5 pharmacies, from steering to particular plans out of concern
6 of conflicts of interest. However, nursing facilities must
7 have to educate residents or their family members about the
8 different plan choices available. Residents can switch
9 plans up to once per month and there's no cost sharing for
10 residents of nursing facilities after 30 days.

11 So now let's reflect the fact that there are lots
12 of beneficiaries at each nursing facility, shown here in
13 blue. Since there are many plan choices available to
14 residents, each facility has residents scattered among
15 different Part D plans. Medicare is making a monthly
16 payment to each of those plans on behalf of those residents.

17 Meanwhile, most nursing facilities have kept a
18 relationship with a single long-term care pharmacy to
19 provide all the pharmacy services. CMS's network access
20 requirements for long-term care have meant that all the
21 major long-term care pharmacies have had to negotiate
22 contracts to be within the networks of all Part D plans. So

1 this has allowed nursing facilities to continue using this
2 approach of a single long-term care pharmacy.

3 Part D has radically changed the sources of
4 financing for long-term care pharmacies, as you might
5 imagine. Since a majority of nursing facility residents are
6 duals, the long-term care pharmacies used to be able to look
7 to a single state Medicaid program for the bulk of their
8 financing. Now they have to negotiate with each of the Part
9 D plans.

10 Each plan has its own formulary, its own
11 requirements for prior authorization, its own processes for
12 grievance and appeals, and its own set of rebates from drug
13 manufacturers. The nursing facilities and long-term care
14 pharmacies now have to help residents navigate different
15 plans and formularies and coordinate documentation for prior
16 authorizations.

17 Now David is going to provide more detail on what
18 he and his team have found from interviewing many of the key
19 stakeholders.

20 DR. STEVENSON: Thanks, Rachel.

21 To assess the impact of Part D on the nursing home
22 and long-term care pharmacy sectors, we conducted 31

1 telephone interviews between November 2006 and January 2007.
2 We interviewed a wide range of stakeholders including
3 nursing homes, long-term care pharmacies, group purchasing
4 organizations, Part D plans, clinicians, and others. We
5 sampled systematically to maximize representation of
6 Medicare beneficiaries, meaning simply that we interviewed
7 the larger or tried to interview the larger nursing home
8 chains, long-term care pharmacies, and Part D plans.

9 The key areas of focus that I'll talk about today
10 are five: first, Part D enrollment and plan selection;
11 second, dealing with multiple PDPs at the nursing home
12 level; third, the clinical impact on nursing home residents;
13 fourth, the financial and administrative impacts on nursing
14 homes and long-term care pharmacies; and then finally, the
15 competitive impact of Part D in the long-term care pharmacy
16 sector.

17 As Rachel mentioned, duals are randomly assigned
18 to plans with premiums at or below the regional benchmarks.
19 Even though nursing home residents can switch PDPs at any
20 time -- and that includes duals and non-duals -- there is
21 some concern the prevalence of cognitive impairment in the
22 nursing home setting could impede the consumer choice model,

1 could impede consumers' ability to choose among plans. Not
2 all residents have access to family members or legal
3 guardians who can help them navigate Part D plans and choose
4 the one that's best for their needs.

5 Importantly, as Rachel also mentioned, nursing
6 homes are prohibited from steering residents to particular
7 plans.

8 In our stakeholder interviews, several nursing
9 home providers with whom we spoke expressed a great deal of
10 frustration at these limits, particularly on their ability
11 to direct residents to a particular plan. Some nursing
12 homes, however, it should be noted, do not want to assume
13 this role. So there's a tension between directing residents
14 based on what they may want to particular plans and then not
15 taking on a potential conflict of interest.

16 The practice with respect to these marketing
17 guidelines, importantly, varies across the nursing home
18 providers. Some are much more cautious than others about
19 overstepping CMS's guidelines. I should say there's also a
20 little bit of confusion about interpreting those guidelines.

21 Data are not yet available to track plan switching
22 at the facility level. Anecdotal accounts about the extent

1 to which this is happening seem to vary. The locus of
2 enforcement of these non-steerage clauses seems like it will
3 happen largely at the state survey agency level, although
4 several chain providers mentioned the OIG, as well.

5 Dealing with multiple PDPs at the nursing home
6 level. As discussed above, Part D introduced a lot more
7 variation to the nursing home clinical and administrative
8 environments. For duals, nursing homes now have to work
9 across multiple PDPs, as opposed to just a single Medicaid
10 program. And the six to 10 plans are fairly typical for a
11 facility of 100 residents or so. Plans can differ, as
12 Rachel said, in coverage, use of utilization management, and
13 also administrative processes.

14 We heard about wide variation in how "friendly"
15 PDPs were perceived to be to long-term care. This fell on
16 several dimensions. Formulary characteristics, both
17 coverage and utilization management processes. Ease of
18 administrative processes, getting claims paid, for instance.
19 And also accommodating long-term care specific needs such as
20 emergency medicine supplies and also certain formulations of
21 drugs such as solutions that nursing home residents use more
22 often than other beneficiaries.

1 I'd like to note a particular role that nursing
2 home physicians play in Part D prescribing, both in the
3 initial prescribing and also in navigating the utilization
4 management requirements across plans. They expressed a
5 great deal of frustration with the administrative burden
6 despite steps by CMS to make this easier. CMS, for
7 instance, has instituted a standardized appeals and
8 exemption form but some stakeholders indicated that this
9 form was not always honored. Or if it was accepted, that
10 the PDP-specific form was required in addition to it.

11 Typical practice characteristics of nursing home
12 physicians, at least attending physicians, can make some of
13 these Part D challenges more difficult. Many nursing home
14 physicians practice offsite and work across several nursing
15 homes, so dealing with prior authorization or step therapy
16 requirements they might not have access to the resident's
17 medical records at hand.

18 In terms of the clinical impact of Part D on
19 nursing home residents, it's really difficult to assess
20 without quantitative data on drug utilization and also other
21 aspects of nursing home care and quality. With that said,
22 stakeholders report within class utilization shifts but they

1 don't report a broader shift in total drug use. Advocates
2 and long-term care providers also don't report more
3 generally negative health outcomes that they think are
4 attributable to Part D/

5 They did mention safeguards such as the protected
6 classes under Part D, where all or substantially all drugs
7 within a class have to be covered by PDP, and also nursing
8 home requirements under the Nursing Home Reform Act or OBRA,
9 where nursing homes are required to adhere to a clinical
10 plan, regardless of an individual's ability to pay or have
11 coverage for those clinical plans.

12 Although medication access generally seems
13 sufficient among stakeholders, specific areas of concern
14 were identified. These included Alzheimer's drugs, EPO
15 drugs, selected antibiotics, and the antidepressant Lexapro,
16 among others. For these and also for other drugs the
17 clinical impact of this limited access depends on multiple
18 factors including the prevalence of use, the availability of
19 therapeutic equivalence, the efficacy of particular drugs in
20 question. Importantly, some limits could be appropriate
21 clinically, especially in the context of what Rachel talked
22 about, concerns about overuse and utilization.

1 Financial and administrative impact on nursing
2 homes and long-term care pharmacies. Part D changes the
3 relationship between nursing homes and their long-term care
4 pharmacies. Prior to Part D, timely delivery of drugs,
5 clinical predictability, and compliance with regulatory
6 standards were really cited as the most important things for
7 nursing homes in their long-term care pharmacies'
8 performance.

9 Part D introduces a new tension. It's a tension
10 between nursing homes need for timely dispensing of drugs
11 and long-term care pharmacies' assuring coverage for these
12 drugs. Both parties have an incentive to minimize
13 prescriptions for non-covered medications but neither wants
14 to be on the hook financially.

15 As I mentioned before, per OBRA '87, nursing homes
16 are the ones that are legally responsible for following care
17 plans administrating and dispensing the drugs.

18 I should also note that there's variation in the
19 timing and the extent to which long-term care pharmacies are
20 pursuing payment of these non-covered drugs from nursing
21 homes. Rejected claims that we'll talk about in the next
22 few slides are a visible sign of this tension. There's

1 variation in these rejected claims across drugs and classes
2 and also there's variation across PDPs.

3 So this slide uses data from one long-term care
4 pharmacy from 2006. Just to orient you to the table, on the
5 left-most column are the top 20 drugs in terms of rejected
6 claims and in the top row are the reasons for the rejected
7 claims. They're mostly self-explanatory, a drug not being
8 covered, no history record on file which can include not
9 only step therapy requirements but also certain diagnostic
10 tests that must be performed before allowing coverage for a
11 drug. Refill too soon, prior authorization requirements,
12 and then also other administrative reasons.

13 The main point of this slide that I want you to
14 take away from it is that there's variation across drugs and
15 also drug classes in the reasons why drug claims can be
16 rejected. For instance, the top row, Lexapro. It's in the
17 protected class of antidepressants but plans can cover
18 either Lexapro or Celexa. They don't necessarily have to
19 cover both. So the main reason here that claims were
20 rejected for Lexapro is that the NDC is not covered.

21 A little further down the table you'll see Aricept
22 and Namenda, which are two Alzheimer's drugs. The main

1 reasons that those claims are being rejected is in prior
2 authorization requirements. Similarly, below Namenda is
3 Procrit, an EPO drug. And the main reason it's getting
4 rejected is for prior authorization requirements. But
5 again, the key point is that limited access can be because
6 of different reasons. It might be because of drugs not
7 covered. It might also be because prior authorization
8 requirements aren't met.

9 This next slide uses data from the same long-term
10 care pharmacy from 2006. to orient you again to the slide,
11 the left column is 16 of the Part D plans this long-term
12 care pharmacy works with. The right column is a plan
13 rejection rate relative to the average plan's rejection
14 rate. So for this one long-term care pharmacy, if you have
15 a rate of one that means you're on par with the average in
16 terms of the percent rejected claims versus the percent
17 claims you have filled.

18 You can see, and my main point is, that this
19 varies quite a lot of across the 16 PDPs on this slide, from
20 0.23 to 3.54.

21 If you assume a reject rate of around 4 percent,
22 which is what we heard from some long-term care pharmacies,

1 the implication of that is that the rejection rate varies
2 from around 1 percent to around 14 percent across PDPs.

3 Before talking about the impact of Part D on the
4 competitiveness of the long-term care pharmacy sector, it's
5 useful to have a slide that shows the share of nursing home
6 beds by long-term care pharmacy firms. As you can see from
7 the slide, Omnicare covers a large portion of the nursing
8 home beds in this country, around 50 percent. PharMerica
9 and Kindred cover the next largest shares at 13 percent and
10 6 percent respectively. Then smaller, local, regional and
11 also retail pharmacies cover the remaining third of nursing
12 home beds in the country. So it's a rather concentrated
13 market.

14 The competitive impact of Part D on the long-term
15 care pharmacy sectors really is still evolving. We heard
16 little about market entry or exit thus far, although there
17 is some consolidation in the sector. Importantly from the
18 previous slide, PharMerica and Kindred are set to merge in
19 the second quarter of this year, and we've heard about other
20 consolidations within this sector, as well.

21 Group purchasing organizations and also long-term
22 care pharmacy network organizations are playing an important

1 role in this field, in this sector, to help level the
2 playing field. Group purchasing organizations have been
3 around a while, but the long-term care pharmacy network
4 organizations are more Part D specific and they negotiate on
5 their members behalf collectively with Part D plans.

6 Also, we should note that economies of scale are
7 still important. Despite the role that group purchasing
8 organizations and these network associations can play,
9 larger long-term care pharmacies still can have advantages
10 in terms of warehousing and packaging. But then on the
11 other hand, local relationships and services are important
12 as well, and the smaller long-term care pharmacies might be
13 better able to deliver some of those.

14 Continuing the competitive impact, information on
15 the importance of rebates, past, present and future, was
16 difficult to obtain in the interviews. The larger long-term
17 care pharmacies have likely benefitted more from these
18 rebates in the past. Prior to Part D, these rebate revenues
19 reportedly subsidized services to nursing homes, for example
20 consultant pharmacist services might be bundled in with
21 other services at low or no cost to the nursing home.

22 In the context of Part D, CMS hasn't disallowed

1 these rebates but they have expressed strong reservations
2 about them. They cite potential incentives for
3 inappropriate prescribing, overutilization, and also higher
4 Medicare costs.

5 The consensus among stakeholders was that long-
6 term care pharmacy rebates continued in 2006 but would
7 likely decline in future years. If they do decline, if this
8 does indeed happen, it could lead to greater transparency of
9 pricing and increased price competition if services are
10 indeed unbundled. It could also help level the long-term
11 care pharmacy playing field between the larger pharmacies
12 and the smaller pharmacies. But it also could lead to
13 higher prices for nursing homes.

14 Just to sum up some key findings from our work.
15 Some nursing home providers expressed a desire for greater
16 flexibility in directing residents to a smaller number of
17 long-term care friendly plans. There's a tension here.
18 Steering could help match residents to plans based on their
19 needs or it could be driven by financial considerations that
20 aren't necessarily in residents' best interest.

21 Second, Part D introduced greater clinical and
22 administrative variation into the nursing home prescribing

1 environment. There's a tension now between utilization
2 management strategies used by the PDPs and then the burden
3 of these strategies on nursing home, clinical, and also
4 pharmacy staff. As I noted above, there were some access
5 challenges that stakeholders cited in particular drugs and
6 classes.

7 Finally, although stakeholders do not report major
8 problems for beneficiaries to date, the clinical impact
9 really needs further study. Most people were speaking
10 anecdotally. They weren't really based firmly in data.

11 There is a changed nature that Part D brings about
12 between the nursing home and long-term care pharmacy
13 relationship. There's a tension between the nursing homes'
14 need to dispense drugs quickly and long-term care pharmacies
15 assuring coverage for these drugs. There's also variation
16 across this contracting in terms of how rejected claims are
17 handled.

18 Finally, the competitive impact of Part D on the
19 long-term care pharmacy sector is currently unclear, with
20 the potential impact of changing rebate structures being
21 particularly important. There's a potential for increased
22 cost being passed down to nursing homes.

1 DR. SCHMIDT: We wanted to finish up by returning
2 to this slide of key issues. With this presentation, we
3 wanted to talk through how pharmacy benefits are delivered
4 in this long-term care setting and how Part D is changing
5 things. But at this point, we're not bringing any
6 recommendations to you to consider. We simply wanted to
7 start a conversation about this topic and address any of
8 your questions and get your feedback on it.

9 As you can see, it's a very complicated topic and
10 the changes underway are going to have important
11 implications for the beneficiaries who reside in long-term
12 care settings, other stakeholders in the Medicare program,
13 and potentially even other payers such as Medicaid.

14 In the future, as things evolve further, we may
15 come back to you with potential recommendations based on
16 your feedback but we see this as just the start of a longer-
17 term conversation about this topic.

18 MR. HACKBARTH: Thank you. Well done.

19 Here's the question that leaps out at me. Could
20 you go back to one of the initial slides where you went
21 through the series that showed the layers of complexity that
22 are added by this?

1 We've introduced new complexity into this
2 situation and we've done that as a result of an effort to
3 offer a choice to Medicare beneficiaries in their
4 prescription drug coverage. There's often a trade-off to be
5 made between choice and competition and administrative
6 complexity. So here we've introduced complexity in the name
7 of choice for a population, a significant percentage of whom
8 are auto-assigned to plans and another increment are
9 cognitively impaired.

10 I wonder whether the complexity/choice balance is
11 being well struck here. I guess that's the basic question
12 that leaps out at me.

13 DR. KANE: Isn't competition also supposed to
14 lower costs? So besides choice, shouldn't that be another
15 one of the questions?

16 MR. BERTKO: I was going to add just what you
17 said, Nancy, in a different way. That's that one of the
18 things that drives down costs is the competition for the
19 auto-assigned members which, of course, cross much broader
20 than just the nursing home folks.

21 The flip side of that, also, though is that
22 nursing home folks, as Rachel mentioned, are very expensive.

1 The risk adjuster works pretty well. But the random
2 assignment of these to plans bidding for these things
3 actually helps smooth out the worries of how you bid and
4 then to make sure that you don't either get the wrong kinds
5 of incentives present.

6 MR. HACKBARTH: You can have competition of
7 different types. You can also have wholesale competition
8 through the long-term care pharmacies driving down drug
9 prices as well. Individual patient choice, especially by
10 cognitively impaired people, may not be the most efficient
11 way to get price competition in the drug marketplace.

12 DR. SCHMIDT: Also though, some of these people do
13 have legal guardians who can help in the decision making. I
14 don't think that the entire nursing home community
15 necessarily wants to play a part in narrowing down the
16 choice. I think there was a variety of responses among them
17 on that.

18 DR. MILSTEIN: In ancient times I used to be the
19 medical director of a skilled nursing facility. And I think
20 one of the points on the slide, I think, bears further
21 emphasis. It's this notion of impact on better clinical
22 management of people in these facilities. By and large, I

1 think it's a fair statement to say that most people in these
2 facilities do not have great access to sophisticated
3 thinking about how to optimize therapy as the course of
4 their care changes or even in relation to unsatisfactory
5 baselines that are unappreciated.

6 I think in weighing these two primary choices, I
7 think it's very important to realize that it's a huge
8 advantage both to the physicians who are writing these
9 orders in the nursing homes and to the beneficiaries in the
10 nursing homes, to have one clinical pharmacist who is on the
11 beat and closely tied in with the pharmacy.

12 Once you begin to dilute that you not only get
13 people from far away at a much greater disadvantage in
14 deciding what might work best in waiving or not waiving
15 based on prior authorization, but you also lose the access
16 to a concentrated important sophisticated asset to both the
17 doctors and the charge nurses in these facilities, which is
18 a dedicated pharmacist who is trying to make this work.

19 I think the question that John and Nancy raised is
20 an important for us to answer which is the question of can
21 we come up with some kind of estimate of the incremental
22 economic value of introducing all these additional spaghetti

1 lines in the equation. And then we can weigh that against
2 the likely significant loss of clinical resources that
3 occurs when you no longer have the concentrated force of a
4 single pharmacist whose job it is to help a facility succeed
5 in managing very, very difficult to treat patients.

6 DR. SCHMIDT: I just want to clarify that, as is
7 shown in this slide, there's still a single long-term-care
8 pharmacy involved in the situation. But yes, there's the
9 complexity introduced by all of the plans and all of the
10 prior auth, et cetera.

11 DR. MILLER: On this point, the thing that also
12 jumps out at me, and we want to return to the beneficiary
13 perspective immediately. But just to stay off it for a
14 second, that long-term care pharmacy's separate incentives
15 and separate relationship with the drug manufacturer, I mean
16 there may be a great clinical advantage there. But then
17 there's also this other kind of question in the middle of
18 the nursing home.

19 MS. HANSEN: This is also, in terms of long time
20 ago, I spent 25 years actually with this population and with
21 many in the nursing home. So I just want to concur on the
22 beneficiary side of what Arnie brought up. I think one of

1 the things that, relative to the newness of this and the
2 clinical relationship, is two things with the new system.
3 One is the loss of the consultancy possibilities at this
4 point if the rebates are going to be in question, because
5 the complexity of meds and those kinds of things are really
6 important to have that kind of consultancy.

7 The second point that I have some concern about is
8 perhaps some greater detail at some point of the impact to
9 the administrative complexity or kind of the operational
10 aspect of the drug delivery mechanisms. I think it goes
11 without saying it's tough enough already to get people to
12 want to work in long-term care facilities. Turnover rates
13 already are about 100 percent a year. This is something
14 that if you add greater burden, which is one of the
15 commentary I heard you make to this, the whole issue of
16 quality of care and this population -- I think a colleague
17 of mine has said there's nothing so unequal as equal
18 treatment of unequal people. The ability to have people,
19 two-thirds of whom are cognitively impaired, and even if
20 they have patient representatives it's not an easy area to
21 deal with.

22 So I just want to proceed cautiously on the

1 different matrices of judgment, whether it's cost and
2 competition in that aspect. I think at the end of it what
3 happens to the ability to get the safe drugs in a cost
4 competitive way with full transparency but with the kind of
5 consultancy that is involved when people take, on average,
6 whether it's six to 10, my experience is eight to 10
7 medications, on a daily basis.

8 So it is one of the things that I just want to
9 drive back to, looking at the complexity of operationalizing
10 this. And then also thinking about the importance of having
11 competency advice by clinical pharmacists with oftentimes
12 not just the medical director but the host of physicians
13 that oftentimes consult with a given nursing home.

14 DR. CROSSON: Assuming that one way out of this
15 which you implied a bit might be to provide, allow, nursing
16 homes to play some role, some agency role, some
17 responsibility, some coordinating role or the like, you
18 noted that that idea received mixed support from the nursing
19 homes.

20 So the question is among the ones who said gee, we
21 don't think we really want to do this, is that an issue of
22 administrative burden, concerns about liability, concerns

1 about accusations of conflict of interest?

2 And then the second part of that is could you
3 imagine that some of those things could be managed or an
4 environment created in which those concerns might be
5 minimized?

6 DR. STEVENSON: In terms of the concerns we heard
7 about from the providers who don't want to take on this
8 role, it was really the last two that you mentioned, the
9 concerns about liability. And also what they expressed is a
10 belief that it was in potential conflict of interest for
11 their facilities to advise residents.

12 Nursing homes often get, under Part D, information
13 from their long-term care pharmacies about which Part D plan
14 cover their residents' drugs better and worse than others.
15 So the nursing homes have a sense of that. But as I said,
16 from some nursing homes, they don't want to take on this
17 added role.

18 In terms of whether things can be put into place
19 to mitigate those concerns, I'm not quite so sure. I would
20 leave that to others to chime in.

21 I just want to add a couple of things based on the
22 previous discussion, as well. That is in terms of the role

1 of the consultant pharmacist, I think it's important also to
2 remember the consultant pharmacist typically works for the
3 long-term care pharmacy. Some of the stakeholders with whom
4 we spoke expressed some concern about this and talked about
5 the previous pre-Part D system didn't necessarily work as
6 well for beneficiaries as it could, especially citing
7 overutilization as one of the potential outcomes of that.
8 So I just wanted to raise that, as well.

9 MR. HACKBARTH: Could I just ask a follow-up
10 question on that? I understand the potential difficulty and
11 risk involved in a nursing home advising or choosing on
12 behalf of a patient a private plan. But aren't many of the
13 same issues involved in their selection of the long-term
14 care pharmacy under the old system? Conflicts of interest,
15 you're choosing them because you get a better rebate, as
16 opposed to for clinical reasons.

17 It seems like in the role there's an inherent
18 potential conflicts and risks and liability and it's just
19 one versus another type.

20 DR. SCANLON: I agree with you. And on top of
21 that we've got another chart we could draw for the Medicare
22 Part A patient where the nursing home is supplying the drug

1 as part of the payment and has this relationship with the
2 long-term care pharmacy that they've chosen.

3 DR. STEVENSON: The residents going into a nursing
4 home for a Part A stay obviously don't have a choice of PDP.
5 It's bundled into the nursing home rate.

6 MR. HACKBARTH: But they're making choices, which
7 has important implications for patients.

8 DR. HOLTZ-EAKIN: I basically want to echo that
9 and say that I come to this blessed with complete ignorance
10 of how this all works. If you look at that chart you can
11 tell a lot of stories.

12 I guess my question was is there, out there in the
13 future, the prospect of better systemic data that would tell
14 us something about cost savings of this versus the old
15 system and appropriateness of dosing and prescription?

16 I want to thank you for the evidence you've
17 brought. Is that really the best we're going to see?

18 DR. SCHMIDT: We're hopeful at some point in time
19 we're able to look at the prescription drug event data from
20 plans and identify people who are in a long-term care stay
21 and take a look at some measures of appropriateness from the
22 literature and try to get a sense on how actual use compares

1 with suggested use.

2 DR. REISCHAUER: But will we have any baseline
3 data to compare it to? When David was talking about
4 clinical impacts, I'm thinking what are we going to compare
5 this to?

6 DR. HUSKAMP: For the dual eligibles, you could
7 link the Medicaid data. For the non-duals, it's a problem.
8 You wouldn't be able to compare but for the duals you could
9 compare to the former system by linking the Medicare and
10 Medicaid data. And then you could also add in data from the
11 Minimum Data Set of quality of adverse drug events, other
12 outcomes, and things like that to look at as well. But none
13 of that data is available yet.

14 DR. MILSTEIN: Does anybody know whether in the
15 legislative deliberations associated with MMA consideration
16 was given to allowing the long-term care pharmacies to
17 select a Part D insurance company partner and be able to
18 essentially offer a limited Part D plan that would only
19 apply to patients in facilities in which they offered long-
20 term care pharmacy services?

21 DR. SCHMIDT: I don't know the exact answer to
22 that question. I think that a lot of these concerns about

1 this particular setting were brought up at the last minute
2 in the whole debate about the MMA. So I suspect not but I
3 do not know that for sure.

4 DR. KANE: It would be helpful, I think, in
5 talking about this to know what the policy options might be.
6 I'm kind of lost because it's not clear that we can go back
7 to the old system in any meaningful way. And we don't know
8 if the old system was particularly better, although it's
9 clearly administratively simpler, the old system.

10 But what do you see as the options? Because there
11 is no perfect out there and this looks pretty
12 administratively complex and has dubious impact on clinical
13 quality. But what are the options? It's hard for us, not
14 knowing the environment, to get a sense of the options.

15 DR. SCHMIDT: Again, we don't know the exact
16 clinical outcomes and we weren't, we felt, quite prepared to
17 come to you with recommendations or options. But just in
18 thinking these things through, it could range from the
19 status quo, living as things are with Part D, to kind of
20 delivering this in an entirely different way where you have
21 -- I think Joe has thought through some ideas for having
22 some regionally-based contracts to particular providers to

1 provide to individuals living in a long-term care setting.

2 Or something in between might be doing things like
3 beefing up quality reporting for this population while Part
4 D continues or looking to the medication therapy management
5 programs that Part D plans now have and seeing if there's
6 some way to accommodate this population a little more fully
7 in those.

8 MR. DURENBERGER: Nancy's mention of the policy
9 options brings me probably more to a comment or an
10 observation than anything else.

11 First, let me express my gratitude to the staff
12 for introducing this, and you, Mr. Chairman, for introducing
13 this issue. I've been here five years now trying to get
14 dual eligibles and things like that on this agenda, as you
15 know, and it's very hard to do. I think in the last couple
16 of days, this in particular puts it in perspective, I think
17 we've come to realize how important thinking about the
18 policy of Medicare, Medicaid, a lot of other things is.

19 Like many people here, I have been a proxy for
20 parents, in my case maybe 12 years. For some of you it may
21 have been a longer period of time. And the "policy issue"
22 that's difficult for me as I address the specifics, whether

1 it's the quality of care issues or service issues or this
2 issue, or IT, comparative effectiveness, take all of the
3 things we've been talking about. But bringing it to a
4 population that has to have a proxy of some kind, whether
5 it's by choice or it's by incapacity or disability, they
6 have to have a proxy.

7 The question that's raised in so many ways by the
8 research here is if you're a public policymaker and you're
9 going to decide, try to decide, what's best for the
10 beneficiary, where do you invest accountability for that?

11 It's easy to say family and things like that and
12 I'm illustrating the difficulty of a family member. But
13 Arnie's mention of his past experience leads me to observe
14 that the persons in the system that we value the least but
15 depend on the most are the medical directors, the
16 physician's assistant, the same people we rely on for our
17 aches and pains for our kids and ourselves and the rest of
18 the system. But we've never valued these people.

19 I don't know why you're no longer a medical
20 director in something else, but it's attribute to those who
21 will stay --

22 MR. HACKBARTH: I've got an idea.

1 MR. DURENBERGER: For those who will stay in this
2 field, given the fact that we have not, as a society, vested
3 that particular part of the profession with the kind of
4 accountability, responsibility and then rewards that we do
5 in every other part of the medical profession.

6 And so as we go through this I'm hoping that we
7 will also deal with that kind of proxy issue and try to
8 focus Congressional thinking on the importance of elevating
9 certain people -- particularly, I think, the professional
10 side -- of focusing them on how do you best do the
11 accountability not just for the dollars but for the
12 beneficiary?

13 MR. HACKBARTH: Other questions or comments?

14 Thank you. That was thought-provoking.

15 We'll now have a brief public comment period and
16 I'd ask you, as always, to identify yourself and please keep
17 your comments brief. Thank you.

18 MS. LLOYD: Good afternoon, Danielle Lloyd with
19 the American Hospital Association, getting back to the
20 discussion earlier today on the wage index.

21 First of all, I wanted to commend the staff on the
22 creation or development of a very complex wage index

1 proposal. We appreciate all their work on that.

2 The AHA has our own workgroup that we've convened
3 of state, regional and metropolitan association executives
4 that's also been looking at this issue. We did send you a
5 letter last week that detailed some of the questions really.
6 It was mostly questions that the group wanted to bring to
7 your attention about the proposal. But let me make a couple
8 of quick comments related to that.

9 Firstly, three of the big issues, or if we rank
10 the issues among this workgroup that are most important,
11 three of the top ones are the volatility issues, the
12 unrealistic labor market definitions, and then also the
13 cliffs when neighbors have very different wage indices.

14 The group is very intrigued by a couple of aspects
15 of the proposal in particular. The idea of a three-year
16 rolling average for the data, county by county variation
17 within the MSAs and then also for the rest of the state, and
18 then also this smoothing idea.

19 But one thing we thought would be helpful is if
20 the Commission could look into these three ideas on the
21 existing CMS data as opposed to on the BLS data for a couple
22 of reasons. First of all, as outlined in the letter, this

1 group and the AHA has some major concerns and reservations
2 about the BLS data. I won't go into those because I think
3 we gave 10 examples in the letter that you all, I'm sure,
4 don't want to hear.

5 The other thing is that, as was pointed out by the
6 staff, these three things could potentially be done by CMS
7 without changes to legislation, unlike the data source
8 because the use of BLS itself would need a change to
9 legislation. So these are things that might be able to move
10 forward without that change.

11 A couple of other things is we were very happy to
12 see that you guys are going to be looking into or running
13 more data on volatility. We're very interested to see that.
14 Hopefully you'll share that in April.

15 Also, as Mark Miller pointed out, the 10 percent
16 number on the smoothing, as an example, we don't know if
17 that's a magic number or that's the right number. There are
18 some areas of the proposal that it might be helpful if you
19 guys did some sort of analyses on that 10 percent, for
20 instance, also maybe on the 5 percent difference from the
21 mean on the county by county variation to see can you get a
22 sense of what might be the right number for these types of

1 proposals. That would be helpful.

2 The last thing I want to just say is we're very
3 appreciative that you all have put some more effort into the
4 benefits issue that Mitra brought up last year, since then,
5 and have worked on that adjustment. It would be helpful for
6 us to have a little bit more detail on exactly that was
7 developed and a little bit more specifics on that adjustment
8 because it was really sort of just set out there as a new
9 adjustment for benefits. So at least for the public
10 audience. So that will be helpful.

11 Thanks very much.

12 MR. BAKER: My name is Dale Baker and my company
13 is Baker Health Care consulting out of Indianapolis. I work
14 with hospitals on Medicare geographic reclassification
15 matters, and I work with hospitals and hospital associations
16 on wage index matters. I'm going to give you kind of a view
17 from the trenches on some of the issues that I think might
18 require just a little bit further refinement on some of the
19 premises that have been made.

20 First of all, how accurate is the data that
21 hospitals are turning in today? I would to you it's very
22 accurate. There's a 100 percent audit rate by the fiscal

1 intermediaries and the hospitals have a period of time when
2 they "scrub" the data. Let me tell you, they take it very
3 seriously.

4 Here's our book that we use with hospital
5 associations and we update every year in terms of showing
6 them what they need to do and all the regulations going back
7 to 1994 so that they can get their data right. The vast
8 majority of hospitals in the industry are doing what I would
9 consider to be a very good job of scrubbing the data, and
10 then it gets audited subsequently by the fiscal
11 intermediaries. At the time it's prepared, it can be pretty
12 crude.

13 That gets back to one of the premises that the OIG
14 came up with, and that is that there's a whole lot of errors
15 that are embedded in this data. I think the use of the OIG
16 reports have to be put into a little bit different context.
17 OIG had a structural problem. They started this in February
18 of 2005, their audits of the 14 hospitals. They found out
19 from CMS that they had two weeks to complete the audits to
20 give them the data if they were going to use the data in the
21 2006 cycle.

22 They immediately concluded they could not do that.

1 So instead of using the data that had been scrubbed and
2 audited, they studied the data from the raw cost reports.
3 And so they made their adjustments from the raw cost
4 reporting data that had not yet been scrubbed by the
5 hospitals in the normal process that CMS has put out.

6 At the time, with the Massachusetts Hospital
7 Association, I met with the lead OIG person in the Boston
8 office and we asked them if they would segregate their
9 findings between the adjustments that would be made in the
10 normal scrubbing process by the hospitals and the
11 intermediaries from their true audit findings. And at the
12 time they told us they would do that, but in the final
13 reports they did not.

14 So when you look at the results of that OIG audit,
15 there's nothing wrong with what OIG did. It's just the use
16 of that data, if you don't understand that you can get a
17 misleading result.

18 The other thing that OIG did is they challenged
19 CMS on the policy of how they record pension and post-
20 retirement benefits. They actually wrote CMS a letter
21 saying that these should be funded, not recognized under
22 generally accepted accounting principles. Some of the

1 biggest adjustments that they put in their report are
2 related to this change in interpretation, which the
3 hospitals had no clue of and were actually using in
4 accordance with generally accepted accounting principles.

5 So the OIG report, I think, is not a very good
6 indicator of the accuracy of the data. I would tell you
7 that when the scrubbing process is through, this data is
8 very good, very, very good.

9 Secondly, an issue is do the hospitals manipulate
10 the data? Some of the questions is well what about a single
11 hospital MSA? Are they manipulating data? I would tell
12 you, in my judgment, no. I get the phone calls from CEOs
13 all the time saying wait a minute, if I give my employees an
14 increase won't that give me a better wage index and won't
15 that allow me to be reclassified? And the answer is yes,
16 but there's a four-year lag between the time you change your
17 data and when it would be reflected in your wage index.

18 If you're talking about geographic classification,
19 you're using three year's data so it can take you up to
20 seven years before any kind of adjustment you might make in
21 your data is going to help you in a geographic
22 reclassification process. So I would tell you that

1 manipulation of data in today's system is really not an
2 issue, even in single hospital MSAs.

3 Another statistic that I'd like to just clarify is
4 only about -- it's 20.7 percent of the hospitals in the
5 country are geographically reclassified, 14.4 percent of the
6 urban hospitals and 40.1 percent of the rural hospitals.
7 The number that has been tossed around is one-third. The
8 different from that is the out-migration adjustment, which
9 was brought in I believe a couple of years ago in the
10 Medicare Prescription Drug Bill and it affects about 600
11 hospitals. It does exactly what you're talking about, it
12 smooths, it's a smoothing type of a process. I think those
13 two adjustments need to be considered separately.

14 Another item is wage related costs. According to
15 this year's data files, wage related costs vary from 5.11
16 percent of salaries to 47.77 percent of salaries. So there
17 are some very, very big variation in terms of wage related
18 costs, and I think that's something that's important for
19 your staff to consider.

20 Also, there was discussion about the impact of
21 geographic reclassification. I think it's around \$750
22 million a year now, is what the impact of that is. I do

1 have the number, I just don't have it with me today.

2 But the real shift in these monies coming out
3 actually occurred on October 1st, 1991 when geographic
4 reclassification was first implemented. The impact today is
5 merely the difference between the 2007 reclassifications and
6 the 2006 reclassifications, and I would tell you it's a
7 very, very small number.

8 Two other things. On the volatility issue, the
9 Connecticut Hospital Association just asked us to do a study
10 that said what if you limited the volatility of wage indexes
11 to 1.5 percentage points? What would it cost? Our number
12 that we came up with is about \$287 million. So that's
13 another approach to one of the issues that you guys are
14 taking a look at.

15 Lastly, in the Dakotas, if you include those
16 critical access hospitals in the database I think you'd get
17 better data to take care of the Dakotas.

18 Thank you very much and I salute you for what you
19 do for our country.

20 MR. TUTEN: That's a tough act to follow. On
21 behalf of the Long-Term Care Pharmacy Alliance I'm Todd
22 Tuten from Patton Boggs. I just wanted to address a point

1 that came up in a question to Commission staff about the
2 legislative history from our perspective.

3 Really, the outcome placing the duals drug
4 coverage under Part D, as we saw it, was driven by competing
5 philosophies and cost considerations. Initially, there was
6 a move and the Senate approved a proposal to keep the duals
7 under Medicaid. The issue then in the House became do these
8 individuals get the same benefit as all other beneficiaries?
9 And what would the cost of creating a special benefit for
10 them or keeping them in Medicaid be?

11 In the end, the decision was made to bring them
12 under Part D. But there was a proposal advanced to create
13 long-term care specific prescription drug plans. Our
14 understanding, from committee staff at the time, was that
15 that would raise cost concerns under the \$400 billion cap of
16 the bill, and also that there was philosophical objection in
17 some quarters, notably then-Chairman Thomas, about carving
18 out a separate benefit for these individuals.

19 Thank you.

20 MR. BAKER: If I may make one more comment, under
21 Bureau of Labor Statistics data --

22 MR. HACKBARTH: Tell us how good we are first,

1 before you proceed. Just one more time.

2 [Laughter.]

3 MR. BAKER: I got a phone call from a New Orleans
4 area hospital CFO a few days ago that was using \$1 million a
5 month worth of contract labor for his RNs because there's no
6 RNs left in the New Orleans area. I don't know where the
7 contract comes out of. It could be Atlanta or it could be
8 Houston. But BLS data may not pick that up in the location
9 where the services are actually rendered. And that could
10 create some significant variations.

11 Also, as I mentioned, hospitals are scrubbing
12 their data. Some of the issues for the BLS is what about
13 shift differential hours, weekend differential hours, charge
14 nurse premium hours, Baylor Plan hours, self-funded
15 disability hours, on-call time, all these types of things.
16 There are some real issues in the use of that BLS data.

17 And also last, but not least, what about home
18 offices?

19 Thank you.

20 MR. HACKBARTH: Okay. Thank you very much.

21 We're adjourned.

22 [Whereupon, at 11:43 a.m., the meeting was

1 adjourned.]