

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Wednesday, April 19, 2006  
10:15 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair  
ROBERT D. REISCHAUER, Ph.D., Vice Chair  
JOHN M. BERTKO  
SHEILA P. BURKE  
FRANCIS J. CROSSON, M.D.  
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DAVID F. DURENBERGER  
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ARNOLD MILSTEIN, M.D.  
RALPH W. MULLER  
ALAN R. NELSON, M.D.  
WILLIAM J. SCANLON, Ph.D.  
DAVID A. SMITH  
RAY E. STOWERS, D.O.  
NICHOLAS J. WOLTER, M.D.

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

2 MR. HACKBARTH: Good morning, everybody. Welcome  
3 to our guests.

4 This is our last meeting in this annual cycle  
5 leading up to a publication of our June report. There will  
6 be no formal recommendations in the June report, and hence  
7 no votes on recommendations at this meeting.

8 Today we begin with a presentation on Medicare  
9 Advantage and special needs plans. Scott?

10 DR. HARRISON: Good morning. In my part of the  
11 presentation today I want to respond to some commissioner  
12 requests from last meeting for more information on benefits  
13 offered by the different type of plans and benefits offered  
14 in different areas. Jennifer will follow with a summary of  
15 our work on special needs plans and begin a discussion about  
16 the future direction of the plans.

17 One request we were not able to respond to was to  
18 compare MA payments with Medicare fee-for-service spending.  
19 Unfortunately, CMS has not yet released the plan-level  
20 enrollment data that is crucial to this analysis. We hope  
21 to get the data soon and will present the analysis in a  
22 forthcoming meeting.

1           Remember last time I described general plan  
2   availability and the availability of MA-PDs. This time I  
3   will show the availability of plans with specific cost  
4   sharing characteristics that beneficiaries may find  
5   valuable.

6           To recap, virtually all beneficiaries have MA  
7   plans available to them up from the previous high of 84  
8   percent last year. Zero premium MA plans are available to  
9   86 percent of beneficiaries this year, an increase from 58  
10   percent. Almost three-quarters of beneficiaries will have  
11   access to zero premium plans that also include the Part D  
12   benefit, and 27 percent have zero premium plans available  
13   that include some coverage and meet Part D coverage gap.

14           As for the bidding that produced the availability,  
15   about 95 percent of bids were under the benchmark and thus  
16   almost all plans had funds to rebate to their members.  
17   However, the size of the rebates varied by plan type. Local  
18   HMOs tended to have much higher rebates than other plan  
19   types. They were followed by local PPOs, private fee-for-  
20   service plans, and regional PPOs had the lowest rebates.  
21   This means that, on average, the local HMOs submitted the  
22   lowest bids.

1           This time we examined two plan benefit  
2 characteristics that beneficiaries might find attractive.  
3 First we looked at total out-of-pocket caps for Medicare  
4 non-drug services. Such a benefit, which is not included in  
5 fee-for-service Medicare, limits beneficiary cost sharing  
6 liability for covered Medicare services provided in network.  
7 I want to make two notes about this type of benefit  
8 characteristic.

9           First, the MMA mandated that regional PPOs have  
10 such a cap. However, the law did not that specific dollar  
11 values for the required cap. We found that regional PPOs  
12 had limits ranging from \$1,000 to \$5,000 per year with  
13 \$5,000 being the most common value.

14           Secondly, I want to note that some plans charge  
15 low enough cost sharing that beneficiaries would rarely, if  
16 ever, reach an out-of-pocket cap and therefore they don't  
17 bother specifying one.

18           We looked at plans that had a \$2,000 or lower  
19 annual out-of-pocket cap. Sixty-five percent of Medicare  
20 beneficiaries have access to such a plan. We see that  
21 private fee-for-service plans with this limit are the most  
22 widely available followed by local HMOs. And while 88

1 percent of beneficiaries have access to a regional PPO with  
2 a cap, only 4 percent of beneficiaries have access to one  
3 with a cap this low.

4           For the second benefit characteristic we examined  
5 the expected cost sharing for an average inpatient hospital  
6 stay. An inpatient hospital stay is a relatively common and  
7 costly service in terms of cost sharing. In fee-for-service  
8 Medicare there was a \$952 deductible for a hospital stay in  
9 2006. Most plans impose a flat daily copayment and often  
10 have a limit on total cost sharing for a hospital stay.

11           Across all plans cost sharing liability for an  
12 average hospital stay varies from zero to over \$2,000. We  
13 focused on the availability of plans with cost sharing of  
14 \$500 or less for a stay because we view that level of cost  
15 sharing as a significant savings from fee-for-service  
16 Medicare.

17           In all, 87 percent of Medicare beneficiaries have  
18 access to a plan with expected cost sharing of \$500 or less  
19 for an average stay. Availability of these plans is greater  
20 for HMOs and other local plans. Only 13 percent of  
21 beneficiaries have access to a regional PPO with this level  
22 of cost sharing.

1           At the last meeting some commissioners asked about  
2 urban/rural differences in benefits. We find that some of  
3 the more attractive benefits are more widely available in  
4 urban than in rural areas. Zero premium plans are available  
5 to about 89 percent of beneficiaries living in urban areas  
6 and about 65 percent of rural beneficiaries. Availability  
7 is also wider in urban areas for zero premium plans that  
8 include Part D benefits and for those include some coverage  
9 in the coverage cap. Plans with out-of-pocket caps of  
10 \$2,000 or less are available to 65 percent of urban  
11 beneficiaries and 55 percent of rural beneficiaries.

12           And finally, 92 percent of urban beneficiaries  
13 have access to a plan that has a \$500 or lower expected  
14 hospital stay cost while only 70 percent of rural  
15 beneficiaries have access to such a plan.

16           One of the factors in the differences between  
17 urban and rural areas is that benefits tend to vary by plan  
18 type, and while the overall availability of plans is similar  
19 in urban and rural areas, the types of plans available tend  
20 to differ. Urban beneficiaries are much more likely to have  
21 local HMOs and local PPOs available than beneficiaries who  
22 live in rural areas. Meanwhile, private fee-for-service



1 plans are more likely to be available in rural areas.

2 We know that the plans in rural areas are more  
3 likely to be the regional PPOs and private fee-for-service  
4 plans that do not generally have tight networks of providers  
5 and tend a bit higher than local managed care plans. Over  
6 90 percent of beneficiaries have local HMOs or PPOs  
7 available compared with about 40 percent of rural  
8 beneficiaries.

9 We see, therefore, that the plans in urban areas,  
10 through the greater ability to build networks and managed  
11 care, tend to be able to bid lower relative to their  
12 benchmarks than plans in rural areas even though benchmarks  
13 in rural areas tend to be higher relative to local fee-for-  
14 service costs. As a result, the rebates tend to be larger  
15 in urban areas, thus allowing the managed care plans there  
16 to offer some more attractive benefits.

17 MS. PODULKA: You recall from past meetings that  
18 SNPs are a new type of Medicare Advantage plan created by  
19 the 2003 MMA. They're targeted to beneficiaries who are  
20 either dually eligible for Medicare and Medicaid, residing  
21 in an institution, or chronically ill or disabled. SNPs  
22 offer the opportunity to improve the coordination of care

1 for these special needs beneficiaries. Dual eligible SNPs,  
2 or any SNP that also covers Medicaid services also offer the  
3 opportunity to improve the coordination of the two programs.

4 SNPs function essentially like any other MA plan.  
5 In addition, they must provide the Part D drug benefit and  
6 additional services tailored to their targeted population.  
7 In exchange they are allowed to limit their enrollment to  
8 their targeted population.

9 SNPs are paid on the same basis as regular MA  
10 plans, including the same risk adjustment. This accounts  
11 for differences in expected beneficiary costs and therefore  
12 risk adjustment generally results in higher payments for  
13 special needs beneficiaries than for the general Medicare  
14 population.

15 The number of SNPs have increased quickly since  
16 they were created. This year the total number of SNPs more  
17 than doubled from last year with the introduction of 150 new  
18 plans. Organizations entering the SNP market include those  
19 with experience with Medicaid and special needs populations,  
20 such as Evercare, but also include MA organizations that  
21 have chosen to add SNPs to the menu of plans available to  
22 their members. Most SNPs, about 80 percent, are<sup>4</sup> for dual

1 eligibles.

2           To describe how SNPs that have entered the market  
3 are taking advantage of the opportunity to better coordinate  
4 care for their members we chose to conduct site visits in  
5 four locations: Baltimore, Boston, Phoenix and Fort  
6 Lauderdale. As a whole, these areas show us SNPs in markets  
7 where there are many SNPs, existing plans converted into  
8 SNPs, dual eligibles passively enrolled into the plans,  
9 organizations offer multiple dual eligible plans, and all  
10 three types of SNPs exist: dual eligible, institutional, and  
11 chronic care.

12           Based on the information we've gathered so far  
13 we've identified a key concern about SNPs' ability to better  
14 coordinate care. SNPs, even dual eligible SNPs, are not  
15 required to contract with states, and in fact CMS does not  
16 consider or track which ones do. We found that few dual  
17 eligible SNPs receive payment from states to include  
18 Medicaid benefits in their package.

19           Because states financial responsibility for dual  
20 eligibles has been reduced over time, they may now have  
21 little incentive to partner with SNPs. This is in large  
22 part because prescription drugs are now covered under Part D

1 Medicare. This leaves Medicaid responsible for services  
2 like transportation, dental, vision as well as wraparound  
3 services and long-term care.

4 In addition, about one third of states have set  
5 their Medicaid rates at or below 80 percent of Medicare  
6 rates, which limits their cost sharing liability.

7 This leaves us with some questions going forward.  
8 Because most SNPs began operating just this year it's too  
9 early to determine whether SNPs result in improved quality  
10 and significant program savings. There is cause for concern  
11 about their ability to fulfill the opportunity to better  
12 coordinate care, especially to better coordinate Medicare  
13 and Medicaid.

14 We plan to continue to seek answers to, and would  
15 appreciate your comments on the listed questions. As SNPs  
16 are a new benefit package type we plan to continue to assist  
17 CMS and the Congress in defining what delineates these plans  
18 from other MA plans. To do so we will further evaluate  
19 plans that enter the market and describe their special  
20 characteristics. Institutional and chronic condition SNPs  
21 have a clearer target population and mission. The goal for  
22 dual eligible SNPs has been made less clear now that

1 coverage for prescription drugs has been moved from Medicaid  
2 to Medicare.

3 Finally, because of the rapid growth of new SNPs  
4 we plan to look at how the CMS HCC risk adjuster applies to  
5 special needs beneficiaries.

6 This concludes our presentation. We look forward  
7 to questions and any comments on future research.

8 MS. BURKE: This was very helpful. I very much  
9 appreciate it, and I particularly appreciate the following  
10 up on our series of questions, Scott, on how these plans  
11 differ and how they work. I have two questions that I'm  
12 interested in understanding.

13 One has to do with Scott's presentation. Scott, I  
14 appreciate that we can't yet do the cost analysis given that  
15 we don't have all the data but I continue to be interested,  
16 to the extent that we continue to see bids that are way  
17 below the benchmark, and it will be interesting to see how  
18 they vary against the benchmark, what that says about the  
19 benchmark, and getting some further understanding of how  
20 we're pricing. That will be something that, obviously, when  
21 you get the data I will be interested in continuing to  
22 understand.

1           And obviously it will vary urban and rural, but a  
2 further understanding of that because obviously the extent  
3 to which you don't have a rebate, you have less opportunity  
4 to provide benefits to populations, and that differentiation  
5 between urban and rural populations. I feel like I have to  
6 replace Mary as the ruralette, so just think like Mary does  
7 and come back prepared with those answers in her behalf.

8           The second question is this issue of the SNPs and  
9 the question of what it is we're trying to achieve with  
10 respected to duals. It would seem to me, although I'd be  
11 interested in my colleagues' view as well, it would seem to  
12 me that the goal here is not dissimilar from that that  
13 relates more broadly, and that is how you integrate services  
14 and integrate care for a population that are in fact quite  
15 at risk. So I am surprised to find in fact that so few  
16 states have chosen to utilize this opportunity and I'm  
17 interested in understanding what it is that they do with  
18 respect to this population. What are we seeing in terms of  
19 states and the coverage of the Medicaid services for these  
20 folks?

21           I understand now with Part D it's a slightly  
22 different mix, but nonetheless, Medicaid has traditionally

1 provided services Medicare does not provide for a vulnerable  
2 population. And if our goal ultimately is to have these  
3 people coordinated and treated in a way that essentially  
4 consolidates and organizes their services, the fact that the  
5 states are going in a different direction with that piece of  
6 it seems to me counterintuitive.

7           So as least philosophically my goal would in fact  
8 be to see more coordination. So I'm interested in  
9 understanding what the states are doing, why they're not  
10 going in this direction, and in fact what's happening with  
11 the management of those patients in those states where in  
12 fact it's not coordinated.

13           DR. MILLER: Was it clear from the presentation  
14 that some of the motivation for the states desire to  
15 coordinate here is changed because of the drug benefit?

16           MS. BURKE: Is it all -- because there are a whole  
17 host of other services that still -- what do we know about  
18 what's happening to these people?

19           MS. PODULKA: We don't have a complete picture of  
20 what each of the 50 states are doing yet. Because state  
21 benefit packages for dual eligible members differ, and  
22 because many of the key extra services have either been, as

1 in the case of Part D, shifted to Medicare, or perhaps  
2 reduced over time because of state budget pressures, we feel  
3 that there are many situations where states lack the  
4 incentive to partner with a SNP because they have so little  
5 liability right now for their duals, if that helps answer  
6 the question.

7 MS. BURKE: It doesn't. Well, it does and it  
8 doesn't. I shouldn't say that. I think we're presupposing  
9 that the states have little risk because they've essentially  
10 knocked out all those benefits, therefore, the individual is  
11 not any less well off under this scenario. But it would  
12 seem to me there is this broader question about how one  
13 coordinates services and there must be some aspect of the  
14 fundamental Medicaid benefits that remain that somehow are  
15 disconnected from our goal here to coordinate services.

16 So I think getting a better understanding of what  
17 is in fact happening in those states, how in fact they're  
18 providing whatever remains of the Medicaid piece, and how  
19 these patients are essentially experiencing the system will  
20 be very helpful, if we can get more information on that.  
21 And I think Nancy and Bill would like to comment.

22 DR. KANE: I was going to respond to that. The



1 Medicare senior care option plan in Massachusetts, which is  
2 a dual eligible with Medicaid involved, took approximately  
3 eight years to negotiate. So I'm just wondering if this  
4 isn't just the first step. You haven't really asked them  
5 about intention perhaps, but it takes a long time to get  
6 that Medicaid part built into it. So I'm just wondering if  
7 it isn't just a matter of time in that these are new and  
8 it's a new idea and Medicare is available but Medicaid may  
9 have to work its way in. So maybe we should ask the states  
10 or the plane whether they're trying to get Medicaid in.

11 MS. BURKE: It would be interesting to understand  
12 in that context, are the states with respect to Medicaid,  
13 going through managed care plans for other pieces? Are we  
14 essentially looking at two different contractual  
15 relationships and how ultimately -- because there was  
16 clearly a movement by the states towards the use of managed  
17 care for that population. So the question is, . are they  
18 doing that but doing it with different contracts? Is it  
19 their goal, as Nancy suggests, to ultimately coordinate  
20 because it is relatively new?

21 But it was clear that there was a movement on the  
22 part of states in this direction, that they had seen real

1 value in that kind of management of chronically ill and  
2 other Medicaid populations. And again, this is a  
3 particularly vulnerable population so some better  
4 understanding of that, because the goal really ought to be  
5 not to have these people not coordinated. That's the whole  
6 point of this. We've been fighting that for years.

7 MS. PODULKA: In the four locations we went to we  
8 did ask both plans and state officials about coordination.  
9 As Nancy mentioned, there are states where there's a long  
10 history of relationships between Medicaid and Medicare.  
11 That's working very well. There are other states where  
12 there's practically no history and they almost don't even  
13 know each other.

14 Many of the plans said that they were pursuing a  
15 partnership with the state but that there were obstacles so  
16 far that they had not overcome. However, I do have to say  
17 that there were a number of plans -- and I can't quantify  
18 this because obviously these are site visits and not like a  
19 survey. There were plans that for now were not planning on  
20 pursuing partnerships with states.

21 MS. BURKE: Do we know what the barriers -- do we  
22 have a sense of the nature of the barriers? Is it price?

1 Is it capacity? Is it networks? Do we know?

2 MS. HANSEN: Sheila, if I could add something to  
3 this. The PACE programs have actually been doing this for  
4 the past 15 years. I think the Massachusetts' experience of  
5 doing eight years of this, we're finding that it's like a  
6 zipper. In other words, what has happened is you have two  
7 sides of the -- the Medicare side and the Medicaid side and  
8 that goes all the way through from CMS Baltimore to the  
9 regional offices and so forth, and they are not accustomed  
10 to working together. So actually when PACE started to come  
11 was the first time the two parties came together.

12 MS. BURKE: [Off microphone] That's the whole  
13 point. That was when all principles behind PACE was his  
14 desire to --

15 MS. HANSEN: But the practical side has been this  
16 eight year gnashing of teeth before the zipper comes  
17 together. It also is this -- I think there is some text in  
18 this chapter about how complicated it is to talk about  
19 grievance and each system. So what's happened is if it's a  
20 small project many of the states historically, even before  
21 the passing of the Part D side, thought it was just not  
22 worth their effort. So it seems to be much more, certainly

1 from a pragmatic standpoint, stuck at the operational level,  
2 that the magnitude of change for the results that you get  
3 until there's enough momentum.

4 DR. SCANLON: Bringing up PACE I think is  
5 important because I have encountered a lot of confusion  
6 about special needs plans and I think in a lot of people's  
7 minds they are identified with PACE. I think they are going  
8 to be, very often, far from PACE. They're going to be much  
9 more like a regular MA plan and I think that's very  
10 important for us to make sure that people know.

11 In terms of the states, besides Massachusetts,  
12 besides Wisconsin and Minnesota -- AARP has done a recent  
13 report on states interested in moving towards Medicaid  
14 managed care including long-term care. So there's  
15 definitely interest in doing it but they're probably the  
16 exceptions rather than the rule.

17 In terms of what we're losing, I guess there's a  
18 question of -- there's gains from coordination but it's  
19 maybe along a spectrum. As you move from fee-for-service  
20 there's a clear gain if there's some organization that's  
21 going to be responsible for management. If you're in a MA  
22 plan, we would hope that that organization's coordination

1 would do a lot in terms of those gains.

2 Now if you're only paying for dental, it's less  
3 clear what the advantage of integration there is. Now if we  
4 start integrate acute and long-term care, then the  
5 coordination gains are potentially much different. How many  
6 special needs plans are going to be interested in taking on  
7 long-term care is a big issue? Even if states get active in  
8 this, are they going to find the participants on the plan  
9 side that are going to be willing and able to do long-term  
10 care? Because as Jenny can tell us about PACE, it's not  
11 just an issue of dealing with the two parts of CMS, it's and  
12 issue of pulling that off on the ground in terms of  
13 delivering that full range of services.

14 DR. REISCHAUER: A couple questions. One, do we  
15 have any idea what fraction of these new plans that have  
16 proliferated are sponsored by for-profit as opposed to non-  
17 profit organizations?

18 MS. PODULKA: I haven't split it that way but I  
19 can and get back to you.

20 DR. REISCHAUER: Because that might tell us  
21 something about what this marketplace looks like. I'm  
22 wondering whether there's lots of empty boxes, lots of plans

1 but no real enrollment in a lot of these.

2           And do we know whether the reluctance to combine  
3 the Medicaid with the Medicare is more from the plan's  
4 perspective or the state's perspective? Because I was  
5 thinking if I were setting up one of these things and this  
6 is the first year and I'm suddenly going to have a whole  
7 bunch of dual eligibles just to provide Medicare for, and  
8 I'm bearing some risk, this is a highly uncertain world.  
9 And then to throw in a whole other set of uncertainty, I  
10 think you'd have to be a very bold person to try to swallow  
11 that all at once, as opposed to say, a few years down the  
12 line I'll begin thinking about this.

13           You're talking about coordinating two different  
14 price systems and sets of expectations. Presumably these  
15 would be capitated Medicaid payments for a set of services  
16 that is smaller than the old set because drugs have been  
17 taken out and maybe long-term care is taken out, and the  
18 states wouldn't know what to do, and you running an  
19 organization wouldn't have the faintest idea what to do.

20           So I'm not surprised at all that when we look out,  
21 whatever it is, four months into the game that there's not a  
22 lot of these coordinated players.

1 MS. BURKE: Bob, to that point, I think it would  
2 be interesting -- I think you've done a very good job in the  
3 chapter of laying out what those challenges are. But would  
4 be interesting, because there are in fact a number of states  
5 who have chosen to contract through managed care plans for  
6 their Medicaid population.

7 DR. REISCHAUER: Mostly the kids and adults, not  
8 the elderly.

9 MS. BURKE: Right, but it would be interesting to  
10 see -- but they bring to the table some experience in  
11 working with the state. So it would be interesting to know  
12 whether or not where we have begun to see some willingness  
13 or some options, whether they in fact are the plans that  
14 have developed essentially some knowledge of it. As Jenny  
15 suggests, the negotiations over PACE were tortuous. And in  
16 fact, they're completely disconnected at the state level.  
17 As we always knew, the Medicaid guys never talked to the  
18 Medicare folks.

19 But there are now, recently, cases where Medicaid  
20 plans have in some of the more progressive states chosen to  
21 go in this direction. It would be interested to see whether  
22 those are the places that are picking it up because they

1 have some history, notwithstanding the fact that it's  
2 largely around moms and kids, and not the chronic elderly.  
3 But it would be interesting to see whether that experience  
4 lends itself to more likelihood of these people moving  
5 forward in these collaborations.

6           Because the concept of people, again, continuing  
7 to go forward and being managed by two entirely different  
8 systems is counter to everything we've tried to do. So the  
9 extent to which there's some progress or breaking down those  
10 barriers it would be interesting to see if that's where in  
11 fact we've seen that movement.

12           DR. KANE: I was just going to say, the dual  
13 eligible elderly population is mostly institutional. They  
14 are long-term care people. So it doesn't make sense to  
15 leave it out. In fact it's quite negative to think that's  
16 someone's managing the hospitalization benefit and is not  
17 managing the long-term care and frail elderly and the  
18 community-based, because you can really manage your  
19 inpatient very well just by dumping it all into Medicaid.  
20 So it doesn't make sense because most of those dual eligible  
21 elders are already in the long-term care system and that's  
22 where they need the coordination.



1 DR. WOLTER: Hopefully I'll be able to articulate  
2 what I'm interested in. I'm really interested in this link  
3 between the underlying fee-for-service payment and how the  
4 Medicare Advantage program and benefits and rebates unfold.  
5 When we see in here that the local HMOs in the urban areas  
6 have more rebate and tend to have richer benefits will we  
7 ultimately be able to be more explicit about the potential  
8 linkage of that too high underlying fee-for-service payments  
9 that allow bids that can come under that in a way that  
10 allows the 75 percent to come back and then enhance  
11 benefits?

12 Related to that interest I guess there is at least  
13 some concern that over time we may see rather significant  
14 inequities in terms of what beneficiaries have available to  
15 them over time based on that underlying fee-for-service  
16 payment and how it can drive the potential for plans to  
17 provide those additional benefits.

18 So I hope we'll be able to follow that to some  
19 degree over the next year or two and understand it.

20 We say in the chapter that it's more costly in the  
21 private fee-for-service plans, for example. I assume we  
22 mean it's more costly compared to the local county fee-for-

1 service payment. It may still be significantly less costly  
2 than what it costs to provide beneficiary care in other  
3 parts of the country. We may want to be more careful about  
4 the information in terms of how we portray that.

5           Then as we look at this linkage between fee-for-  
6 service payment and these plans I hope when we have the  
7 information we'll not look just at the local comparisons,  
8 but will there be some way to globally look at what is being  
9 spent in Medicare Advantage compared to global fee-for-  
10 service, so that we look at this blend in no way of the  
11 individual counties.

12           In other words, if there's enough bidding under  
13 high fee-for-service payment rates, does that offset to some  
14 degree those areas where there are floors that are above  
15 local fee-for-service rates? So that it will help us think  
16 through these issues about, do we want to peg ultimately the  
17 local county fee-for-service rate versus some more global  
18 way of trying not to be over fee-for-service rates? I hope  
19 I explained that well.

20           Then the other set of comments I wanted to make  
21 had to do with the provider community. I'm sensing there's  
22 a lot of confusion out there from providers about all this.

1 Of course it's still pretty new. It would be useful in the  
2 next year or two as this unfolds, to have more of a sense of  
3 how physicians and hospitals are responding to these array  
4 of products, and do they understand what's going on. I hear  
5 concerns that somehow they're going to be paid very  
6 differently than maybe is in fact the case.

7 In the critical access hospital community there's  
8 a lot of concern about how payment will work relative to the  
9 cost plus 1 percent that they receive under fee-for-service.  
10 So that would be, I think, something important to track.

11 Then the other thing that I've recently heard that  
12 was interesting at a meeting I was at that had a lot of  
13 physician groups, I've not heard so much talk about limiting  
14 access to fee-for-service Medicare recipients as I've  
15 recently heard. That's anecdotal. We haven't picked it up  
16 in any of the data that we've looked at from year to year on  
17 access. But there seems to be more discussion in physician  
18 groups about that.

19 On a other side of the coin, there are a few  
20 physician groups who feel that they would like to throw  
21 themselves into Medicare Advantage with the thought that  
22 somehow they feel they will be reimbursed more adequately

1 there. So that will be another interesting thing to try to  
2 follow if we can.

3 MR. HACKBARTH: On the very first point, Nick, I  
4 think there are two factors at work. One is, of course, the  
5 level of payment -- two factors affecting where the bids  
6 come relative to the benchmark and thus how many additional  
7 benefits are available to beneficiaries. One is the level  
8 of the benchmarks. The second is the type of plan.

9 One of the issues in the rural areas that is  
10 pointed out by the presentation is they have fewer local  
11 HMOs that are tightly managed and more of their Medicare  
12 Advantage opportunities are coming in looser network  
13 arrangements or private fee-for-service. So it's a function  
14 of both delivery system design and capability as well as  
15 payment rates.

16 DR. REISCHAUER: Just an elaboration on that  
17 point. I think if we look at this and say what our  
18 objective or goal in the long run is to make sure or assure  
19 that Medicare Advantage offerings in different regions of  
20 the country can offer a similar set of extra benefits we're  
21 going to head down a very complicated and probably a wrong  
22 path because this depends, to a certain extent, on what

1 Medicare is paying, the benchmarks. But it also has to do  
2 with the efficiency, economies of scale, which there's  
3 nothing you can do or should do really to compensate for  
4 market forces, how much competition there is, meaning what  
5 kind of discounts one gets, the restrictiveness of networks,  
6 and underlying costs and wages.

7           The unfortunate reality is, in certain respects --  
8 or fortunate reality for some -- is rural and urban areas  
9 are different. The people in urban areas suck in pollution  
10 that the people in rural areas don't do, but rural areas  
11 don't have the same access to lots of services. It's hard  
12 to think of the Medicare program as trying to make  
13 adjustments for all of that.

14           DR. WOLTER: I don't necessarily have a point of  
15 view on what we should be trying to accomplish. I guess I  
16 just would like understand what does happen over the next  
17 couple of years with this because, very clearly, the fee-  
18 for-service variability in payment, is quite significant, is  
19 a factor in how this is all going to unfold. If that does  
20 lead to significant differences in benefits available to  
21 beneficiaries, it would be like to know that. And where  
22 that would lead us in terms of future policy I'm sure we'll

1 have different points of view.

2 DR. CROSSON: Just on that note and then I had  
3 another point, I would the second what Bob said. I think  
4 the last thing we would want to do would be to look at the  
5 situations in which the greatest deficiency leads to the  
6 greatest benefit and added benefits to beneficiaries and say  
7 on some level that's something that we have to correct for  
8 our or stomp out, because that was the whole purpose of  
9 prepaid Medicare in the first place.

10 I just had one point on the bidding process in the  
11 text that we had and that was on page 15 in the middle of  
12 the page where we go back and talk about the recommendations  
13 in the 2005 June report. It says the Commission recommended  
14 several changes to the benchmarks that would have resulted  
15 in lowering the benchmarks to a level equal to Medicare's  
16 local fee-for-service costs in each payment area, and I  
17 believe the recommendation was overall.

18 DR. HARRISON: We'll fix that.

19 DR. CROSSON: That's it. Thanks.

20 MR. HACKBARTH: Thank you very much. Next is a  
21 presentation on Part D formularies.

22 MS. BOCCUTI: First I'd like introduce Jack

1 Hoadley, to my left, from Georgetown University. He worked  
2 with colleagues from the National Opinion Research Center in  
3 Chicago, Elizabeth Hargrave, Katie Merrell, and Grace Yang,  
4 on an analysis of all the formularies that Part D had in  
5 place at the start of the new Medicare drug benefit. They  
6 took on a very large task and did a terrific job and he'll  
7 be reviewing his findings in just a few minutes.

8 I'll first mention a few of the objectives that we  
9 laid out for Jack and his team and then review some of the  
10 design rules that formularies had to follow at the start of  
11 the benefit.

12 So for the research objectives we asked NORC  
13 Georgetown to examine all the formularies and determine if  
14 and how formularies differ by plan type. So for example, do  
15 enhanced plans list more drugs than basic plans, do MA-PD  
16 formularies differ from PDP formularies?

17 In addition to answering these questions we also  
18 wanted this analysis to provide a baseline for our future  
19 work on the new Medicare drug benefit. As the benefit  
20 evolves we want to be able to track how plan formularies may  
21 affect access to drugs, Medicare and beneficiary spending  
22 and plan quality. So with enrollment data in the future we

1 can evaluate beneficiary choice regarding formularies and  
2 other plan characteristics. Then with claims data we can  
3 begin to look at how formularies influence access and  
4 spending. Then with all this data it will help us in  
5 developing plan performance measures.

6           One note that I'd like to make about formularies  
7 is that our data at this point can only examine the actual  
8 formularies; that is the drug lists themselves. It's  
9 important to remember that formularies give us some insight  
10 on access to these medications but they do not paint the  
11 whole picture in terms of definitive coverage. That is, a  
12 drug that is not listed on a formulary may indeed be covered  
13 through a plan's non-formulary exceptions process, which for  
14 some plans may be very informal and relatively easy while  
15 for other plans it may be more difficult.

16           Alternatively, drugs listed on a formulary may not  
17 necessarily be covered. For example, drugs that require  
18 prior authorization would not be covered without the plan's  
19 approval in most cases.

20           The next two slides list rules for formularies  
21 that are included either in statute or in CMS regulations or  
22 guidance to plans. I'll try to run through these quickly.



1           Regarding the therapeutic categories and classes  
2 that make up the framework for plan formularies, all  
3 formularies must be reviewed by CMS. So plans may design  
4 their own classification system or use a model developed by  
5 the U.S. Pharmacopeia or USP. USP reported that about  
6 three-quarters of Part D formularies use the USP model  
7 system for the initial formularies.

8           Plans must list at least two drugs, if available,  
9 per therapeutic class or category, and list at least one  
10 drug per key drug type. So just to give a quick example, a  
11 therapeutic category could be cardiovascular drugs;  
12 pharmacological class, cholesterol-lowering drugs. Then one  
13 more step down is the key drug type. An example would be a  
14 statin.

15           Plans must list all or substantially all drugs in  
16 six specified categories, namely anti-depressants, anti-  
17 psychotics, anti-convulsants, anti-cancer,  
18 immunosuppressants, and HIV/AIDS drugs.

19           Plans were told that they should only list drugs  
20 on a non-preferred tier when therapeutically similar drugs  
21 are available on a lower tier.

22           Plans may have a specialty tier designed for high-

1 cost drugs; for example, biotech products.

2           The important issue to know about specialty tiers  
3 is that plans do not have to grant any cost sharing appeals  
4 for drugs on that tier, which for the most part are at about  
5 25 percent coinsurance. So the drug listed on a specialty  
6 tier is covered but a beneficiary cannot appeal for the drug  
7 to be covered at a preferred cost sharing level, which they  
8 can do for non-preferred tiers.

9           For 2006, CMS did not explicitly define what drugs  
10 could or could not be placed on a specialty tier. But for  
11 2007 CMS is exploring a price threshold for this tier of  
12 over \$500, so drugs under that amount could not be placed on  
13 the specialty tier.

14           An overriding general rule for formulary design is  
15 that plans may not discourage enrollment for certain  
16 beneficiaries. That goes for their classification system as  
17 well as the drugs they list on their formularies. Plans may  
18 use utilization management tools, such as prior  
19 authorization, and plans must have an exceptions and appeals  
20 process for obtaining non-formulary drugs and more preferred  
21 cost sharing as I just mentioned.

22           Finally, plans had to develop transition policies

1 for beneficiaries who were stabilized on a therapy before  
2 enrolling in a drug plan. Plans have to allow beneficiaries  
3 time to switch over to formulary drugs and CMS guidance  
4 extended this time to 90 days.

5 The last item that I want to mention before I turn  
6 it over to Jack is that it's trickier than you might think  
7 to determine how to define separate drug products. USP and  
8 CMS did not define differences between drugs so some  
9 questions arise when reviewing whether formularies actually  
10 meet all the criteria that I just listed.

11 So now Jack is going to tackle that issue and  
12 review the results.

13 DR. HOADLEY: Thank you. I'm pleased to have the  
14 chance to present the results of these findings to you.

15 As Cristina said, one of the challenges  
16 methodologically is this question of what is a drug. It  
17 seems like that should be a straightforward question but it  
18 really isn't.

19 What definition of drugs should we use? We could  
20 think about the NDC code level. But the NDC code, as you  
21 may know, represents every single separate form, strength,  
22 package size, manufacturer of a drug gets assigned a

1 separate NDC code. So working at that level of detail is  
2 not really the way you want to go.

3 In addition, plans were not even required to file  
4 every single NDC code they covered in the files they  
5 submitted to CMS. So our basic database would not be  
6 complete at the NDC code level.

7 Then you can go to the chemical entity level.  
8 What is the drug that we think of as the drug? Even that is  
9 in an ambiguous concept because there's an extended release  
10 version of fluoxetine, the weekly dosage of fluoxetine,  
11 Prozac, a different chemical entity than the regular single  
12 dose. We can also think of the difference between the brand  
13 and the generic version of the drugs, which is important.  
14 For some purposes you only care which chemical entity you're  
15 working with. Other cases you may care whether a brand  
16 version or a generic version is covered.

17 The point is we need to have a consistent metric  
18 that we use for the analysis to make our analysis consistent  
19 across the plans, and that's what we've tried to do, and  
20 I'll show you in a moment. But what we've come up with may  
21 not be exactly the same metric that any other study might  
22 do, so there are going to be different answers by different

1 analysts coming up with different methodological  
2 definitions. We think that this is one of the first studies  
3 to really extensively use the full CMS file, public use file  
4 of all the formularies and so we've tried to do a  
5 comprehensive analysis in that regard.

6           The next slide shows you a little bit of the  
7 complexity of what we tried to do. The box on the left  
8 illustrates, obviously in a very simplified way, a set of  
9 NDC codes that might be listed. As you can see there are  
10 different dosages, there are extended release versions,  
11 there's different manufacturers perhaps represented on this  
12 list.

13           So what we do in trying to collapse these is take  
14 the NDC codes that represent a particular chemical entity  
15 and collapse those together and indicate that a drug is  
16 covered if any one of the NDC codes in that group that  
17 groups together as drug A or drug B or drug C or drug D is  
18 covered. But the box on the upper left works at that  
19 chemical entity level. We're not so concerned at that point  
20 whether there's generic or brand versions. Some drugs have  
21 generics, some have brands, some have both, . but we've got a  
22 total of four chemical entities in this analysis. That

1 might be the right analysis when we're looking at things  
2 like whether CMS guidelines are met, where we don't really  
3 care whether Prozac is covered or the generic fluoxetine is  
4 covered.

5           The boxes on the lower right corner of the diagram  
6 indicate what happens if you start to look at the separate  
7 products that a consumer might think of where you care about  
8 the generic and brand differences. So there's generic drug  
9 A and brand drug A. There's brand drug B, doesn't have a  
10 generic version. Brand drug C doesn't have a generic  
11 version, and D is available only as a generic.

12           So that gives you an idea. So that's perhaps that  
13 way you might look at this when you're looking from a  
14 beneficiary access point of view or when you want to think  
15 about the cost sharing differences that would exist between  
16 brand and generic drugs.

17           The other methodological issue we needed to think  
18 about was the tier structures, and could we come up with any  
19 way to standardize some of the tiering. As you may know,  
20 the MMA gives the plans flexibility to create cost sharing  
21 tiers within the bounds of actuarial equivalence, although  
22 of course the standard benefit simply provided 25 percent

1 coinsurance across the board for all drugs. Many plans, as  
2 you'll see in a moment, chose to use cost sharing tiers, and  
3 our analytical goal here was to try to standardize the tier  
4 designs as much as possible. So our  
5 principle was that where plans label a larger number of  
6 tiers but in fact applied the same cost sharing and other  
7 rules to those tiers, we combined those into a single tier.

8           On the next page you'll see how that works. This  
9 is a hypothetical plan that has, for example, two generic  
10 tiers, a preferred and a non-preferred, that they list out  
11 in their formulary. But in fact both of those tiers are  
12 charged at the five-dollar level. So effectively for the  
13 consumer there's no difference between those tiers. Those  
14 may have been distinguished for administrative reasons, they  
15 may be something that the plan uses in its commercial  
16 business and just left it in place nominally but decided to  
17 charge the same cost sharing. We don't really know why.  
18 But for our purposes we treated those as a single G tier.

19           In this particular example there's a preferred  
20 brand tier and a non-preferred brand tier. Those are at  
21 different cost sharing levels so we leave those as separate  
22 PB and NPB tiers. So you've noticed we've assigned letters

1 to the tiers rather than the numbers that you typically  
2 hear.

3           Finally, the specialty tiers. In this case, the  
4 plan had a specialty drug tier with 25 percent coinsurance  
5 and it had an injectable drug tier at 25 percent  
6 coinsurance. Again, those appear to be indistinguishable so  
7 we combined them into a S tier. It may be that for purposes  
8 of the appeals exception that Cristina mentioned that that's  
9 only intended to apply to one of those two tiers but there's  
10 no public labeling of where that applies so we can't make  
11 that distinction. So as far as any information we have,  
12 these are indistinguishable tiers. So what appears to be a  
13 six-tier plan actually we treat as a four-tier plan.

14           This begins to give you a little data on what we  
15 see out there. Basically this is asking what tier  
16 structures are the plans actually using. What you'll see  
17 here is that the modal category is the most common tier  
18 design that plans seem to be using is the three-tier  
19 structure of generic, preferred brand and non-preferred  
20 brand plus a specialty tier. So in effect, a four-tier  
21 structure. That's the most common pattern both on the PDP  
22 side and on the MA side.



1 Others that are common include the three-tier  
2 structure without the specialty tier, or the generic brand  
3 structure with a specialty tier on the PDP side.

4 What we also can see in this is the majority of  
5 plans did choose to adopt specialty tiers, about 60 percent  
6 on both the PDP and the MA-PD side. Generally PDPs and MA-  
7 PDs look pretty similar but MA-PDs were a little more likely  
8 to use the three-tier structures and a less likely to use  
9 the two-tier structures with or without the specialty tiers.

10 The next chart looks at where the drugs are  
11 listed. So what we've done here is divide up by the  
12 different tier structures how many drugs are listed. What  
13 you see here is that the plans with the three-tier  
14 structures, with or without the specialty tier, and the  
15 plans with the standard 25 percent coinsurance design, are  
16 the ones that have a few more drugs listed.

17 The differences are not enormous here but there  
18 are definitely differences. What we think is going on,  
19 although we haven't been able to have enough time to go  
20 deeply enough in the analysis to really say this, what you  
21 can see clearly on this is the differences on the brand  
22 side. The ones that add the third, the non-preferred brand

1 structure, have more brand drugs.

2           So what we think they're doing is when they add  
3 that third non-preferred brand tier they're adding  
4 additional drugs to put in that tier. They may be shifting  
5 some drugs from what would otherwise be the single brand  
6 tier, moving them from preferred to non-preferred status.  
7 But what they appear to be doing is adding more drugs.  
8 Similarly, the ones with the standard 25 percent benefit  
9 seemed to have a broader list of drugs on their formulary.

10           But what we do see clearly is that almost all  
11 plans are at least restricting the list from what would  
12 otherwise be the universe of drugs, although the concept of  
13 the universe of drugs -- going back to my what is a drug  
14 question -- is not necessarily a well-defined concept here.

15           This chart gives you an answer to a couple of  
16 interesting policy questions. The first is, do the plans,  
17 do the PDPs that had a lower enough premium that they were  
18 authorized for auto-enrollment of the low-income subsidy  
19 folks and the dual eligibles, do they have a different size  
20 formulary than the plans that were not eligible for auto-  
21 enrollment?

22           The answer is there's only a slight difference.

1 The plans without auto-enrollment have slightly longer lists  
2 of drugs on their formularies, but the difference is really  
3 quite modest. So for the most part it looks like the dual  
4 eligibles and the other low-income subsidy folks got to  
5 enroll in plans that had roughly the same number of drugs  
6 listed on their formulary as the plans that they weren't  
7 eligible for.

8 A similar question about the basic plans versus  
9 the enhanced, the ones that went beyond the actuarial value  
10 to enhance their benefit in some way. Again, the  
11 differences here are very slight. For the most part there's  
12 not a longer formulary listed for the enhanced plans than  
13 for the basic plans. On the MA side you see a slightly  
14 larger list but the differences, again, are quite small.

15 Again what we think is going on here is that the  
16 difference between basic and enhanced plans falls in  
17 coverage in the coverage gap, perhaps less likely to have  
18 deductibles, lower cost sharing levels. The differences is  
19 in the benefit design around the cost sharing not in the  
20 size of formulary. In fact some of the national plans use  
21 identical formularies for both their basic plans and their  
22 enhanced plans.

1           This slide goes to the question of so the PDPs and  
2 the MA-PDs list about the same number of drugs or not. If you  
3 focus just on the top four bars, the PDPs, national and non-  
4 national, and the local MA-PDs, both the HMOs and the PPOs,  
5 what you'll see is pretty similar formulary sizes. They list  
6 about the same number of drugs. You see some differences  
7 between the different types of -- the local PPOs have slightly  
8 larger formularies than the local HMOs. The non-national PDPs  
9 have slightly larger formularies than the national PDPs. I  
10 would note here, when we say national it's not just the 10  
11 national organizations but the additional organizations that  
12 have offerings in nearly all regions.

13           The only real exception here are the very small  
14 sets of plans that are the regional PPOs and the private  
15 fee-for-service plans that seem to have substantially larger  
16 formularies. We're not completely sure why that's the case.  
17 Obviously, the regional PPOs is a relatively small number.  
18 The private fee-for-service plans may be simpler going on  
19 the principle of covering everything the way they do in  
20 their rules for networks for providers. There's also some  
21 difference in the payment structures that apply to these  
22 plans and perhaps that's a factor as well.

1           But I think the overall finding here is that the  
2 PDPs and the local MA-PDs have similar kinds of formularies  
3 here.

4           The last couple of slides relate to the use of  
5 utilization management tools. Let me remind you that the  
6 two utilization management tools we're looking at here,  
7 prior authorization where the physician must show that a  
8 drug is medically necessary before the plan is going to  
9 grant authorization to dispense that drug, and step therapy  
10 where the plan will restrict coverage of a drug unless or  
11 until other therapies are tried first. So these are two of  
12 the management tools that are flagged in the formulary  
13 files.

14           We asked two questions here. What proportion of  
15 plans ever use these tools? And then, for the plans that  
16 use them, what is the percentage of drugs for which they're  
17 used?

18           What you'll see here is there's not much  
19 difference first of all between PDPs and MA-PDs, but there's  
20 a lot of difference between the use of prior authorization  
21 and step therapy. Prior authorization is used by nearly  
22 every plan. Where they use it, they use it for a relatively

1 modest subset of drugs, about 9 percent of their drugs.

2           The step therapy on the other hand is much less  
3 commonly used. Only about a quarter of the PDPs and about a  
4 fifth of the MA-PDs use step therapy at all. When they do use  
5 it is used for a very small number of drugs, less than 1  
6 percent of their drugs.

7           The next slide basically shows you though how this  
8 can vary by drug class. These tools are really used very  
9 selectively and very differently in drug class. Let me just  
10 emphasize two of the classes here. You can look at the  
11 others on the slide.

12           The top row, the opioid analgesics, the pain  
13 relievers, prior authorization is used on only about a tenth  
14 of the drugs in that class. Again, we haven't gotten into  
15 all the details of exactly which drugs but you can imagine  
16 here it's the Oxycodones and the hydrocodones that are  
17 subject to abuse that might be subjected to prior  
18 authorization to make sure they're legitimate prescriptions.  
19 And none of the drugs in this class had step therapy there  
20 be involved.

21           If you looked then in contrast at the last row of  
22 this table, the proton pump inhibitors used for ulcers and

1 GERD, all of the drugs in this class have step therapy  
2 applied. Here's a class where typically the rule is that  
3 you've got to try some of the less costly remedies, the H2  
4 blockers, for these ailments before you move onto the more  
5 expensive PPIs, or perhaps require you to try to use the  
6 over-the-counter Prilosec before moving on to some of the  
7 prescription versions of the drugs.

8           Same thing with prior authorization. Half or  
9 three-quarters of the drugs have that, presumably for some  
10 of the same motivations. You'll see some of other classes  
11 that are different. So what you really are seeing is a very  
12 targeted and hopefully a very clinically appropriate use of  
13 these kinds of tools, attempting to target them where  
14 there's clinical justification or abuse questions or other  
15 kinds of reasons why they're needed in these particular  
16 instances.

17           That's it.

18           DR. MILLER: Can I just say one thing before we do  
19 this, and this is unscripted. I think the way for the  
20 audience and for the commissioners to hear what's going on  
21 here is, we have a lot of work ahead of us on the drug  
22 benefit, and the formulary is the heart of that benefit.

1           Step one is -- and we had some of this exchange  
2 with I think Jay and I in the last meeting -- is how are we  
3 even going to construct the framework that we're going to  
4 use to look at this? And how somebody can get to a drug is  
5 the number of drugs, what tier it's on, is there any kind of  
6 utilization management, appeals exemptions process? So this  
7 is us trying to come out of the blocks. Jack and his crew  
8 have done really good work in helping us build the framework  
9 and begin to get the initial look on it. That's the  
10 context. Then this will drive much more of our analysis of  
11 the future.

12           DR. NELSON: A question and comment. I will do  
13 them both at once.

14           The question is, do you have any idea how the  
15 formulary size, number of drugs covered, compares with other  
16 large purchasers such as the VA or the military, in terms of  
17 the number of drugs they cover in their formulary?

18           My comment is, one of the things that will be  
19 important to track is how burdensome and time consuming the  
20 appeals and exceptions process is. Because we are hearing  
21 from physicians where they have to get prior authorization  
22 and it takes them an hour to do it. They have to fill out



1 15 pages of a request in order to continue a person on the  
2 drug they've been on for years and so forth.

3 DR. HOADLEY: To answer your question, I think we  
4 do not at this point -- we're not able to say how the size  
5 of these formularies compares with things like the VA or  
6 commercial plans or anything else. The first challenge in  
7 doing that is the methodological question, what is the drug?  
8 We'll have to go through the same kind of processing of  
9 those files to make sure we're really comparing apples to  
10 apples before we can really make that kind of statement.

11 MS. BOCCUTI: I'll mention also that we did look a  
12 little bit into the grievance and appeals process in the  
13 June chapter last year and tried to talk to plans about how  
14 that's carried out. We also spoke with physicians. But  
15 we'll want to be looking at that in future. And I think CMS  
16 is interested in that too.

17 MR. SMITH: Jack and Cristina, thank you.

18 Jack, I wonder, what do we know about -- we've got  
19 some sense of how many drugs. But what's the standard  
20 deviation? How many drugs are on everybody's formulary?  
21 And is there something important about the drugs which are  
22 missing? Or once you get to the third tier of a three or

1 for-tier plan maybe it doesn't make any difference because  
2 you put anything in and impose a high copayment.

3 But is there something useful to understand  
4 therapeutically about the difference? Are the missing 100  
5 drugs important, or is that a market --

6 DR. HOADLEY: We haven't gotten deep enough in our  
7 analysis to answer those kinds of questions definitively but  
8 I think I can offer a couple of insights. One is on the  
9 question of how much range there is. We did have some  
10 numbers -- I don't have them right in front of me, but  
11 there's a pretty substantial range among the plans of the  
12 size of the formularies. I know for the other analysis I  
13 did for the Kaiser Family Foundation on a much smaller set  
14 of drugs we saw coverage rates between about 60-some percent  
15 then maybe about 85, 87 percent among the plans and that was  
16 for a smaller subset of 152 drugs. We definitely saw a  
17 similar range in the analysis we did here I just don't have  
18 the numbers right on the top of my head.

19 I think the really interesting question you're  
20 getting into is what sort are the missing drugs? One of the  
21 things that we just have started to do and want to get more  
22 into is really looking at class by class. It's a big

1 difference if you're leaving off drugs in a class like the  
2 anti-psychotics. Obviously the rules there say you  
3 basically can't leave them off and that's pretty much what  
4 you find there. But there you're going to see close to 100  
5 percent coverage. Where you don't see completely 100  
6 percent it's because of generic and brand versions, if  
7 you're counting that way, or different variants, extended  
8 release versions or things like that.

9           When you get to perhaps respiratory tract products  
10 where there's a lot of different product that all do the  
11 same thing, or some of the ARBs for -- there's seven ARBs  
12 for hypertension -- many plans chose to cover two, three of  
13 those seven products. The rules simply say you have cover  
14 one. It's a key drug type. And many plans came close to  
15 that smaller number because they feel they're all equivalent  
16 products and people can appropriately choose between them.

17           So I think as you get into the class by class  
18 analysis is where you get the more interesting analysis on  
19 that.

20           DR. CROSSON: I'd like to comment on a place in  
21 the text again but in this case it speaks to Mark's point  
22 which is our evolving sense of purpose here, what it is this

1 piece of work is about. Towards the beginning we talk about  
2 the fact that Part D is a major departure from traditional  
3 Medicare in the sense that the benefit is not defined, it's  
4 rather left to the plans to determine. This approach has  
5 the advantage of providing a range of plan options that  
6 could potentially better suit individual needs but also  
7 raises concerns about whether beneficiaries will enroll when  
8 faced with many choices.

9           It seems to me the major concern it raises is the  
10 question of whether the plan design has the effect of  
11 creating selection bias. Or to use the terminology that the  
12 guideline uses, discouraging enrollment by certain  
13 beneficiaries.

14           I suppose you could also apply that, I hadn't  
15 thought about it particularly but I suppose that principle  
16 also applies to the use of utilization management  
17 techniques. It seems to me that if we can provide value  
18 over time here it would be to look at, I mean catalog what's  
19 so going on, but also look at the patterns over time from  
20 those two perspectives. And probably it would be worthwhile  
21 calling that out right in the beginning.

22           DR. MILLER: I agree and I think the other thing,

1 just what we're talking down the road and I think we've said  
2 this in the last meeting as well, you can also eventually  
3 get to the analysis of which plan's designs can distinguish  
4 on the level of, or different patterns of utilization, total  
5 expenditures per beneficiary, are there quality differences,  
6 just to carry that thought further out. But we'll make sure  
7 that the chapter's written that way.

8 DR. REISCHAUER: The first point is to elaborate a  
9 bit on what Alan mentioned, and that is to be useful we  
10 really have to have some reference point or else you're  
11 comparing what Part D offers to some ideal, which is offer  
12 everything and give it away for free, I think which is a set  
13 of expectations some have. It strikes me the appropriate  
14 reference framework would be what people had before. But  
15 that's history and there's no way to get it.

16 I wonder if we know anything about what  
17 formularies and arrangements look like for those who have  
18 retiree policies that are being subsidized through Part D  
19 and how generous, restrictive, whatever, they are compared  
20 to the situation here as opposed to the commercial insurance  
21 for those under age 65. These aren't questions but just  
22 observation.

1           I would think it is absolutely impossible to  
2 figure out actuarial equivalence. I mean it's an ambiguous  
3 concept to begin with. If everybody's structure was \$250  
4 deductible, 25 percent coinsurance, some of the analysts  
5 could sit around and roughly come out with some notion of is  
6 this actuarially equivalent. But they aren't. They're  
7 designed that are all over the lot.

8           What is CMS doing? I would think there must be a  
9 huge range here in what it is willing to approve as an  
10 actuarial equivalent, by necessity.

11           MS. BOCCUTI: You mean considering the formulary  
12 variation, how that plays into it? Is that part of your  
13 question?

14           DR. REISCHAUER: No, you have tiers, you have  
15 different coinsurance rates, you have no deductibles in  
16 some. In theory what you're trying to do is produce cost  
17 sharing that is equivalent to what somebody faced with a  
18 \$250 deductible, a 25 percent coinsurance, and some array of  
19 drugs, would spend.

20           MR. BERTKO: Let me try that and I'll try to give  
21 you my interpretation of what I think CMS has done on that.  
22 The cost sharing in year one had to be theoretical to get to

1 that benefit which never existed before and we, and I think  
2 everybody else who tried to do this and had their actuarial  
3 equivalence accepted said, here's our past experience from  
4 one or more data sources. Here is what we would have paid  
5 had the benefit been arrayed this way. We actually had a  
6 micro-simulation model that did that. And here is what this  
7 other benefit looks like.

8           So, again, highly theoretical but we've matched  
9 the cost sharing as best we could under that. This year is  
10 too early '07 because we just got three data points so far,  
11 but for '08 we'll actually have defined standard benefits --  
12 CMS will know that -- to compare against all these others.  
13 So this experience will emerge pretty quickly.

14           Can I go with my other comments too at this point?

15           To get a possible second answer to, Bob, your and  
16 Alan's questions, I think the retiree drug benefits are a  
17 good place to look. My recollection, from I know about them  
18 -- and we're not a big player in that though -- is that the  
19 over-65 retiree formularies are, for the most part, the same  
20 as the under-65 formularies. They are a good place to  
21 start. And for the most part my recollection also is that  
22 when the whole USP was being described with 146 categories,

1 those were larger than the roughly 90 or somewhat fewer  
2 categories that many plans like the Blues would have. But I  
3 think that would be a good question for Jack and Cristina to  
4 look at.

5           Then lastly I'll add my comment to them. First of  
6 all, it think this is a very good way to look at this, Jack,  
7 very concise for all the stuff you went through. But there  
8 has been a lot of consolidation and I would suggest, after  
9 we get the membership numbers finally, that you redo just  
10 this package with the membership weighted there. Urban  
11 legend has it that one of the PDP bidders has got exactly  
12 one member and yet you're evenly weighted across everything  
13 here.

14           DR. HOADLEY: We would obviously love to have  
15 enrollment numbers at this point to do that.

16           Let me just make one comment on the comparison  
17 with the commercial. For a project we did last year for HHS  
18 we tried to look at some commercial formularies. This was  
19 it in advance of Part D stuff being available.

20           One of the problems is you don't really have a  
21 database available to do that. What we found ourselves  
22 doing was literally going to the Internet, finding PDF files



1 of formularies listed in any way that that plan chose to  
2 list, perhaps not complete. They don't always claim they  
3 put every drug on their list that they put out for the  
4 consumers or even for the providers. And then, not only  
5 having to make sure we accurately captured this verbal  
6 description of the drug and translated it to a technical  
7 description of the drug, but then worry about the  
8 completeness of the list.

9           So the real challenge to do that would be to get  
10 hold of some kind of a data source or get the cooperation of  
11 plans to provide us databases of their formularies so we  
12 could do some of those kinds of comparison.

13           MS. HANSEN: I just wanted to verify Jay's point  
14 about looking at it from the beneficiary standpoint. I  
15 think once we do the formulary and once we have the members  
16 identified, the ability to take it from on the ground as to  
17 what beneficiaries with certain kind of classic chronic  
18 diseases are having to face in terms of the choices, as well  
19 as the range of differential that the plans will offer so  
20 that it helps beneficiaries make more informed choices as  
21 well.

22           Then finally, the whole area of the low-income

1 population, that's going to be sorted out once the members  
2 were identified to be able to see where they sort out with  
3 some of the different plans would be great. Thank you.

4 DR. MILSTEIN: Other than prior authorization,  
5 which is a very bulky and administratively difficult tool,  
6 under Part B our plan offers, permitted to in any way limit  
7 use of medications on the formulary to the indications and  
8 conditions for which the medication was either listed in the  
9 formulary to begin with in terms of the category it fell  
10 into, or FDA approval. I'm really getting at the question  
11 of is it possible -- have any plans aspired to do this? And  
12 if not, is it related to restrictions embedded in the Part D  
13 regulations?

14 MS. BOCCUTI: I'll take a crack and Jack you can  
15 add in.

16 Whether it's off-label use or use for other  
17 things, I think that is a prescribing physician choice  
18 there. Then even being able to track it is difficult  
19 because you don't really, when you get the data, you won't  
20 be able to say what it was actually used for. In many cases  
21 when you have diagnostic information and what other drugs  
22 they're on you can make an assumption. And in some cases

1 you can look whether it's used for rarer reasons.

2 But I'm not aware of that much prescription in the  
3 drug prescribing for specific conditions. With the USP  
4 classes I think there was some thought about that, but Jack  
5 you might want to add in.

6 DR. HOADLEY: I think Cristina has that just  
7 right. There's no diagnosis on the prescription slip so if  
8 you're just doing this as a straight claims thing there's no  
9 way to verify that. I think that is where prior  
10 authorization enters in.

11 My assumption is that if a plan wants to say, we  
12 only want this drug used for this very narrow purpose,  
13 that's where you place a prior authorization restriction and  
14 you make sure that the doctor is prescribing it for that  
15 purpose before you authorize the dispensing of the drug.

16 DR. KANE: I just had a question around the actual  
17 equivalent issue.

18 If most of the non-low income people, clearly  
19 based on focus group and market work, decided they really  
20 wanted a tiered copayment and yet the low-income group is on  
21 a 25 percent coinsurance, I'm just wondering if that's  
22 really actuarially equivalent. That's what this thing says,

1 that the low-income groups were still mostly on the 25  
2 percent coinsurance. Is that an error in the write-up?

3 MR. BERTKO: No, it's correctly stated, but you  
4 have to remember the low income folks have the cost  
5 subsidies that determine --

6 DR. KANE: I know it's being paid -- I understand  
7 that and that's my question, is that good for Medicare?  
8 Who's paying for it? And is it really actuarially  
9 equivalent or should Medicare as an efficient purchaser  
10 reflecting the best possible deal, should they consider that  
11 actuarially equivalent or should they go with the market and  
12 say, we really want to shop on behalf of these people in the  
13 way that the non-low income people are choosing to shop? Is  
14 it really actuarially equivalent or is it not?

15 MS. BOCCUTI: I can't talk about the -- I don't  
16 know the models and that's been reviewed with CMS reviewing  
17 it. But I'm not sure we can even make a judgment about  
18 what's costing Medicare more money right now. We have to  
19 see some use and see what's going on with what's on the  
20 formulary and what drugs are actually claimed in order to be  
21 able to compare whether there is a better value at one tier  
22 structure over another.

1 DR. HOADLEY: But certainly if the actuarial  
2 equivalence concept works the low income beneficiaries are  
3 only going to be eligible for plans that are non-enhanced  
4 plans, so are either the 25 percent standard benefit or  
5 actuarially equivalent to it with tiered cost sharing. If  
6 the actuarial equivalence model works then they're all in  
7 equivalent models.

8 Obviously, actuarial equivalence is not designed  
9 to be equivalent for every single person. It's across the  
10 aggregate. So for a given individual it may be different.

11 DR. MILLER: I could hear this question just a  
12 little bit differently because I don't know how much we're  
13 going to be commenting on actuarial equivalence. I think  
14 really the policy question I hear here is, once we have some  
15 experience and we see what's going on, are the utilization  
16 patterns in these plans different such that someone might  
17 want to think about how this subsidy is structured and which  
18 plans the low income are being put in? As opposed to, is it  
19 actuarially equivalent, which I think is a different concept  
20 and you can make things actuarially equivalent a lot of  
21 different ways.

22 I see the relevant question being, are these the

1 right plans for these people to be in, and is Medicare  
2 getting the right kind of utilization patterns out of it,  
3 whatever right means in this conversation.

4 MR. BERTKO: Just a quick expansion. Nancy asked  
5 an interesting question but not necessarily the right  
6 question.

7 Setting aside the question of actuarial  
8 equivalence to the one that I think you mean to answer is,  
9 is Medicare, with the low-income subsidy, being a good  
10 purchaser?

11 There's a second part to this which is, compared  
12 to what? The what, in many cases, was no copays. So now  
13 there's a dollar/\$3 copay for almost all of these.

14 And secondly, at least one plan might have some  
15 early indications of very intelligent selection of generic  
16 usage in there. Then I guess I think everybody would agree  
17 or I would hope everybody would agree here that even a  
18 dollar and \$3 per prescription for low-income individuals is  
19 in fact a decent incentive and maybe corresponds to \$10 and  
20 \$30 for average income seniors.

21 DR. MILLER: The very last thing I wanted to say  
22 is there were about three or four comments that I felt were

1 on one subject, and since we have to react to them I want to  
2 be sure that -- as we go forward, I want to make sure that I  
3 capture them.

4 So there's the one comment of, we need to be  
5 thinking about a reference point here, ESI insurance or  
6 whatever the case may be. I think that's pretty clear in my  
7 mind.

8 And then a couple of other people seemed to be  
9 saying, I want you to construct almost a profile of a  
10 beneficiary, or a condition, or something where you could  
11 then use that to track across plans to see how the different  
12 drugs would be treated. I felt like I heard that too.

13 We'll have to follow up and figure out how to  
14 actually do that.

15 DR. NELSON: Including the administrative burden.  
16 It would be really helpful to have an index in addition to  
17 straight class.

18 MR. HACKBARTH: Well done. Thank you.

19 Next Joan is going to make a presentation on  
20 beneficiary education and how they made their choices

21 DR. SOKOLOVSKY: This morning I want to talk to  
22 you about how beneficiaries learned about the drug benefit

1 and their particular individual choices. Some of the key  
2 questions include, did beneficiaries have the information  
3 that they needed to make informed decisions? Who helped  
4 them when they made decisions about enrolling in a drug  
5 plan? And what factors were most important to them in  
6 deciding on a specific plan?

7           This work allows us to evaluate what beneficiaries  
8 most valued in a drug plan and helps us think about the best  
9 ways to support their decisionmaking in the future. The  
10 material we gathered was very rich and I can just give you  
11 really a sample in this presentation. I'd be happy to  
12 provide further details on questions.

13           I think the key findings can be summed up like  
14 this: for beneficiaries who signed up for a drug plan or are  
15 considering signing up, the decisionmaking process has been  
16 long and for many of them rather difficult. However, the  
17 majority do believe they have enough information to make a  
18 decision.

19           Most beneficiaries made their own decisions about  
20 whether to sign up for a drug plan. While beneficiaries  
21 discussed their choices with family and friends, few used  
22 the Medicare help line or web site. About 25 percent of the



1 people who had help relied on advice and information  
2 supplied by insurance agents and drug plans. We found that  
3 many people in our focus group used the Medicare handbook to  
4 find out what plans were offered in their areas and then  
5 contacted the individual plans directly for information.

6 For this project we contracted with a team of  
7 researchers from NORC and Georgetown University to complete  
8 three interrelated studies. The first was a telephone  
9 survey of Medicare beneficiaries that was fielded from  
10 February 8 to March 2. The questionnaire concerned  
11 decisionmaking about the drug benefit and the sample was  
12 nationally representative.

13 The second study consisted of six focus groups,  
14 three held in Richmond, Virginia at the end of February, and  
15 three held in Tucson, Arizona during the third week in  
16 March. In each location we had a separate session with  
17 family members who were helping a beneficiary make a  
18 decision.

19 In Richmond we had one beneficiary group that was  
20 entirely composed of dual eligibles. None of the  
21 beneficiaries in Richmond were involved in a Medicare  
22 Advantage plan. But in Tucson, each group contained a

1 mixture of beneficiaries from MA plans and traditional  
2 Medicare.

3           For the third study we interviewed about 30  
4 counselors in 14 different states. They discussed their  
5 work doing outreach to tell beneficiaries about the benefit  
6 and doing individual counseling to help beneficiaries make  
7 decisions. They also helped beneficiaries with problems  
8 they encountered during the transition in early 2006.

9           About 70 percent of our sample had some drug  
10 coverage before January 1. Those who had employer-sponsored  
11 insurance and intended to keep it were not asked other  
12 questions about decisionmaking since they didn't really have  
13 a decision to make. This slide is about the experiences of  
14 people who did have to make a decision and it doesn't  
15 include, therefore, again the people with employer-sponsored  
16 insurance which in this case includes VA and TriCare.

17           Of those beneficiaries who knew about the benefit  
18 and didn't have drug coverage from these sources the  
19 respondents in our survey were almost equally split between  
20 those who had signed up for a plan, 30 percent, those who  
21 were not considering signing up for a plan, 34 percent, and  
22 another 16 percent were still considering their options.

1           Let me explain that additional box here, the auto-  
2 assignment number. Just over a quarter of those in our  
3 sample who didn't have employer-sponsored insurance reported  
4 receiving a letter assigning them to a specific plan. Of  
5 them, more than half said that they were keeping the plan to  
6 which they were assigned. These are represented by the box,  
7 accepted auto-assignment. About a third of them switched,  
8 chose a different plan, and we put them amongst the people  
9 who had signed up for a benefit since they had made a  
10 decision and signed up. The others who were considering  
11 switching but hadn't yet done so were put in the considering  
12 category.

13           We asked beneficiaries who had signed up for the  
14 benefit or were considering signing up what reasons they  
15 thought were important for signing up for Part D. More than  
16 90 percent said that saving money on drug costs and  
17 protecting themselves in case their drug costs went up in  
18 the future were important or very important reasons to sign  
19 up. Another 72 percent said that avoiding a penalty for  
20 late enrollment was important. That number was even higher  
21 amongst those who had not yet made a decision. Seventy-one  
22 percent thought that being able to buy drugs that they

1 couldn't afford before was an important reason as well.

2 Beneficiaries in our focus groups also said that  
3 saving money on drug costs and avoiding the penalty were  
4 important reasons. But it was very striking to us how few  
5 of them thought of drug plans as an insurance policy against  
6 future costs.

7 There was one incident in particular that I think  
8 captured all of our attention. There was one man in one of  
9 our focus groups who said that he was very healthy and had  
10 no drug costs but his wife was very conscientious and had  
11 done a lot of research and signed both him and her up for  
12 plans before the benefit began. Then at the very end of  
13 December he suffered a massive heart attack and suddenly he  
14 found himself taking many drugs.

15 And he looked around at everybody at the focus  
16 group and he said, you know, if you think about this benefit  
17 as if it was -- I don't know, almost like insurance, it  
18 really makes sense. It was striking not just to us but to  
19 the other people in the focus group, at least one of whom  
20 had said she was not considering signing up and said that  
21 she was reconsidering her decision.

22 The most common reason people in our survey gave

1 for not signing up for a plan was that they had other drug  
2 coverage. Almost half of beneficiaries listed that, in  
3 fact, as their primary reason. Remember, this was true even  
4 though the people with employer-sponsored insurance were  
5 taken of the sample. Other beneficiaries reported that they  
6 did not take many drugs or didn't think the benefit would  
7 save them money. Less than 10 percent reported that they  
8 didn't sign up because the choices were too confusing.

9 I should note that --

10 DR. REISCHAUER: Joan, can you tell us why they  
11 had coverage although they weren't part Medicaid?

12 DR. SOKOLOVSKY: Many of them had Medigap drug  
13 coverage. Some people who had MA drug coverage did not  
14 consider staying in MA getting Part D. They thought of this  
15 as avoiding Part D and they were included in that. Some had  
16 drug coverage from state pharmacy assistance plans. Some of  
17 them had discount cards treated it as if it was drug  
18 coverage. It was definitely something that we had to  
19 follow-up on to try to make sense of, yes.

20 In general beneficiaries who didn't sign up were  
21 more likely to use no drugs on a regular basis and spend  
22 less money on a monthly basis for drugs. In fact about half

1 of beneficiaries in our survey who were not considering  
2 signing up used two or fewer drugs on a regular basis. This  
3 was also true of beneficiaries in our focus groups and  
4 beneficiary counselors reported the same pattern.

5           Most beneficiaries, about two-thirds, researched  
6 and made decisions about signing up for a Part D by  
7 themselves. However, those who signed up or were  
8 considering signing up were more likely to have had help  
9 than those who were not considering signing up. Those who  
10 reported that they did get help or advice from others  
11 primarily relied on family and friends. The next most  
12 common source of help and advice were insurance agents and  
13 drug plans. Twenty-six percent of those who got help  
14 consulted these resources. Relatively few beneficiaries  
15 reported receiving help from a doctor, a pharmacist, or a  
16 counselor.

17           Focus group members also discussed consulting the  
18 Medicare & You handbook, although they did report that they  
19 found it confusing and, in one case, used the term  
20 legalistic. They also mentioned talking to representatives  
21 from individual plans, sometimes at events held in stores.  
22 Some used the handbook to get a list of local plans, all of

1 their options, and then contacted the plans directly for  
2 information, including whether there particular drugs were  
3 covered.

4 The beneficiaries in our focus groups reported  
5 more contact with pharmacists, but that was really the only  
6 difference we found.

7 About one-fifth of survey respondents said they or  
8 someone who helped them called 1-800-Medicare, and only 11  
9 percent said they used Medicare.gov web site. The majority,  
10 about 60 percent who did use these sources, found them  
11 helpful. In general, few focus group participants described  
12 using web-based tools or counselors to help them make  
13 decisions. They were more likely, again, to describe plan  
14 descriptions that they received in the mail, phone calls to  
15 plans, and conversations with plan representatives. More  
16 family members in our focus groups noted that they used the  
17 Medicare web site, but even here this was a minority.

18 MR. MULLER: Where is this number on chart 7? I  
19 didn't see it in seven.

20 DR. SOKOLOVSKY: What I'm saying now is on chart  
21 8.

22 MR. MULLER: I know, but if you go back one where

1 are the people who went to the web site on this one?

2 DR. SOKOLOVSKY: It's not on this one. In fact  
3 this one asks whether you or whoever helped you used these  
4 sources, so it should include, for example, the family and  
5 friends on the other chart, also the people who made the  
6 decisions by themselves.

7 MR. MULLER: Wouldn't going to the web site be a  
8 source of help? Why is that not a source of help?

9 DR. SOKOLOVSKY: We wanted to get at, no matter  
10 how you did it, whether you did it by yourself, whether you  
11 did it with the help of family and friends, whether you did  
12 it with the help of a counselor, did you use this source.  
13 We wanted to get the broadest possible number here.

14 MR. MULLER: I'll come back later.

15 DR. SOKOLOVSKY: On the other hand, most SHIP  
16 counselors got their information from CMS and used the web  
17 site to help them narrow down all beneficiary choices. At  
18 least 90 percent of beneficiaries in our survey thought  
19 financial considerations like how much the plans charge for  
20 copays and premiums, whether their particular drugs were  
21 covered, and how much money they would save overall were  
22 important when deciding on a specific plan. The reputation



1 of the company offering the plan was also considered  
2 important by 90 percent of our survey.

3 In our focus groups this factor was also  
4 considered important with beneficiaries saying that they  
5 were wary of unfamiliar companies because they didn't know  
6 if they'd still be there in the following year.

7 Using their customary pharmacy was important to 84  
8 percent of beneficiaries with a somewhat higher number of  
9 beneficiaries in rural areas reporting that this was  
10 important.

11 Fewer than half thought it was important to sign  
12 up with the same company that their spouse used, but yet 42  
13 percent of beneficiaries did think that this was important.

14 Beneficiaries in our focus groups also thought  
15 cost and coverage of their drugs were the most important  
16 factors. Some beneficiaries found customer service a  
17 determining factor. For example, one man called all of his  
18 plan options and eliminated any plan that would not give  
19 him, promptly and clearly, answers to his questions. Many  
20 reported difficulty getting service lines to tell them  
21 whether their specific medications were covered. They were  
22 often told by the customer service line that they only gave

1 that information to people who were enrolled in the plans.

2 [Laughter.]

3 DR. SOKOLOVSKY: Individual counseling for  
4 beneficiaries has been conducted through state SHIPs and  
5 other volunteer grass-roots organizations. SHIPs are state-  
6 based organizations that receive federal funds to counsel  
7 Medicare beneficiaries about insurance issues. The MMA  
8 increased funding for these groups from about \$12.5 million  
9 in 2003 to \$32.7 million in 2005. For 2006 that funding has  
10 been reduced by about \$1 million. The SHIPs provide  
11 individual counseling to beneficiaries as well as organizing  
12 informational events.

13 Although only a small percentage of beneficiaries  
14 reported having used the SHIP services, when you look at  
15 actual numbers it translates into 4.2 million beneficiaries  
16 in the past year receiving individual counseling from SHIP  
17 counselors.

18 Counselors report that they were in fact  
19 overwhelmed by the volume of calls that they received. For  
20 example, one office reported that calls increased from 3,000  
21 a month before October 2005 to over 30,000 a month in  
22 November and December.

1           We generally heard that SHIPs are counseling more  
2 of the disabled beneficiaries and dually eligible  
3 beneficiaries than they ever had before but were still  
4 having trouble reaching the population that was likely to be  
5 eligible for the low-income subsidy. Some groups provide  
6 help in languages other than English, and some groups  
7 representing people with particular disabilities or medical  
8 conditions also provide counseling to their members.

9           We were told from the SHIPs that beneficiaries are  
10 confused by the number of plans, the variation in benefit  
11 structure, and the penalty for late enrollment. We heard  
12 these same thoughts expressed in our focus groups.

13           While the majority of the beneficiaries in our  
14 survey thought they had enough information to make a  
15 decision, more than half of the beneficiaries who signed up  
16 or are considering signing up have found the decision rather  
17 difficult. Beneficiaries who have signed up are more likely  
18 to think that they had too much information, while those who  
19 were still considering the decision were more likely to  
20 report that they had too little.

21           Beneficiaries have found the decisionmaking  
22 process very time consuming. Half of the beneficiaries who

1 signed up for a plan said it took them eight hours or more  
2 to come to a decision. Forty-four percent of those who were  
3 still considering their options have reported that they have  
4 already spent eight hours or more on the decision.

5 In our focus groups, beneficiaries complained  
6 about the lack of comparability in the information that they  
7 received from plans. Several spoke of wanting a document  
8 that compares plans in an apples to apples way. Others  
9 suggested a comparison chart or a simple checklist that  
10 clearly shows the prices and coverage policies of each plan  
11 or provides answers to frequently asked questions. Some  
12 suggested that Medicare should standardize the benefit  
13 packages that plans could offer so that then the beneficiary  
14 could compare more clearly their choices.

15 Counselors, on the other hand, were more likely to  
16 emphasize that plans' offering should be limited because  
17 beneficiaries were confused by the large number of choices.

18 Again I can really only skim over some very rich  
19 material and await your comments and whether there are other  
20 areas you would like to see more information on.

21 MS. BURKE: Joan, first a question that probably  
22 seems a little odd but just, to what extent can we determine

1 the gender of the person who gave counseling on plan choice?

2 DR. SOKOLOVSKY: The SHIP counselors?

3 MS. BURKE: Not just the SHIP counselors. There  
4 has been traditionally a view that women tend to be the  
5 primary decisionmakers, certainly under age 65, in making  
6 plan choices or in making insurance choices for their  
7 families. Obviously, the gender of those over the age of 65  
8 is predominantly, if you were to look at it, female anyway.

9 But it would be interesting to understand and to  
10 know whether or not that pattern has continued here. As a  
11 look at family members and you look at others, has it  
12 predominantly been women in the family who have provided  
13 this information? But it's an interesting question only to  
14 the extent that as you think about how you market the  
15 information, where you market the information, whether  
16 there's any kind of gender bias -- I don't mean that in a  
17 pejorative way -- that might assist us in understanding how  
18 this information is provided, and by whom, and in what  
19 settings. So that the further detail we get on that chart  
20 that you provided on where they got it and from whom might  
21 be helpful to us going forward.

22 The other question I think is a more fundamental

1 one, Glenn, in terms of this chapter as well as the chapter  
2 before. And it may well be something we want to think about  
3 in the context of our retreat this summer, and that is, at  
4 the end of the day what is it that we think we ought to be  
5 tracking? What are the questions that we really need to  
6 fully understand as we go forward with the implementation of  
7 this benefit?

8           Certainly in this chapter the whole question of  
9 how one navigates through very complicated information, how  
10 we distribute the information, the source as well as the  
11 complexity of it, all those kinds of questions that are more  
12 broadly applicable to Medicare, and to the extent that we  
13 move in this direction in terms of choices going forward,  
14 would be very helpful.

15           But I think for the Commission's standpoint  
16 pausing and thinking, as this thing is implemented what are  
17 really the things that we want to understand, prices,  
18 choices, design features, all those kinds of questions. But  
19 it would be nice to get a handle on and a structure as we go  
20 forward, what are the things we want the staff to begin to  
21 routinely report back to us on? What are the indications  
22 that will be helpful to us and to what end? What is the

1 question we're asking, other than the obvious one, is the  
2 benefit worth it? Are we paying the right thing? Are the  
3 people getting the right services?

4 But it would be good to get a sense of that in  
5 both of these chapters and in this broad benefit. What is  
6 it we want to learn and what is it that we should be  
7 understanding and asking the staff to track as we go  
8 forward? Because there are about 87 different moving pieces  
9 here and to get some sense of that might be helpful for us.

10 MR. HACKBARTH: In one of our previous reports,  
11 and remind me which one it was, we began the process of  
12 laying out what sort of ongoing measures of performance we  
13 might want to track in general about Part D. When was that?

14 DR. SOKOLOVSKY: Last June.

15 DR. MILLER: June '05. That's right where I was  
16 going to go and say, for the summer of session when we start  
17 laying out plans for the cycle that starts in September,  
18 first step would be to bring that back up and get that back  
19 in front of you. I think even from Joan's work and Cristina  
20 and Jack prior to this, we've begun to get a little richer  
21 understanding on a couple other of these elements and we can  
22 try -- some of the reference points that you were talking

1 about -- bring that in, put it all in front of you again and  
2 ask ourselves, is this how we're going to be tracking this  
3 benefit.

4 MS. BURKE: The other thing that I have raised at  
5 previous meetings and I continue to be concerned about --  
6 and it may well just be that I'm not informed currently  
7 about what's going on -- and that is the mining of the data  
8 that will be produced from the benefit, and how we are going  
9 to use that information, and how CMS is structuring that  
10 question. How quickly will we begin to see patterns? How  
11 quickly will we begin to be able to look at how different  
12 physicians behave in fact of their prescribing patterns and  
13 best practices?

14 I remain somewhat concerned that that hasn't yet  
15 been fully thought through, and I know that the coordination  
16 with the FDA and with others, while everyone says that's  
17 going to happen, I'm not yet even certain that that is  
18 happening to the degree we might ultimately want to have it  
19 happen for a variety of purposes, both for the FDA's  
20 purposes in terms of watching what happens in terms of  
21 medications, but also for our own purposes in terms of best  
22 practices. So particular attention to that issue, which is



1 what is happening with the production of data, how quickly  
2 we'll be able to look at the data.

3 I don't want to get back into the pattern we're in  
4 currently where we're looking at cost data that's four years  
5 old or five years old. Are we planning at the outset of  
6 this new benefit to really begin to understand that and  
7 gather that information? I'd feel better if we had a better  
8 sense of that as well.

9 MR. HACKBARTH: At this point again there's a very  
10 basic issue about what data we will get and when we will get  
11 it, which is an ongoing matter of some interest, shall we  
12 say.

13 Dave actually participated in some of this  
14 research as I recall.

15 MR. SMITH: I attended the focus groups, so I  
16 didn't participate as much as I observed.

17 MR. HACKBARTH: Watched it, shall we say.

18 MR. SMITH: Joan did a terrific job. Just a few  
19 observations.

20 The survey was fielded and the focus groups were  
21 help before some critical benchmarks, the 90-day benchmark  
22 being the most important one, and the run-up to May 15. So

1 both of those things are likely -- we don't know whether the  
2 population that was energized and signed up and paid  
3 attention, or energized and paid attention and didn't sign  
4 up, we don't know if they're different than the group of  
5 people who will be signing up now. So this is useful  
6 partway information but there's a lot more to know.

7           A couple of thoughts, and again this is just from  
8 the focus groups and Joan has mentioned most of it. A lot  
9 of anger. Too confusing, too hard, mad at plan  
10 representatives who couldn't answer questions, mad at  
11 Medicare for having created such a complex and unwieldy  
12 thing. And a surprising amount of satisfaction. Anger was  
13 there, but people who managed to negotiate it or had  
14 somebody to negotiate it for them, or were auto-enrolled, to  
15 the extent that they had experience with filling a  
16 prescription, accessing the system, were quite satisfied.

17           The third part of that observation, an awful lot  
18 of suspicion that something bad is going to happen. The  
19 plan is going to go away, prices are going to go up, they're  
20 going to change their formularies so my drug isn't on it.  
21 That set of suspicions were partly born by how complicated  
22 it is. It wouldn't be so complicated if they weren't trying

1 to mess with me. So the worst is yet to come was the answer  
2 even among those, or was the view even among those who were  
3 relatively satisfied with what happened so far.

4 Three last thoughts. Helpers weren't very  
5 helpful. Helpers, whether or not they were kids or  
6 neighbors or counselors didn't provide very good help. One  
7 of the focus groups in Richmond was helpers. It was  
8 probably the least informed, least articulate group of any  
9 of the folks that we met with.

10 The most successful people it seemed to us, I  
11 think we all agreed, were the young, computer-friendly  
12 recent retirees. So they had time, which was important, and  
13 they could use the technology in ways that most of the  
14 helpers found difficult and the older elderly found  
15 difficult.

16 Joan said this but I really would emphasize it,  
17 virtually everybody who either enrolled or not who expressed  
18 a view about what was most important, put my drugs before  
19 any of the -- I want to make sure I can get my stuff, and  
20 everything else fell behind that. But people started with,  
21 I'm on, and to the extent that I've got a first sort, that's  
22 what it is.

1           MR. MULLER: As these chapters note, this is the  
2 first benefit that really isn't offered in the regular fee-  
3 for-service system so I want to comment a little bit about  
4 what we might learn about that. One, just following up on  
5 David's point insofar as the beneficiaries make this choice  
6 once a year, though the formularies perhaps can change, it  
7 forces people to make a choice. And if they're making their  
8 choice primarily on the drug "my drug" it would be  
9 interesting to see how satisfied they are with that. Maybe  
10 one of the reactions is that it can't just have a dynamic  
11 change of formulary at the same time we have a static choice  
12 of plans.

13           It's also interesting, if you look at some of the  
14 evidence of choice in 401(k) plans where there's a  
15 considerable difference by income as to whether people make  
16 any contributions beyond the kind of, to use the phraseology  
17 of Part D, the auto-enrollment, basically the basic  
18 contribution that the employer makes. And by and large you  
19 find there of the lower income populations in 401(k) plans  
20 barely 10 percent of them do anything beyond the auto-  
21 enrollment, to use that metaphor, and the higher income  
22 participants make more contributions, in the sense that it's

1 obvious based on income.

2 But it would be interesting to see inside of this  
3 whether we start seeing different behaviors in terms of plan  
4 choice as it evolves where the more higher income  
5 beneficiaries making and being more dynamic in terms of  
6 their choices that they do make over time, being more  
7 responsive to their changing medical needs. Obviously in  
8 the fee-for-service system, in a sense one can make a choice  
9 as your health needs of all because basically by having  
10 access to a physician you can change your -- in a sense, if  
11 you had on other services aside from pharmaceutical benefits  
12 you obviously have a choice on your doctor can decide what  
13 kind of services you need. Here you have more of a static  
14 choice.

15 So I'd be interested in seeing, in terms of what  
16 we follow over a period of time, some of these demographic  
17 variables if in fact they evolve. Are there big differences  
18 between the more higher income rather than the lower income  
19 beneficiaries within the plans? What kind of changes are  
20 made as people's health needs change? Understanding some  
21 difficulties exactly in tracking those health needs.

22 I also want to also then, in addition to those

1 comments, come back to the point I was making earlier.  
2 Since a big part of the effort by CMS was in fact to have  
3 the web site and the 800 number available I wasn't able to  
4 follow off the charts how important that was in terms of  
5 people making choices. The obvious point, most people on  
6 most big decisions in life, go to their friends and family  
7 first, so I understand that.

8 But how important was the web site and the 800  
9 number in terms of helping people to make choices? That  
10 goes back to my question about how page 7 and page 8  
11 interrelate.

12 DR. SOKOLOVSKY: Again, two-thirds of our  
13 beneficiaries said they made the decision by themselves and  
14 49 percent of the people that were left said they went to  
15 family and friends. We asked, did you yourself or whoever  
16 was helping you, call 1-800-Medicare or use of Medicare web  
17 site. About one-fifth made the phone call, called the  
18 Medicare help line. But only 11 percent, counting  
19 themselves and their family and friends -- although it's  
20 possible they don't necessarily know all that their family  
21 and friends did -- used the web site.

22 MR. MULLER: So that's 11 percent of the total

1 population used that?

2 DR. SOKOLOVSKY: That were making a decision.

3 MR. MULLER: Did anybody have any a priorities on --  
4 I would have thought many more people would use it given the  
5 complexity of the choice. I would assume that might be -- I  
6 know the President said people should rely on their families  
7 and friends but that strikes me as a low number. I didn't  
8 know if there were any estimates in advance as to how many  
9 people go to it. I tried it myself just to -- and in fact I  
10 thought it was quite, like many people, it was quite  
11 helpful. But again being reasonably used to computers it  
12 probably would be more helpful to people who do this all the  
13 time.

14 DR. SOKOLOVSKY: One thing that was interesting  
15 was that there were people who did a lot of research but  
16 they did research in the way that they were accustomed to  
17 doing research all their life before computers, which was I  
18 went to the book, I found out what plans were offered, then  
19 I got in touch with every plan -- in some cases that was a  
20 lot -- that was offering and asked them to send me all their  
21 materials so I could look at them and make a choice. Or it  
22 could call them and ask them about my particular drugs.

1           MR. HACKBARTH: Is it a concern that people will  
2 look at numbers like that, those low percentages, and say  
3 these are tools that weren't widely used, therefore we ought  
4 not invest in them? You can imagine, like the web site,  
5 that in subsequent iterations of this process that over time  
6 it might build up --

7           MR. MULLER: Age into it.

8           MR. HACKBARTH: In part because of the aging-in of  
9 the population, people more comfortable with computers aging  
10 in, but just word of mouth, people saying, this really  
11 worked good for --

12          MR. MULLER: Because e-mail use is quite high  
13 among the young elderly, way above 11 percent.

14          DR. MILLER: Joan, I also think you hit this point  
15 in your presentation but just to reinforce it, the  
16 counselors who were counseling the beneficiaries do depend  
17 very heavily on the web site.

18                 Let me just ask one more time on this number, the  
19 low usage. So we were able through either the survey -- I  
20 guess the survey in this instance, to determine that if  
21 somebody helped the beneficiary whether they had used the  
22 web site?



1 DR. SOKOLOVSKY: That's what the question asked.  
2 To course with all surveys you don't know exactly what  
3 people are answering compared to the question, but that is  
4 what the question asked, not just you but also the family or  
5 whoever helped you.

6 DR. MILLER: So the question was to the  
7 beneficiary, did someone help you, and did that person use  
8 the web site, was a sort of the question. We weren't asking  
9 the helper directly if they had used the web site?

10 DR. SOKOLOVSKY: That's right.

11 DR. MILLER: This is what I thought, because we  
12 had some of this conversation when we were just getting our  
13 heads around it. So that number that we just arrived at  
14 there, remember that's through the beneficiary. Somebody  
15 helped me. Did they use the web site? Then you're getting  
16 that second recall there. So I would just give you some  
17 caution on that number.

18 And then not to put you on the spot but the other  
19 way to inform this question is, when you were doing the  
20 focus groups, in there, either from the elderly or from the  
21 beneficiaries or from the helpers what was your sense of the  
22 use of the web sites in that setting?

1 DR. SOKOLOVSKY: It was still definitely a  
2 minority. The ones who were more likely to do it were the  
3 younger elderly, and in some cases the family members. But  
4 the family members complained they didn't have the time to  
5 do it.

6 DR. CROSSON: A question for Joan. Earlier on in  
7 the presentation, when you were talking about the  
8 categorization of people I got a little confused as to where  
9 the MA-PD people were. So on slide four, were they in the  
10 have signed up, the auto-enrollment category, or were they  
11 in the already had drug coverage category on slide six?

12 DR. SOKOLOVSKY: I think you've put your finger on  
13 one of the most puzzling aspects of the survey. If they  
14 said they got an auto-enrollment letter and it was from  
15 their MA-PD and they kept it, they were in the accepted  
16 auto-assignment. Some people clearly didn't understand the  
17 question and instead treated it as an alternative source of  
18 drug coverage. We saw that in the focus groups. In Tucson  
19 there were many people who were in MA plans and said, I  
20 didn't have to worry about Part D, I have drug coverage  
21 through my health plan. I really like it. I'm sticking  
22 with it, and it's even better this year than it was before,

1 with absolutely no concept that this was an MA-PD; it was  
2 just their MA plan. So I think that those people are  
3 scattered into different boxes.

4 MS. HANSEN: Two questions. I think we've been  
5 talking about some observations made/lessons learned and  
6 thinking that people will probably have another iteration of  
7 choice when the market starts to change. Are there some  
8 summary areas that we could identify as to how to do it  
9 differently and more effectively next time? That's one  
10 question.

11 The second question is, given the challenge of  
12 outreach in terms of -- which perhaps is an earlier  
13 presentation to the low income population that's still hard  
14 to find, and noted by the SHIP counselors, are there best  
15 practices that have been able to be identified as to groups  
16 that have been more effective in reaching this tough to  
17 access population?

18 DR. SOKOLOVSKY: I think that's an area where we  
19 need to do more work. It's clear that there has been a --  
20 all the counselors say that they're having a problem  
21 reaching them. I suspect we could find some sources that  
22 have been more helpful.

1           I can tell you that in our survey 10 percent of  
2 the survey said they applied for the low income subsidy, but  
3 of those only a third received it. So I think there is also  
4 that kind of issue.

5           DR. MILLER: To the first part of your question,  
6 some of my reaction in listening to this is the concept of  
7 communicating that we're talking about an insurance benefit  
8 here, and again what that means in marketing strategy and  
9 how one translates that I have no idea. But the notion that  
10 that doesn't seem to be breaking through.

11           And then secondly, if it is in fact that people  
12 are going to be going to the plan materials in their area,  
13 what attention is paid to be sure that those materials are  
14 readable, as comparable as possible from plan to plan, so  
15 that people can understand what they're looking at from plan  
16 to plan, are at least two things that struck me when I was  
17 listening to Joan.

18           MR. HACKBARTH: I agree with both of those points.  
19 I've looked at this step in the process as primarily trying  
20 to understand what's happening, as opposed to formulate very  
21 concrete recommendations. We can and should do that at a  
22 later point. But where this falls in our cycle and relative

1 to the report I think first and foremost this is information  
2 for us and for others to chew on on what's been happening  
3 real-time.

4 DR. REISCHAUER: I'm going to offer a couple of  
5 radical observations here. I think the big danger is that  
6 we spend too much time focusing on this issue and analyzing  
7 it, slicing it and dicing it. As several of you have said,  
8 this isn't the most consequential or irreversible decision  
9 in the world. People are going to have an opportunity once  
10 a year to change, number one.

11 Number two, the consequences of making a bad  
12 decision, meaning choosing plan B rather than plan A, are  
13 not huge here. They might be a few bucks here or there, and  
14 there is an element that ex ante one never knows what ex  
15 post is going to be the "right" plan given your drug needs  
16 over the course of the next 12 months, which you don't  
17 really know what they are. The wrong decision or bad  
18 decision is not to sign up at all, and that is clearly a  
19 wrong decision for somebody who has a heart attack the next  
20 month. But maybe not the most consequential wrong decision  
21 if you end up not having a catastrophic drug-dependent  
22 problem before the next sign up period. Then you're just

1 subject to the extra payment over the rest of your lifetime.

2 To take the very extreme example, you're somebody  
3 in Iowa who has as an opportunity a \$2.50 a month premium  
4 and I wait three years before I sign up and so I'm subject  
5 to 12 percent a year. Rather than \$2.50 I'm going to have  
6 to spend \$3.50 for the rest of my life on premiums. That's  
7 not the biggest hit in the world. So even the consequences  
8 of "wrong" decisions aren't --

9 We study and analyze what is a once in the history  
10 of this program situation, which is signing up a lot of  
11 people who are in other coverage or didn't have coverage and  
12 range in age from 65 to 100 and X. But three years from now  
13 that's not going to be the issue. It's going to be new 65-  
14 year-olds coming in and signing up who are going to do it in  
15 a very, very different way as part of the signing up for  
16 Medicare to begin with. And they're going to be in an  
17 environment which has a lot of experience out there, a lot  
18 of different kind of information that isn't available now,  
19 probably a much reduced set of alternatives because the  
20 number of offerings is undoubtedly going to shrink. They're  
21 going to have different capacities because they're going to  
22 be the young-old who are much more computer savvy, et

1 cetera.

2           So whatever we can learn from this process now  
3 might be very informative for political frustration and  
4 reaction in the next couple of elections but I don't think  
5 it's going to tell us a whole lot about how to design  
6 information systems and mechanisms for the decision process  
7 that we're going to face over the long run.

8           MR. DURENBERGER: I've been doing a lot of public  
9 television back in the fall and then again quite recently  
10 and I just want to go on record thanking Sarah and Joan and  
11 the staff you started this process for doing it because it  
12 was incredibly helpful to us in designing this last one,  
13 which is going to run twice a week between now and May 15th  
14 in the Twin Cities market and in some of the other related  
15 markets. Particularly the story about insurance, because it  
16 was very, very helpful to know how people have been making  
17 decisions. I agree with Bob about the fact, the emphasis  
18 has always been you can't get hurt making a decision. Make  
19 one. But some of you are going to make it for this reason,  
20 some of you make it for that reason, but understand the  
21 insurance.

22           Anyway, I'm really grateful to the staff for the

1 work and for taking the time to be helpful

2 My second comment, for some reason or other I  
3 often think like a legislator, but when I think in terms of  
4 the potential for near-term legislative changes two of the  
5 things that occur to me, one of them is, that I think I  
6 recall from Joan's information, a lot of people made a  
7 decision simply because of fear of the penalty. So one of  
8 the questions that will occur to people over time is, why  
9 the penalty? It's obviously a fundraiser. And the first  
10 time around it might have a lot of weight, but is that an  
11 appropriate mechanism for decisionmaking?

12 I don't know the answer to that but I'd love to  
13 know it.

14 The second one she raised also is the issue of  
15 comparability. I think we have all found over time, yes,  
16 obviously it's hard to do the first time around, maybe the  
17 second time around, but the changes that made consumer  
18 choice in the Federal Employee Health Benefit Plan work  
19 probably the best is, the more comparable you could make the  
20 plans, the benefits within the plan, the prices for those  
21 benefits and so forth, the easier it made the employee's  
22 choices. So I'd have a fairly strong interest in any



1 recommendations we might come up and the analysis that goes  
2 with it that would aim us in the direction of comparability  
3 of plans, benefits, and so forth in the future.

4 MR. BERTKO: I'd just like to respond to at least  
5 a part of Dave's second comment here in the penalty. Number  
6 one, there's comparability to Part B which has the penalty.  
7 It's same size of penalty percentage-wise in voluntary  
8 versus involuntary.

9 Number two, in the bidding for this, having a  
10 penalty there influences the risk mix. So using Joan's  
11 example there of the guy who was glad he had signed up  
12 because he then had an incident, the selection dynamics of  
13 who chooses, were they to be able to come in the month after  
14 they have a massive event is different than if you have a  
15 penalty in which they say, once a year I should think about  
16 signing up on this date, so that you have a more even mix of  
17 folks there.

18 If you change that, you then change the bids, you  
19 then change the cost to the Treasury. There's a whole set  
20 of dominoes that fall were you to make those changes.

21 MR. HACKBARTH: The logic of the penalties still  
22 seems sound to me for all those reasons, although Bob's

1 example about Iowa and the magnitude of the penalty being  
2 linked to the choice you make and the variation in premiums,  
3 on reflection does seem odd to me. To achieve the results  
4 that you're shooting for, you'd want it linked more to the  
5 underlying total cost of the program as opposed to the  
6 beneficiary's share.

7 MR. BERTKO: Let me answer that. The words in the  
8 statute actually are to be linked to that. But the default  
9 is, use 1 percent until you know what the actual cost is.  
10 And it's 1 percent of the average premium. So it's 1  
11 percent per month of \$32.20 a year for this year and then  
12 whatever it emerges in future years.

13 DR. MILLER: That was key to get out in this  
14 discussion because the penalty is linked to the average cost  
15 of the contracts.

16 MR. HACKBARTH: But it's still to a share of the  
17 cost as opposed to the total program cost including --

18 DR. MILLER: The beneficiary's share; that's  
19 right.

20 DR. MILSTEIN: I found the qualitative information  
21 on beneficiary success in decisionmaking extremely helpful.  
22 I think it would be even more helpful if we could find a way

1 to more routinely populate, I'll refer to it as our MedPAC  
2 dashboard, with quantitative information on the topic of  
3 quality of beneficiary decisionmaking, not just in relation  
4 to drug plans but in relation to all the important decisions  
5 that is implicit in Medicare enrollment, choice of doctor,  
6 choice of hospital, et cetera. I think it is especially  
7 important, obviously for a population that has the burden of  
8 increasing cognitive impairment.

9           The good news is I think there's been some pretty  
10 good social science progress, especially over the last 10  
11 years, in quantified measures of decisionmaking quality.  
12 I'm thinking about research on simply whether or not people  
13 had the correct understanding of the information done by  
14 Judy Hibbard. Some of her early work, for example, showed  
15 us that not just Medicare but any American beneficiaries  
16 shown HEDIS scores, to a very high percentage, were  
17 incorrect in what they believed was the favorable direction  
18 of the score. Often a low score was desirable. They  
19 thought and the cognitive testing showed that the  
20 beneficiaries thought that the high score was better. It's  
21 that kind of fundamental chaos in cognitive grasp.

22           And then secondly, and more recently folks like Al

1 Mulley have done some really nice -- assuming people do  
2 understand the fundamental facts, have done some very nice  
3 work on how we go about quantifying beneficiaries'  
4 concordance of choice with their intended preferences. So  
5 those are two needles that over time it would be, I think,  
6 very helpful for all us to begin to have on our dashboard,  
7 irrespective of the category of beneficiary decision that  
8 we're looking at. I think the qualitative evidence we've  
9 seen suggests a big opportunity to improve Medicare decision  
10 support and the value to us, if we could have a quantified  
11 measure that would allow us to build our recommendations  
12 around.

13 In retrospect, I helped three family members with  
14 their decisionmaking. I have to tell you, at the end I did  
15 not feel confident about the advice I gave and I'm only  
16 mildly cognitively impaired.

17 [Laughter.]

18 DR. SCANLON: Let me just disagree a little bit  
19 with some of Bob's heresy. I subscribed to most of it, but  
20 the idea that there is no bad decision at this point I think  
21 is something that we need to -- I want to take issue with.

22 For some individuals I think there can be a bad

1 decision and it's not one that we necessarily could have  
2 prevented. Part of the problem we have now is that there  
3 isn't enough information about plans. We've got some  
4 information about formularies and if you go the web site you  
5 can get some information about the formulary and the cost  
6 sharing. You can't get good information about the prior  
7 authorization. You can't get good information about the  
8 step therapy requirements and how they're going to work out  
9 in practice.

10           For people with chronic illnesses on a lot of  
11 medications, it may make a difference if they come into a  
12 plan and they do end up in a process of changing  
13 prescriptions and feeling that they have no choice but to go  
14 with the plan because this is what they can afford through  
15 their cost sharing. It's important for this next year and  
16 for the subsequent years to get more information about how  
17 plans are really working out there so people can make  
18 informed choices.

19           The other scary thing I think about what Joan has  
20 presented is I wouldn't say that the choices that have been  
21 made have necessarily been informed choices. It appears  
22 that a lot of people went on with very fragmentary

1 information. Going to your family and friends and asking  
2 them, should I buy a Ford or a Chevy may be a fine thing to  
3 do because they've got experience with Fords and Chevys.  
4 This is a new set of products that are out there. No one  
5 had experience with it. And where were they getting the  
6 information that they were using for advice?

7           Arnie, I would think would be responsible, he went  
8 and probably got information before he gave advice. But  
9 that's not necessarily the case for the large majority of  
10 the people that Joan has referenced as the source of  
11 information.

12           I think that we really need to think of what the  
13 short-term steps are we need to take to improve the  
14 information. Then we can use Bob's strategy for the longer  
15 run when we have a much smaller group and a much more  
16 informed -- and a very different market because we're going  
17 to have a very different set of plans out there that are  
18 going to be competing at some point in the future.

19           MR. HACKBARTH: Okay, thank you, Joan. Well done  
20 as always.

21           We'll have a brief public comment period.

22           Just the right length. We will reconvene at 1:30.

1                   [Whereupon, at 12:28 p.m., the meeting was  
2 recessed, to reconvene at 1:30 p.m., this same day.]  
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1           As this slide shows, the number of physician-owned  
2 specialty hospitals roughly doubled from 2002 to 2004. The  
3 proportion of physician-owned hospitals that specialize in  
4 cardiac care remained fairly constant.

5           As you may notice, we combined the orthopedic and  
6 surgical categories in this year's analysis. We do this  
7 because these hospitals often provide both orthopedic and  
8 general surgery services.

9           As this slide shows, the new specialty hospitals,  
10 shown there in pink, have tended to locate in many of the  
11 same states where specialty hospitals have located in the  
12 past. These were primarily states without certificate of  
13 need laws. The one state that didn't have specialty  
14 hospitals before that has gained some is Louisiana.

15           Physician-owned heart hospitals are often roughly  
16 50 beds. While some have struggled to obtain patients, most  
17 have an occupancy level that is above 60 percent.

18           Heart hospitals tend to focus on inpatient  
19 services and Medicare usually represents a majority of their  
20 patients. While some heart hospitals lose money and others  
21 are highly profitable, the median heart hospital tends to be  
22 slightly more profitable than the median community hospital.

1 As we explained last year, part of this is due to providing  
2 services that are favorably paid under our current payment  
3 system.

4           However, heart hospital profitability also depends  
5 on having a significant number of profitable private payer  
6 patients.

7           Orthopedic and surgical hospitals are smaller and  
8 have lower occupancy. Despite the low occupancy, most are  
9 highly profitable and generate a high rate of return on  
10 invested capital. By having a strong outpatient business,  
11 serving relatively less severe cases, and having a favorable  
12 mix of payers, most of these hospitals have been able to  
13 remain highly profitable despite lacking inpatient economies  
14 of scale.

15           Physician investors have told us they benefit from  
16 working in a specialty hospital with operating rooms that  
17 turnover at a predictable and rapid pace. Physicians can  
18 decrease the average amount of time they spend in the  
19 hospital per surgery. This allows them to either do more  
20 surgeries or to get home earlier to their families.

21           Operating rooms can turnover on a rapid schedule  
22 due to at least two reasons. First, they do not face

1 disruption from emergency cases. Second, they rarely face  
2 delays from operating on severely ill patients with  
3 complications.

4 Due to the practice style benefits and financial  
5 benefits of investing in these hospitals, physicians  
6 continue to have a strong incentive to invest in this type  
7 of facility.

8 Julian will now compare the relative costliness of  
9 physician-owned specialty hospitals with competing community  
10 hospitals.

11 MR. PETTENGILL: As Jeff mentioned, one of the  
12 issues that we wanted to revisit was the question of whether  
13 physician-owned specialty hospitals have lower cost than  
14 other hospitals.

15 As you recall, in our earlier analysis of 2002  
16 data, we found that physician-owned heart, orthopedic and  
17 surgical hospitals all had somewhat higher costs than their  
18 competitors and their peers. But none of the differences  
19 were statistically significant.

20 The 2002 length of stay data, however, showed that  
21 all three specialty hospital groups had shorter than  
22 expected lengths of stay. These results puzzled everyone

1 because everyone concluded well, if they have shorter stays  
2 why don't they have lower costs?

3           This time we're looking at cost data from the year  
4 2004 and we're using the expanded set of specialty  
5 hospitals. Again, we're also examining length of stay using  
6 claims data from the 2004 MedPAR file. As Jeff mentioned  
7 earlier, we combined the orthopedic and surgical hospitals  
8 into a single specialty group.

9           Overall our findings based on the 2004 data are  
10 very similar to the findings from 2002.

11           The next slide is just to remind you of the main  
12 features of our methods and then we'll get to the specific  
13 results. We standardized hospitals cost to control for  
14 factors such as case-mix and input prices that affect costs  
15 but are not related to efficiency. In the length of stay  
16 comparisons, we controlled for hospitals' case-mix and we  
17 also controlled for the regional pattern of length of stay  
18 in their location.

19           We compared standardized costs per case in length  
20 of stay in physician-owned hospitals, specialty hospitals,  
21 against their peers, competitors and all other community  
22 hospitals. As you may recall, the peer hospitals have a

1 high concentration in the same clinical specialty but they  
2 are not physician-owned and they are typically not located  
3 in the same market as the specialty hospitals. The  
4 competitor hospitals offer some of the same services as the  
5 specialty hospitals and they are located in the same market.  
6 All other community hospitals includes all other non-  
7 specialized community hospitals nationwide.

8           The next slide shows the mean and median  
9 standardized inpatient costs per case for these comparison  
10 groups. Standardized costs here are expressed as a  
11 percentage that is relative to the national amounts for all  
12 non-specialized community hospitals. In the middle column,  
13 for example, we see that the mean standardize costs per case  
14 are about 8 percent higher in physician-owned heart  
15 hospitals than in either the relevant peer or competitor  
16 hospitals.

17           The median in the right hand column, however, is  
18 just about the same, at 101, as those for the peers and the  
19 competitors. None of the differences here among heart  
20 comparison hospitals are statistically significant.

21           In contrast, the mean and median standardized  
22 costs for orthopedic and surgical hospitals are 31 percent

1 and 20 percent higher than the national amounts. The costs  
2 in these hospitals are significantly higher than their  
3 competitors.

4 The specialty hospitals' costs are also higher  
5 than the peers but the difference is not quite significant.

6 We conclude that heart specialty hospitals'  
7 inpatient costs are similar to those in other hospitals but  
8 orthopedic and surgical specialty hospitals clearly have  
9 higher inpatient costs than their competitors.

10 The length of stay data for 2004 tell essentially  
11 the same story that we saw in 2002. The middle column in  
12 this table shows the ratio of actual to expected length of  
13 stay, the expected length of stay accounts for the hospitals  
14 mix of cases, and the regional average length of stay in  
15 each APR-DRG and severity class.

16 Here both types of physician-owned specialty  
17 hospitals have shorter than expected lengths of stay and the  
18 differences are statistically significant when compared with  
19 the peers and the competitors. So again they have shorter  
20 lengths of stay but, at least in the case of orthopedic and  
21 surgical hospitals, they have higher costs.

22 As the next slide shows, two factors may account

1 for these apparently contradictory findings. Some owners of  
2 specialty hospitals suggested that their costs might be  
3 higher because they have higher capital costs. This would  
4 make sense because new plant and equipment would generate  
5 higher depreciation and lease costs than older assets found  
6 in competing hospitals. Excluding interest expenses capital  
7 costs are about four percentage points higher in the  
8 specialty hospitals as a share of operating expenses than  
9 they are in other hospitals. So higher capital cost might  
10 be part of the story.

11 But probably the most important factor here,  
12 particularly for the orthopedic and surgical specialty  
13 hospitals, appears to be that they operate with low  
14 inpatient volume, and they have chronically underused  
15 capacity. 60 percent of the physician-owned orthopedic and  
16 surgical specialty hospitals have fewer than 20 beds and  
17 more than 70 percent of them have occupancy rates under 35  
18 percent. It's hard to achieve low inpatient costs per unit  
19 when nearly two-thirds of your capacity is empty.

20 The next slide, and last slide in this section,  
21 shows this graphically. As you can see on the left-hand  
22 side of the chart, almost half of the specialty orthopedic

1 and surgical hospitals, who are in yellow, have under 500  
2 discharges per year. Many of them also have low occupancy  
3 rates which tends to raise their costs even higher than they  
4 would be otherwise. But this is a price that they seem to  
5 be willing to accept on the inpatient side while they carry  
6 out the bulk of their business performing outpatient  
7 procedures.

8           Now Jeff will come back to the new findings on  
9 specialty hospitals' Medicaid shares.

10           DR. STENSLAND: An additional issue from our  
11 specialty hospital report last year was the payer mix of  
12 physician-owned hospitals. The median community hospital  
13 reported that 13 percent of their discharges were Medicaid  
14 patients in 2004. We would expect specialty hospitals to  
15 have a lower share of Medicaid patients due to not offering  
16 specific types of services such as obstetrics. However,  
17 when we compare physician-owned specialty hospitals to peer  
18 hospitals that have a similar level of specialization, we  
19 find that the median physician-owned hospital still has a  
20 slightly lower Medicaid share. Our findings are similar to  
21 research by the GAO.

22           The lower Medicaid share suggests that other



1 specialty hospital characteristics, such as location,  
2 mission, insurance contracts or physician financial  
3 incentives, may contribute to physician-owned hospitals  
4 having a slightly lower median Medicare share than their  
5 peer hospitals.

6           We also examined the question of utilization last  
7 year. Historically, when physicians have invested in  
8 imaging centers or diagnostic labs, the physicians'  
9 investment was then often followed by an increase in  
10 utilization of the lab or imaging services. However, it's  
11 not clear that physician investment in heart hospitals would  
12 induce more invasive procedures such as cardiac surgery.

13           First, we test whether utilization increases when  
14 a physician-owned heart hospital enters a market. Second,  
15 we evaluate whether physicians are following their financial  
16 incentives to shift surgical volumes toward the more  
17 profitable surgeries such as CABG surgery or surgery on less  
18 severely ill patients. We use the ratio of low severity  
19 surgeries to high severity surgeries in any market as an  
20 indicator of whether cardiologists and surgeon investors are  
21 changing the mix of cardiac surgeries when they become  
22 investors in a heart hospital.

1           We examined utilization from 1996, a year prior to  
2 the opening of heart hospitals, to 2004. From 1996 to 2004  
3 the rate of cardiac surgeries per capita increased by 5.2  
4 surgeries per 1,000 beneficiaries in markets without  
5 physician-owned hospitals and by 7.8 surgeries per 1,000  
6 beneficiaries in markets with physician-owned hospitals.  
7 That difference is statistically significant.

8           Our multivariate analysis suggests that the  
9 overall rate of cardiac surgeries increased by roughly 6  
10 percent following the entrance of a typically sized heart  
11 hospital.

12           Our regression model also estimated the impact on  
13 specific types of surgeries. An increase in heart  
14 hospitals' market share is associated with a statistically  
15 significant increase in CABG surgeries. The increases in  
16 angioplasties and defibrillator implantation are not  
17 statistically significant. Interestingly, the ratio of more  
18 profitable low severity surgeries to less profitable high  
19 severity surgeries did not increase significantly faster in  
20 markets with physician-owned heart hospitals. We found that  
21 the entrance of physician-owned heart hospitals may increase  
22 both the rate of highly profitable surgeries and the rate of

1 less profitable surgeries. Therefore, the increase in  
2 cardiac surgeries associated with physician-owned hospitals  
3 may be purely due to the increased surgical capacity  
4 associated with building a new heart hospital.

5           If the physicians' financial incentives are  
6 causing a shift toward more profitable surgeries, the  
7 magnitude of that shift is too small to be detected with our  
8 tests of statistical significance.

9           To sum up here, heart hospitals do appear to cause  
10 an increase in utilization. The increase may be purely due  
11 to surgical capacity in the market, though we can't rule out  
12 the possibility that financial incentives are having some  
13 effect.

14           The increased utilization only accounts for  
15 roughly 6 percent of the median heart hospitals' 26 percent  
16 market share. Therefore, the heart hospitals appear to  
17 obtain roughly four-fifths of their patients by capturing  
18 market share from community hospitals.

19           A logical next question is how does this affect  
20 the community hospital?

21           We examined profit margins, revenue and patient  
22 flows at community hospitals given those same years, from

1 1997 through 2004, and we found that heart hospitals do  
2 divert patients from community hospitals, causing a decline  
3 in the community hospitals' Medicare revenue. However,  
4 representatives of community hospitals have told us they  
5 have been able to expand other sources of revenue to  
6 compensate for much of the revenue loss to specialty  
7 hospitals.

8           The net result has been no statistically  
9 significant impact on the hospitals' total revenue or total  
10 margins. The median community hospital competing with heart  
11 hospitals had a total margin that was in line with the  
12 national average.

13           You may ask why community hospitals in markets  
14 with physician-owned hospitals tend to have fairly healthy  
15 profit margins. Our data indicates that physicians tend to  
16 invest in hospitals that locate in growing markets. A  
17 regression analysis found that population growth has had a  
18 significantly positive effect on hospital profit margins but  
19 the competition from physician-owned specialty hospitals has  
20 not.

21           We also tested for the impact of the much smaller  
22 orthopedic and surgical hospitals on community hospitals.

1 In that case we found no statistically significant effect on  
2 community hospitals' revenue or profit margins.

3 We'd now like to hear your comments and answer any  
4 questions you have.

5 DR. KANE: A couple of questions both on the total  
6 revenue and total margins, did you include investment income  
7 or did you try to pull that out so just closer to operating  
8 results?

9 DR. STENSLAND: I left that in there basically  
10 because I don't have that much great confidence in them  
11 distinguishing between operating and total on the cost  
12 reports.

13 DR. KANE: So it's hard to tell whether there was  
14 just better returns in the stock market.

15 DR. STENSLAND: I think because we did it across  
16 the nation we're comparing different parts and to see how  
17 fast did you grow from 1996 to 2004. Unless there was  
18 something unique about markets that had physician-owned  
19 specialty hospitals and somehow they were invested in better  
20 stocks than hospitals in other parts of the country, we  
21 should be okay.

22 DR. KANE: I think the other question, and I think

1 it raises a theme that I keep bringing up and maybe it's not  
2 MedPAC's concern but maybe we should talk about it, is the  
3 issue of affordability of all of these different things that  
4 happen. For instance, if Medicare allows specialty  
5 hospitals to pull revenues out of community hospitals and  
6 community hospitals find ways to make up for that, that  
7 could be one way to make up for that is to raise the charges  
8 to the private payer and do something that makes it less  
9 affordable on the non-Medicare side.

10 So the other question is a little bit broader and  
11 probably not even directed at you, which is should we be  
12 thinking about those kinds of costs or potential cost shifts  
13 when we're thinking about Medicare policy? That's maybe a  
14 broader discussion.

15 DR. STENSLAND: I'll give you a just a small  
16 tidbit from our less discussion on our site visits. There  
17 were a few people that we asked how did you overcome the  
18 loss of revenue. In a couple of cases their answer was we  
19 had some aggressive price negotiations with the insurers.

20 MR. HACKBARTH: But as I recall that report, there  
21 were a variety of reasons. In some cases they cut costs.  
22 In other cases they developed new services that were

1 profitable. There were just a variety of reasons and  
2 methods. Is that right?

3 DR. STENSLAND: They said those two things.  
4 Somebody said specifically we took a hard look at our FTEs,  
5 meaning they were looking at cutting costs. Some other  
6 people said we started up other activities such as pain  
7 management clinics and that kind of thing. So there was a  
8 broad range.

9 MR. MULLER: Thank you. This is helpful.

10 It's kind of a bizarre public policy outcome that  
11 we have occupancy of less than 35 percent on 70 percent of  
12 the facilities and yet we have high margins. I think  
13 normally, as one thinks to try and use expensive assets  
14 quite well and one has occupancy rates of 60 or 70 or 80 or  
15 90 percent. And yet here we have below 35 in a whole number  
16 of facilities with very high margins. So it strikes me that  
17 we've brought capacity into the system that has high margin.

18 I note that, as we did two years ago, there's a  
19 very low Medicaid percentage. So obviously one could get a  
20 little bit more occupancy by taking some Medicaid patients  
21 but that obviously would have some effect on margin. These  
22 things seem to run together, low occupancy and high margins.

1           Again, having that kind of investment in capacity  
2 that isn't fully utilized just strikes me as a bizarre set  
3 of investments for us to have.

4           What's the kind of sense that -- are there any  
5 plans to increase his occupancy? Or is that outside our --

6           MR. PETTENGILL: I think it's important to  
7 remember here that the group of hospitals that that finding  
8 applies to are the orthopedic and surgical hospitals. And  
9 the margins that we're talking about here are total margins,  
10 not Medicare margins or Medicare inpatient margins. And so  
11 they have very low occupancy on the inpatient side and they  
12 have high costs on the inpatient side, and in fact they're  
13 almost certainly losing money on the inpatient side. But  
14 most of their business is outpatient business and private  
15 payers are a much bigger fraction of their patient load than  
16 would be the case say for heart hospitals.

17           So I think that's what reconciles all this.  
18 They're making a lot of money on outpatient activity,  
19 primarily in the private sector.

20           MR. MULLER: Again, I would assume, as we find in  
21 other hospitals, they would lose money on their outpatient  
22 side in Medicare or not? Do you have numbers on that?



1 MR. PETTENGILL: I don't know.

2 MR. MULLER: We always have -- that's more general  
3 community rates. We have like minus 12 or minus 15 percent  
4 margins across the whole book of business on the outpatient  
5 side normally. But my guess is about the full array of  
6 services, they may not have that so it may be too hard to  
7 extrapolate.

8 DR. STENSLAND: We have that data but not with us  
9 here. We can get back to you on that.

10 MR. HACKBARTH: And the ortho surgical hospitals  
11 are very small, on average, 14 beds. So the difference  
12 between a 25 percent occupancy rate and a 60 percent  
13 occupancy rate is a few patients a day.

14 MR. MULLER: And they're almost like a big surgery  
15 center. In a sense, when you have 35 percent on 20 beds  
16 it's like a surgery center with a few beds attached almost.  
17 If you think of a mental image of what they are.

18 DR. REISCHAUER: These are occupancy rates on 365  
19 days a year? Because I would think small physician-owned  
20 facilities would maybe close down for a couple of weeks and  
21 Christmas.

22 MR. MULLER: Open Tuesday and Wednesday.

1 DR. REISCHAUER: So you've got huge variation.

2 MR. BERTKO: Jeff, can I ask a follow-up question  
3 to slide 16? The numbers here, as you've displayed them,  
4 are pretty small, 1 percent. And I guess it's clarification  
5 here. If you do the multiplication at 26 percent market  
6 share, that looks like it's an increase of about two  
7 surgeries per thousand Medicare beneficiaries, if I'm  
8 interpreting that about right.

9 DR. STENSLAND: That would be about right.

10 MR. BERTKO: So the next question is can you  
11 compare that to something? The number I've got running  
12 around in my head, from the back of here is that it's a  
13 total of about 60 to 70 admissions per any thousand Medicare  
14 members. And again a second one on cardiac care is about 1  
15 to 2 percent, so maybe 10 to 20.

16 My question there would be a follow-up point might  
17 be that increase of two compared to 10 or 20. If it's  
18 compared to two, I'd say that a 20 percent increase in  
19 supplier induced demand is a pretty big number. If it's  
20 part of some much bigger denominator, perhaps then you don't  
21 worry about it.

22 Am I thinking about this correctly?

1 DR. STENSLAND: The typical market had about 32  
2 cardiac surgeries per 1,000 Medicare beneficiaries. So then  
3 you're getting back, it's still closer to around that six,  
4 or a little less than 10 percent. It's not nothing but it  
5 is -- and there's also, I've got to remind people that there  
6 is a confidence interval around here. We're not saying it's  
7 exactly 6 percent. It could be a few percent lower or a few  
8 percent higher because we have a limited sample of data.

9 MR. BERTKO: So that might be another follow-up  
10 point, looking at the Wennberg small market analysis and say  
11 where do these kind of places, markets with specialty  
12 hospitals fit in it? While the costs all seem okay for  
13 cardiac, the supplier induced demand might be something we  
14 should be worried about.

15 DR. CROSSON: I think maybe I have a little  
16 different perspective. I'm fully aware of how politicized  
17 the issue has become since we started talking about it two  
18 years ago, almost two years ago.

19 But it seemed to me at the time, when we discussed  
20 this, we were saying what do we think about this phenomenon?  
21 Is it a good thing or a bad thing? Because there are  
22 certain aspects of innovation and perhaps useful competition

1 that are inherent in this and a desire to not simply stifle  
2 that out of hand. We had two concerns at the time and  
3 inadequate data or early data to analyze it.

4 One was was this going to have a progressive  
5 deleterious effect on community hospitals? And therefore,  
6 for a whole range of reasons, that would outweigh the  
7 inherent value that we saw in it.

8 And number two, was there something inherent in  
9 this that was, in fact, an obvious conflict of interest as  
10 it related to the physician ownership piece?

11 I think, as we then went further on, we said well  
12 let's follow this for awhile. But in the meantime, as part  
13 of a larger set of questions, we should at least recommend a  
14 level playing field with respect to payments. And we  
15 recommended the rebasing of the DRGs, which apparently is  
16 going forward.

17 So assuming that that does go forward I guess I  
18 wonder now, two years later, whether we have sufficient  
19 reason to believe that either one of our two concerns are  
20 manifestly true. Because I don't see it in this data.

21 So I guess that would lead me to say we should be  
22 more cautious rather than not at this point, since the

1 evidence is not mounting, at least one from what I can see  
2 here, the evidence is not mounting to support either at  
3 significant deleterious effect on community hospitals or an  
4 obvious impact of so-called conflict of interest on the part  
5 of physicians. That's what I see in the facts. And if  
6 that's not the case, then I'm wrong. But that's what I see.

7           We were worried two years ago about, at this  
8 point, seeing significant harm to community hospitals and  
9 seeing data that appeared to show progressive financially  
10 driven decisionmaking on the part of physicians. And I  
11 don't see either one of those.

12           MR. HACKBARTH: I suspect we'll have some people  
13 who want to think about that and respond to it. Let me just  
14 proceed with the queue and then we can tackle Jay's  
15 questions.

16           MR. DURENBERGER: Jay has asked my first question,  
17 which relates particularly to conflict of interest. Arnie  
18 just mentioned another one, which was the volume increase  
19 issue.

20           But my other question deals with the nature of  
21 both cardiac surgery, orthopedic surgery, and other  
22 surgeries. And it's an apples and oranges question. When

1 we compare beds and beds and beds and beds, we don't  
2 recognize the rapid changes that take place in the  
3 application of technology to orthopedic surgeries, cardiac  
4 surgeries and other surgeries.

5           While I understand what the data tells us for this  
6 purpose, I don't understand how we can compare an orthopedic  
7 hospital bed with a community hospital bed unless in every  
8 community hospital there's a dedicated orthopedic bed or a  
9 dedicated cardio or thoracic or something bed, which I don't  
10 assume there is.

11           So what's that got to do with costs -- I'm getting  
12 to the cost. Does it cost the same thing to build a bed or  
13 design a bed and equip it and so forth in a community  
14 hospital as it does in an orthopedic hospital? I'm assuming  
15 it costs a lot -- probably costs less in an orthopedic  
16 hospital. But I don't know because I don't have that kind  
17 of information.

18           Is that an inappropriate question?

19           DR. STENSLAND: I think that relates a little bit  
20 to the depreciation number, that you have this apples and  
21 oranges situation, where you do see a little higher  
22 depreciation in these specialty hospitals. We can't exactly

1 say how much of that is due to them being newer facilities  
2 and how much of it is due that they have a different service  
3 mix.

4           For example, if their patients are using the OR  
5 and the equipment in the OR, maybe it's a more capital  
6 intensive kind of an operation.

7           So it does fit in there. We have to have some  
8 sort of caution in our 4 percent depreciation figure. The  
9 occupancy, I think it's pretty straightforward. In some of  
10 these cases they did tell us on the weekends we're kind of  
11 shut down.

12           MR. DURENBERGER: And I think this was a poorly  
13 stated question. I think about my recent orthopedic  
14 surgery, relatively minor. But I was in a big public  
15 hospital, in their main OR, and I was in there because there  
16 isn't some separate ortho OR or something like that. But I  
17 think if there could be a separate ortho OR, unless you tell  
18 me no, all operating rooms have to be the same, they have to  
19 be equipped the same, they have to be staffed the same, all  
20 the rest of that sort of thing. Somehow I don't believe  
21 that.

22           So I'm getting at the apples and the apples and

1 the apples versus the oranges when we compare costs and  
2 margins of an orthopedic or other surgery facility,  
3 specialized surgery facility with a community hospital.

4 DR. MILLER: Can I try something here? I'm not  
5 100 percent sure I've got a grasp of with your question.  
6 But I thought what they were saying when they went through  
7 the result on the orthopedic is this is a different animal.  
8 And I think Ralph ended up with the kind of one sentence  
9 version of it, which is when you make these comparisons and  
10 you find this drastic difference between the occupancy  
11 rates, to take Ralph's view on it -- but I think these guys  
12 were saying it as well -- these are basically outpatient  
13 operations with some beds. And so the occupancy rates are  
14 considerably lower.

15 In that sense it is a different animal. And I  
16 think that's what they were getting across. But I'm still  
17 not sure that's your question.

18 MR. DURENBERGER: No, it is my question and I'm  
19 raising it only because when we take summary information and  
20 we pass it on to people that don't spend the amount of time  
21 trying to analyze it that we spend here trying to analyze  
22 it, they may come to very different conclusions, unless they



1 have something like Ralph to raise the kinds of questions  
2 that he raised.

3 DR. MILLER: We could think about sending Ralph  
4 around.

5 First of all, I think your point in this room and  
6 this slide is well taken because people could walk out with  
7 the slide and end up with different conclusions.

8 In the chapter however, I think this point is  
9 drilled pretty hard if I remember the text right. I could  
10 take a nod from one of you two, if that's true.

11 DR. STENSLAND: One thing we can do to clarify it  
12 is maybe we could you put in some -- the lower 10 percent  
13 occupancy and the upper 90 percent occupancy for orthopedic  
14 hospitals and their peers. Because we do see some range,  
15 they're not all the same thing. We're reporting the median.  
16 But we do see some orthopedic hospitals, in particular some  
17 of the peer hospitals stuck in my mind as having some fairly  
18 high occupancy rates.

19 So that tells me well, it can be done. It's not  
20 like it's technologically infeasible to have a high  
21 occupancy rate in an orthopedic hospital. It's just that  
22 some of these orthopedic and surgical hospitals, in some

1 cases they used to be ASCs and when they become a hospital  
2 they can get higher outpatient rates and they can also  
3 engage in more imaging and things. So there is some  
4 rationale behind pure efficiency for becoming a hospital.

5 MR. PETTENGILL: It's worth noting that even among  
6 the orthopedic and surgical specialty hospitals, there's  
7 quite a range in size. There are quite a few that are under  
8 10 beds. But there are some others that have 60 beds. So  
9 they're not all the same thing. And the occupancy rates are  
10 similarly variable. There are a few hospitals that have  
11 occupancy rates over 60 percent but not many. Most of them  
12 are lower.

13 MR. DURENBERGER: Mr. Chairman, I am only raising  
14 the question because of we're concerned about saving  
15 community hospitals from whatever this phenomenon is, then  
16 that's one issue. If we're concerned about accessing  
17 beneficiaries to the highest and best and the latest and  
18 whatnot, then that's a whole another question or it seems to  
19 be a whole another question. I know we're working our way  
20 towards that one but I'm not sure that we're more than  
21 halfway there.

22 DR. REISCHAUER: Dave was talking about apples and

1 oranges. I think I'm going to slide into kumquats here.

2 This maybe is a question for Nancy more than  
3 anybody else and I want to know how to think about capital  
4 costs in a physician-owned enterprise. If capital costs are  
5 high, isn't the equity of owners increasing? And so in a  
6 sense this should be on the physician reimbursement side?

7 You know, in a non-profit situation the capital  
8 gets paid for and then a non-profit owns it. In a  
9 physician-owned enterprise it ends up being an equity  
10 position of the physician who then can retire, sell out and  
11 walk away. No?

12 DR. KANE: I don't think that's how their  
13 measuring it. They're taking the actual write-off of the  
14 acquisition costs of the building and the materials, the  
15 building and equipment and then adding probably the  
16 borrowing costs for the building and equipment. There's an  
17 interest expense that you were mentioning. I don't think  
18 they're taking the accumulated -- I don't think the return  
19 on equity is being consider part of the capital costs of  
20 these things yet. It doesn't look like that's how you did  
21 it. You said depreciation and interest.

22 DR. STENSLAND: What we did is we --

1 DR. KANE: But you're right, that would make it  
2 even higher if you added the equity takedown after -- if you  
3 take out the equity later.

4 DR. STENSLAND: We consider depreciation a real  
5 expense. I guess the financial analysts could do this two  
6 different ways. In one they consider depreciation is really  
7 an expense, things are wearing out. And sometimes they just  
8 look at the cash flow and say this is a non-cash expense.  
9 And maybe that building really isn't becoming less valuable  
10 over time and then you wouldn't take it out. But we did take  
11 that out when we looked at the relative profitability of  
12 these things.

13 In terms of the interest expense, because what  
14 usually happens, often for the community hospitals you get a  
15 lot of the money donated to build your new building. With  
16 these hospitals a lot of times they're borrowing a lot of  
17 the capital to build the facility. So there's kind of a  
18 difference in the financing mechanism there.

19 Therefore, we brought that back out. So these are  
20 costs exclusive of interest because we didn't want to, in  
21 essence, make the physician-owned hospitals look less  
22 profitable just because they're borrowing the money to build

1 the hospital rather than having the money given to them to  
2 build a hospital.

3 MR. HACKBARTH: I want to go back and take a stab  
4 at Jay's question. My personal bias is in favor of more  
5 competition, not less. To the extent that we identify  
6 problems I always want to, where possible, use the least  
7 restrictive alternative, restrictive in terms of reducing  
8 competition for dealing with the problem.

9 Issues about competition among hospitals are not  
10 new. Complaints among hospitals about their competitors are  
11 not new. Many of the same things being said about specialty  
12 hospitals have been said by not-for-profit hospitals about  
13 poor profits and by urban hospitals about suburban  
14 hospitals. That's just, to me, in part the nature of  
15 competition.

16 Given that, my preference has always been first  
17 and foremost let's fix payment problems which level out the  
18 playing field. We've made our recommendations on that and  
19 I'm hopeful that significant headway will be made there.

20 I happen to think, and this is just my personal  
21 hunch, that if that were to happen that would significantly,  
22 in and of itself, dampen investment in physician-owned

1 specialty hospitals. I'm not sure that it would eliminate  
2 it but I think the rapid growth that we saw in 2001, 2002,  
3 2003 would not be continued under a fair payment system.

4           To take the added step of outlawing this type of  
5 institution, just a priori we won't permit it, to me  
6 requires a really compelling case because of my preference  
7 for competition. And like Jay, I don't see that threshold  
8 as having been met to this point.

9           As I look at the evidence I see a mixed bag.  
10 There are pieces of it that are somewhat troubling but not  
11 so much so that I think they amount to a really convincing  
12 case that this is absolutely a bad thing.

13           As I said in our previous discussions of this, I  
14 have some sympathy for physicians about the challenges they  
15 face in at least some hospitals in getting a practice  
16 environment that allows them to practice efficiently and  
17 practice high-quality and high satisfaction medicine for  
18 their patients. Those are real tangible issues at some  
19 places. And this is one type of response that physicians  
20 can take under those circumstances. I have some sympathy  
21 for that.

22           I've been particularly interested in evidence

1 about the quality of care because to me the hypothesis that  
2 you might be able to produce a higher quality of care in  
3 this sort of setting is not an outrageous one on the face of  
4 it, that you might be able to organize the process  
5 differently, hire differently, staff differently to produce  
6 a better product.

7           To this point the evidence, as I understand it,  
8 with regard to cardiac care, which I think has been most  
9 studied, is that well, there is some evidence of improved  
10 outcomes but they may be accountable based on size and the  
11 amount of surgery being done as opposed to something  
12 inherent in physician ownership. There is a fair statement?

13           I think that's an issue that needs to be studied  
14 further. Again, I don't think it's an outrageous idea that  
15 this sort of organization might be able to improve quality.

16           Given the challenges we face with quality in our  
17 health care system to just a priori say this is outlawed,  
18 when the evidence is this ambiguous, I think would be just a  
19 real public policy mistake. Not looking for the least  
20 restrictive alternative but for the most dramatic  
21 alternative.

22           So let's fix the payment system and I think that

1 will largely resolve the issue. And then let's let the  
2 evidence accumulate a bit and see what it says.

3 MR. MULLER: I remember the data differently than  
4 you just summarized it. My memory of our information a  
5 year-and-a-half ago was that the severity was much less in  
6 the specialty hospitals and therefore when you have lower  
7 severity even within a DRG, you should have a better outcome  
8 if the outcome measure is not appropriately severity  
9 adjusted.

10 So the why I would read that -- I'm trying to  
11 remember now, I haven't looked at the chapter in over a  
12 year. There's anywhere from 20 to 50 percent difference in  
13 the severity which one might mitigate with the APR-DRG  
14 system. But there was quite a big difference in severity  
15 between the specialty hospital mix and the regular mix. So  
16 therefore one should have much better outcomes with that --

17 MR. HACKBARTH: What I'm referring to Peter Cram's  
18 study at Iowa which to the best of my limited knowledge is  
19 the one that's taken the deepest look at quality differences  
20 for cardiac care. I think he adjusted for severity  
21 differences, found slightly better outcomes. But his  
22 hypothesis that that might be attributable to scale. Is



1 that a fair summary of his work?

2 DR. STENSLAND: I think he said that on average,  
3 controlling for severity, the specialty hospitals looked a  
4 little bit better. But then when you also controlled for  
5 size they didn't look any better. So once you control for  
6 size and severity, he basically said there was no  
7 difference.

8 I think the one cautionary tale we get from our  
9 specialty hospital volume chart that we see out there is not  
10 all physician-owned special hospitals really have high  
11 volume. There's a couple of them that are really low volume  
12 facilities. So we can't just always categorize physician  
13 ownership equals high volume.

14 MR. HACKBARTH: I vaguely recall that there was  
15 also a more recent study done on quality in orthopedic and  
16 surgical hospitals.

17 DR. MILLER: That's not out.

18 MR. MULLER: Just looking at slide four on the  
19 geographic dispersion, the concentration, and my memory  
20 looked remarkable similar to the graph we had a long-term  
21 care hospitals before they started diffusing around the  
22 country.

1           Obviously, with the certificate of need  
2 limitations in most of the Eastern states, in the green, you  
3 could see why before the moratorium they perhaps didn't get  
4 there. Obviously without a moratorium -- and if the payment  
5 changes go through then I think I agree with Glenn and Jay  
6 that that should have a big effect on the spread, if in fact  
7 those changes are made.

8           If they're not made, one could certainly see the  
9 concentration that's basically in the southern middle of the  
10 country now going to other parts of the country because they  
11 would be seen for a variety of reasons as very attractive  
12 places to invest with 30 or 40 percent rate of returns for  
13 one set of them and so forth.

14           Obviously, the extent to which those rules have  
15 now been announced, those you pointed out earlier today in  
16 another setting, they may be implemented in a two-year  
17 period rather than a one-year period. When we made our  
18 recommendations a year or so ago, we had preferred they be  
19 implemented in one stroke together, rather than over a  
20 period of time.

21           MR. HACKBARTH: Just a couple of quick reactions  
22 to that. Within our system if there are states who don't

1 share my preference for competition and who are very  
2 concerned about this development, they can prohibit it and  
3 we don't have to do it on a national basis. We can do it on  
4 a more local basis. That's point number one.

5 Point number two is I'm troubled that we have some  
6 people, some organizations, simultaneously arguing that we  
7 shouldn't refine the payment system and we ought to outlaw  
8 physician-owned specialty hospitals. They're doing what  
9 they can to block more accurate payment. And then they also  
10 want to block competition. That's a combination that I find  
11 especially unpalatable.

12 DR. MILSTEIN: A couple of comments and then a  
13 question.

14 First, I'd like to join the chorus of those who  
15 believe that competition that would likely benefit the  
16 Medicare program and all of their payers and that we ought  
17 to be biased substantially in favor of embracing innovations  
18 that appear to be a more cost-effective means of health care  
19 delivery than what we've got.

20 That said, I think that we have evidence in this  
21 presentation that simply better tuning the payment system  
22 ain't enough. If we could just put slide 15 up there, it

1 is, I think, a nice anchor point.

2 Slide 15 shows us, in the far right-hand column,  
3 that we have a 2.5 point impact on rate of growth of  
4 procedures associated with introduction of specialty  
5 hospitals. I submit to you that a 2.5 point opportunity in  
6 growth of services, absent pre-existing evidence that there  
7 was some kind of a supply constraint, which we don't have  
8 here, is fairly alarming from the point of view of  
9 sustainability of the Medicare program. If anything, we  
10 ought to feel comfortable at approving things that generate  
11 a 2.5 point increase in volume. Absent evidence that that's  
12 more than offset by some reduce in unit price, it would be  
13 enough to take our unsustainability and the actuarial  
14 projections for Medicare into a very alarming place.

15 So as I look at the evidence I come at it a little  
16 differently than Jay for that particular reason.

17 My question really relates to this. As I'm  
18 thinking about cost comparisons between these focused  
19 factories and general acute hospitals, it's obvious that one  
20 of the costs that we need to make sure we account for in  
21 doing these comparisons is the cost burden on the community  
22 hospital of stepping in when things don't go well in the

1 specialty hospital. I'm wondering whether or not -- I'm  
2 trying to remember back in our prior calculations whether at  
3 any point along the way we attempted to factor in to the  
4 cost comparison the incremental cost burden on the community  
5 hospital of providing the backup capacity to handle cases  
6 that go wrong in the focused factories.

7 DR. STENSLAND: I think from the orthopedic and  
8 surgical hospitals, the number of cases that go wrong, if I  
9 remember right from our last analysis, it was pretty small.  
10 That's often because they specifically don't want those  
11 cases. A lot of times they tell us they only want people  
12 with anesthesia risk of one or two, that aren't going to  
13 give them any trouble, so they know when they'll go in,  
14 they'll know when they go out, and they can keep their  
15 operating room humming.

16 The heart hospitals, I still think those cases are  
17 also fairly small. And they were, I think, able to handle  
18 most of their cases. And the number of transfers were  
19 fairly small there, too. There would be a small number of,  
20 I guess multisystem failures they would have to deal with.

21 DR. MILSTEIN: That's reassuring, although a small  
22 number of cases that have a very big cost tail might inform

1 this comparison, at least on heart hospitals.

2 DR. STENSLAND: Maybe the one last thing on the  
3 standby capacity, that is probably a real issue. Not so  
4 much that the community hospital has to have more standby  
5 capacity, it's that the heart specialty hospital doesn't  
6 have to have standby capacity. So sometimes we see these  
7 places with very high occupancy because if they don't have  
8 any room then they just send the person to the community  
9 hospital.

10 DR. MILSTEIN: Is it feasible, within a next  
11 iteration of this, to attempt to bring into that cost  
12 comparison those two factors? Or is that beyond what our  
13 current database would allow?

14 DR. STENSLAND: It might be difficult to get that  
15 done. We would have to conceptualize exactly how we were  
16 going to do it first.

17 DR. MILLER: I would have even chosen a word  
18 that's bigger than difficult. Particularly the transfer  
19 point of the case at a point when it's okay, I've got a  
20 problem here, I need to send it out of the specialty  
21 hospital to the community hospital and it's something that  
22 went south on the physician.

1           We, in the last report, looked at some of the  
2 transfer patterns. And it got pretty complex and started to  
3 stretch the limits of the data, as I recall it.

4           We will absolutely take another look at this but I  
5 don't want to promise in this room that that very question  
6 can be nailed down. I remember us getting well past the  
7 limits of our data in that analysis.

8           DR. REISCHAUER: The right thing to do would be to  
9 take the cases that go wrong over and above what would have  
10 gone wrong in the community hospital, so it makes it an even  
11 smaller number.

12           DR. MILLER: I think that's the word that's bigger  
13 than difficult.

14           [Laughter.]

15           DR. MILLER: I was just reading that section of  
16 the report and remembering how complicated even what little  
17 we had here got.

18           DR. SCANLON: I do think that just as a first step  
19 the payment changes obviously -- I mean, there's no way that  
20 reasonable people should oppose it and it will probably have  
21 a big effect.

22           But in terms of the impact of the specialty

1 hospitals, I guess I believe the evidence is not necessarily  
2 sufficient now to reach a strong conclusion in either  
3 direction.

4 Part of it relates to how I feel about competition  
5 in health care. While competition is normally a good thing,  
6 part of that is based on the premise that demand is fixed  
7 and that suppliers are going to be competing either through  
8 quality or price to try and get a bigger slice of the demand  
9 that's out there.

10 The reality in health care is that we've seen over  
11 and over again that suppliers can influence demand. The  
12 fact that we've seen to date potentially less impact on  
13 community hospitals, we've said that part of that is the  
14 community hospitals have managed to increase demand for  
15 other things. And over a longer period of time we may see  
16 that one of the consequences of having more capacity for  
17 cardiac hospitals is that we have more people going into  
18 that specialty and we see even a bigger increase than what  
19 Arnie just pointed out in terms of this response over this  
20 short period of time.

21 So it's the suppliers response that worries me in  
22 terms of how do we use competition? Do we really fully have



1 control over the consequences of it, that applies, I think,  
2 in this case?

3           The other thing that makes the evidence right now  
4 more preliminary for me is we're still dealing with an  
5 anomalous period. We're dealing in some respects with the  
6 start up period of specialty hospitals that got interrupted  
7 by a moratorium. They were influenced as to where they were  
8 located by certificate of need, which isn't necessarily  
9 completely arbitrary where that is. There's some selection  
10 on the part of the states.

11           You mentioned I think that they've gone into the  
12 higher growth areas for the most part. So in some respects  
13 the community hospitals maybe were in a better position to  
14 absorb some of the loss.

15           And we're still doing, in some respects, with a  
16 fixed supply of physicians in all of these communities which  
17 influences the result as well.

18           So I guess I worry about supplier induced demand,  
19 which maybe is partly an answer to Jay's second question.  
20 And I worry that we haven't got enough evidence about the  
21 impact on community hospitals right now to say one way or  
22 the other how we should feel about specialty hospitals.

1           MR. HACKBARTH: I just want to be clear. I was  
2 just playing back in my own mind the things that I said. I  
3 want to be clear that I'm not an advocate of this. I'm an  
4 agnostic. I just don't think that there's a compelling case  
5 on one side or the other.

6           The issues about induced demand in health are very  
7 real but they are not unique to physician-owned specialty  
8 hospitals. And if there are states that want to constrain  
9 the supply of providers, not just this but others as well,  
10 because of a fear of induced demand they are able to do that  
11 and they can adopt their CON and make it as tight as they  
12 want to make it.

13           But currently that's not the national policy and  
14 there may actually be some merit in having different  
15 approaches to that.

16           DR. SCANLON: I wasn't trying to limit the concern  
17 about supplier demand to specialty hospitals either. In  
18 fact, I was trying to raise the point that the community  
19 hospitals' response could be supplier induced demand. And  
20 THAT we should be just as concerned about that as we are  
21 about what might be happening with respect to the specialty  
22 hospital.

1           MR. MULLER:  If we can go to slide 13, too, I  
2 think that while we can go about the virtues of competition  
3 and what it does to care, I think one of the side effects of  
4 competition is shown here, which is that they don't take  
5 Medicaid or take much less.  I think just around the country  
6 the kind of profit margins that come from the not taking  
7 Medicaid are well known.  They're take a far lower share  
8 just because by and large Medicaid is the lower payer than  
9 Medicare.

10           So obviously we've shown in here that Medicare is  
11 roughly one-third to 40 percent of the market.  So  
12 therefore, with the lack of Medicaid population, it's  
13 largely private.  So in some sense this issue is more in the  
14 private market and we've talked in the past about the  
15 relationship between private payments and Medicare payments.

16           But I would say of the slides that we've shared  
17 here, I mean one thing I've really focused on is this low  
18 Medicaid shares, which is probably the biggest driver --  
19 rather than being a focused factory -- it's probably the  
20 lower Medicare share that drives the profitability more than  
21 any kind of focused factory or better outcome.

22           MR. HACKBARTH:  If you look at any of those

1 categories and look at the variation within the categories,  
2 you'll see wide variation in Medicaid shares among community  
3 hospitals as well.

4 MR. MULLER: But it's well known that if you have  
5 a high Medicaid share, like the public hospitals' 40 or 50  
6 percent, that they're the ones that have -- I mean the  
7 public hospitals have very low margins.

8 MS. BURKE: I was going to raise the same question  
9 or at least concern about the Medicare numbers, simply to  
10 suggest that it's something I think we do have to keep an  
11 eye on because I think it has an impact in terms of margins.

12 But just on the broader policy question, should we  
13 in fact encourage or see the development of a delivery  
14 system that routinely doesn't care for a segment of the  
15 population, in this case the Medicaid population?  
16 Irrespective of the margin question, I think it's just a  
17 fundamental policy question. Do we want to see that or  
18 encourage that kind of behavior?

19 But the other question that I wanted to note, and  
20 it's following up in part on Bill's comment, which is that I  
21 am a little troubled by the statement that suggests that we  
22 needn't ultimately worry about the impact on community

1 hospitals and their relative margins because they just went  
2 out and found different ways to make money. I'm not sure  
3 that's inherently a good answer. It may be the right  
4 answer, it may not be a good thing.

5           So I think again getting some handle on whether or  
6 not we are encouraging behaviors because we are allowing  
7 delivery systems to essentially fracture, I mean I'm like  
8 Glenn, I'm somewhat agnostic on this question. And I do  
9 understand and appreciate the difficulties of physicians'  
10 experience in scheduling and managing patients and the ease  
11 with which you can do it in a smaller setting that's more  
12 controllable and predictable and has the capacity for  
13 dealing with a certain kind of patient.

14           But having said that, I do worry and I do hope  
15 that we continue to try and understand fully the impact on  
16 community hospitals and what's really going on in terms of  
17 their behavior and their response.

18           Because I don't think we should feel better simply  
19 because they went out and found a different way to make  
20 money because these patients are, in fact, being drawn away  
21 and cared for in other settings that may or may not be an  
22 efficient setting.

1           So again, I don't presume to know that based on  
2 the report, which continues to be very helpful in helping us  
3 understand this question. But I do think it's something we  
4 need to continue to probe and understand because I don't  
5 necessarily think that should always be the answer we are  
6 searching for, which is okay, we'll cut you off here, now go  
7 find some other way to do it. And then ultimately, we  
8 become concerned about the other way they found to do it,  
9 inducing demand in other areas.

10           So I just think we need to keep a close eye on  
11 that but I do want to understand more fully this Medicaid  
12 question. It continues to be a population that is  
13 vulnerable and gets shifted around. And I don't think we  
14 ought to encourage behaviors or payment systems that  
15 essentially allow them to continue to be isolated in terms  
16 of where they seek their care.

17           DR. REISCHAUER: Just to defend the analysis of  
18 the staff, they answered the question that was asked, which  
19 was --

20           MS. BURKE: It was not meant as a criticism.

21           DR. REISCHAUER: -- do these hospitals undermine  
22 the fiscal health of these other, not is it socially

1 beneficial that this happens.

2 MS. BURKE: I understand that and it was, by no  
3 means, meant as a criticism. They've done a terrific job.  
4 My point is simply I think as we continue to look at this  
5 question that's a question we ought to understand more  
6 fully, not that you failed to do exactly what we asked you  
7 to do.

8 As usual, you exceeded all expectations in all  
9 ways, for which we are eternally grateful

10 [Laughter.]

11 MR. HACKBARTH: On that note, we will move ahead.  
12 Thank you very much.

13 DR. CROSSON: Just on this question of induced  
14 demand in the community hospitals, did we have evidence of  
15 that? I thought we had evidence that they had fixed their  
16 margin problem; right?

17 MR. HACKBARTH: There is the evidence about the  
18 increased rate of cardiac surgery.

19 DR. CROSSON: No, in the community hospitals. I  
20 thought we had evidence they had fixed --

21 MR. HACKBARTH: We had anecdotal information about  
22 how community hospitals responded to the competition and it

1 was a mixture of things. Some of it was reduced costs.  
2 Some of it was new services that were profitable and  
3 replaced the lost business.

4 To the best of my recollection we actually had no  
5 hard-core analysis. It was just information that we picked  
6 up from our site visits; is that right?

7 DR. MILLER: I think that's right, and Jeff you  
8 should get into this. One of the questions that the higher  
9 utilization in the markets with specialty hospitals raises  
10 is is some of that happening because the community hospitals  
11 backfills by restarting a heart program that they lost or  
12 something like that?

13 But it's not like do we know that is all the  
14 community hospital? No, we don't have a direct -- but  
15 behind that aggregate number, it's sort of how is that  
16 actually occurring? It could be that the community  
17 hospitals are backfilling.

18 DR. STENSLAND: I was going to say is it anecdotal  
19 evidence and we only have one of the providers that was  
20 actually very kind to actually break it down to us. They  
21 said we lost \$2 million and we set up an imaging service  
22 with some of our radiologists and we gained back \$400,000.



1 Then we set up a pain management clinic and we gained back  
2 \$300,000.

3 MR. HACKBARTH: What they did was just increase  
4 the size of the radiology service that they were going to do  
5 anyhow.

6 DR. STOWERS: We keep talking the difference in  
7 competition but we've got to remember the first time we went  
8 through this the competition wasn't all about financial. It  
9 was about getting better services and getting later  
10 equipment that they couldn't get in the community hospital,  
11 which a lot of those things brought better patient care and  
12 efficiencies and so forth.

13 We seem to be all talking the money part of it and  
14 there isn't a big case here for the money part. So I think  
15 we need to keep in mind what really stimulated the growth of  
16 these in the first place, and it all wasn't financial.

17 MR. HACKBARTH: Okay, thank you very much.

18 Now we're going to move to a series of three very  
19 brief sessions on hospice, home health process measures and  
20 Medicare's use of clinical and cost-effectiveness  
21 information.

22 Just to help the people in the audience get

1 oriented, these three sessions are going to be very brief,  
2 hopefully no more than 10 minutes each. And they are a  
3 recap of work that's been presented at previous meetings.  
4 And the purpose of these very brief discussions is just to  
5 make sure that we've captured critical points that  
6 Commissioners have made in previous discussions. So this  
7 isn't going to be a long new presentation but simply a quick  
8 summary on each of these issues.

9 First up is hospice.

10 MS. LINEHAN: First I want to address a couple of  
11 questions that some of you raised at the last meeting. We  
12 looked at the 2002 and 2003 claims data for what we could  
13 know about a non-profit and for-profit patient population  
14 differences. We found that a greater share of beneficiaries  
15 in non-profit hospices had cancer diagnoses than in for-  
16 profit hospices and also had shorter mean lengths of stay in  
17 hospice than patients in for-profits.

18 We also looked the type of days of care, which is  
19 a question that I think Bob had asked.

20 If you will recall, the hospice care is paid at  
21 one of four daily rates. The default type of day is routine  
22 home care. Over 90 percent of days in both for-profit and

1 non-profits are routine home care days. The difference  
2 between the two, for-profits and non-profits, was the share  
3 of days that are in continuous home care, the continuous  
4 home care rate, which is at least eight hours of continuous  
5 home care with at least half of the care provided by a  
6 nurse, an RN.

7           Continuous home care days were 2.6 percent of days  
8 in non-profits and 6.8 percent of days in for-profits. But  
9 like I said, the vast majority of days in both types was  
10 still the routine home care days.

11           I just wanted to call your attention to, and this  
12 was a point that Sheila had raised, about wanting more  
13 information about how the patient populations had changed.  
14 And I added to the chapter there about the nursing home  
15 patients and the diagnoses.

16           Just briefly, the findings of the chapter were  
17 that the PPS was developed about 25 years ago using data on  
18 patients with terminal cancer. Patient changes, modality  
19 changes, though we can actually know little about this using  
20 Medicare data, suggests that the hospice payment system  
21 should be reevaluated to assess whether the payment system  
22 pays accurately for the costs of the contemporary hospice

1 patient. We can't do much with Medicare data so we used a  
2 large chains' patient level data.

3           RAND did this analysis for us and they had two  
4 basic findings: one, that patient demographic and diagnosis  
5 data didn't improve the ability of the payment system to  
6 explain variation in visits and visit labor costs; and that  
7 the beginning and end of hospice stays were more intensive  
8 than the middle days.

9           I want to just caution you again that the results  
10 from one chains' data may not be generalizable to all  
11 hospices.

12           So the results of RAND's analysis didn't provide  
13 evidence that case-mix adjusters would improve the accuracy  
14 of the payment system. But they do suggest that  
15 redistributing payments for the first and last days of care  
16 may improve payment accuracy. But we need to test these  
17 findings with additional data.

18           To answer questions about the care that's provided  
19 to hospice patients and the ability of the current payment  
20 system to explain variation in the costs of care the program  
21 needs to collect additional data like the number, type and  
22 duration of visits, drugs, patient location, none of which

1 it currently collects.

2 In addition, in the future, this Commission could  
3 pursue an analysis of payment adequacy like we do in other  
4 settings.

5 Now I'll take your comments on whether we've  
6 captured what you suggested in March.

7 MS. HANSEN: Just a clarification, Kathryn, with  
8 your last comment that since patient location isn't  
9 captured. I was thinking about the change of diagnoses over  
10 time that not-for-profits have a little bit more of a cancer  
11 diagnoses as compared to the others.

12 I guess the question that I have, and I looked at  
13 the graphs here, the growth of the freestanding hospice  
14 programs, would that be an example of a freestanding program  
15 having the opportunity to provide hospice services in a  
16 nursing home setting? So these are not nursing home  
17 sponsored hospices but freestanding ones providing services  
18 in the nursing home?

19 MS. LINEHAN: Sure, yes.

20 MS. HANSEN: And that's where I just wonder  
21 whether that kind of length of stay and all those things  
22 just kind of, without the analysis, seems to be correlated

1 to people who are already in nursing home beds and therefore  
2 the ability to provide hospice program services has grown  
3 quite a bit.

4 MS. LINEHAN: Yes. I think that's one of the key  
5 things we'd like to look at. We can't know where the  
6 patient is from the claims data. There are a couple of ways  
7 that other studies have tried to get at whether a patient is  
8 actually in a nursing home when they get their hospice care.

9 The best way to do it would require you to match  
10 the patient level data to the MDS, the choice of the patient  
11 assessment in the nursing home, which is a really big data  
12 job. But that's really currently the only way you can know  
13 whether somebody is actually in the nursing home.

14 MS. HANSEN: For some reason, for the first time,  
15 this just struck me that there is such a strong correlation  
16 to that. When that new option became available, was it in  
17 2000 --

18 MS. LINEHAN: To provide hospice to the nursing  
19 home patients? I think it was '86, actually. But that's a  
20 hypothesis that we'd like to look at, tying up the  
21 diagnosis, the location and length of stay.

22 DR. MILSTEIN: One of our prior observations when

1 we last discussed this that I think might warrant inclusion  
2 in our list of conclusions was that case-mix adjustment  
3 could well make a difference if a wider set of patient  
4 morbidity characteristics were collected. We were looking  
5 at a quite impoverished set of patient characteristics which  
6 we then said does this impoverished set -- which is actually  
7 a set of convenience, not a set that we thought might be  
8 predictive of differences in patient morbidity and therefore  
9 service need. We tested that set and concluded that case-  
10 mix adjustment would not make a difference. But that does  
11 not, in turn, support the conclusion that case-mix  
12 adjustment might be warranted in relation to these services.

13 We could slightly modified the -- expand the first  
14 conclusion. And I personally hope that we would advocate  
15 that such a more deliberate -- that a more deliberate set of  
16 patient morbidity characteristics be collected -- be found  
17 and/or collected and tested before concluding that case-mix  
18 adjustment would not make a difference.

19 DR. MILLER: No, I agree that we can be much more  
20 careful about how we state the conclusion. I think  
21 Kathryn's point about the generalizability was a very short  
22 and summary way of saying that. But we can be much more

1 clear in the chapter.

2 I guess the other thing that occurs to me, and I'm  
3 asking Kathryn, when we talked about these -- did we talk  
4 about these results with people out in the community? And I  
5 can't recall, I have a sense that we did that and I was  
6 trying to remember whether people were surprised that case-  
7 mix did or did not explain it. I have this vague sense that  
8 some people weren't particularly surprised given what goes  
9 on with patients in these settings.

10 MS. LINEHAN: Well, RAND had clinicians on their  
11 team and they weren't particularly surprised by this result.  
12 But whether that is representative of the community and what  
13 their response would be, I don't know.

14 DR. MILLER: That was the data point I was looking  
15 for, is they did actually run some of this past their  
16 clinicians. And I remember some comments along these lines  
17 of them not been entirely surprised that that was the case.

18 MR. HACKBARTH: I agree with your point, Arnie,  
19 about softening the message just a little bit, although I  
20 must say it struck me as intuitively plausible, possible,  
21 that in fact a diagnosis may not be a good predictor of  
22 hospice service use. But that's a long way from concluding



1 that it is not.

2 DR. MILSTEIN: I was also thinking about other  
3 cost predictors like circumstances of home environment, et  
4 cetera, that were not tested.

5 MR. HACKBARTH: Anybody else?

6 DR. KANE: [off microphone] A clarification on  
7 page 14 of your paper. You mentioned that in 2000 and 2004  
8 more than 25 percent of beneficiaries were dying in hospice  
9 but they been involved for less than a week and that's not  
10 optimal. I guess I wasn't sure what that means. Optimal  
11 amount of time? And could it be due to the nature, the mix  
12 of patients why that might be shorter? People don't know  
13 [inaudible].

14 Did you have something in mind? I don't  
15 understand that what was, not optimal.

16 MS. LINEHAN: I guess because -- well, there's  
17 literature on -- and I can sort of add more to that about --  
18 that a longer length of stay might allow a patient to  
19 benefit from more hospice services like bereavement  
20 counseling, maybe would allow their families to benefit.

21 But given that the benefit is for six months, I  
22 guess part of the idea behind that, too, is that if we think

1 that six months would allow somebody to benefit from being  
2 in hospice but they're in there for three days or five days,  
3 that perhaps they don't get -- they don't get from the  
4 benefit all the services that are offered under the benefit.

5 MR. HACKBARTH: I think it's a good catch, Nancy.  
6 I think a little bit more elaboration is required to explain  
7 optimal in this context.

8 Other questions or comments on hospice?

9 Okay, let's next move on to home health process  
10 measures.

11 MS. CHENG: My part of the summary is to revisit  
12 the chapter on adding quality measurement to the home health  
13 current measure set.

14 This chapter is part of the Commission's agenda on  
15 measuring quality and moving towards pay for performance.  
16 In 2005 the Commission identified this sector as being one  
17 that was ready for pay for performance and we said at that  
18 time that we would also like to see the quality measure set  
19 continue to change and evolve.

20 We thought that adding some measures to the set  
21 that we have currently in home health could broaden the  
22 patient population that we're able to measure, could capture

1 safety as an aspect of quality, could measure an aspect of  
2 care that is directly under the providers' control, reduce  
3 variation in practice, and also perhaps provide incentives  
4 to adopt or improve information technology for the providers  
5 in this setting.

6           So as a step toward that we held a panel on best  
7 practices. We discussed wound care and fall prevention as  
8 the focus of the panel. One of the things that we were  
9 asked to do was to add a little text here. And so what we  
10 tried to do in the draft that you have right now is to  
11 explain a little bit more about why we looked in these two  
12 areas.

13           We found that best practices or processes in these  
14 two areas could potentially apply to all patients. They're  
15 not condition specific. They could capture safety as an  
16 aspect of being able to keep a patient safely at home.

17           The panel told us that these are two areas where  
18 they were very aware of wide variation in practices. So to  
19 the extent that introducing process measures could encourage  
20 a reduction in variation where variation is caused by not  
21 adhering to best practice that we could reduce variation by  
22 making these process measures more widely used and known.

1           We also tried to add some text to emphasize that  
2 we understand that the scope of the home health benefit is  
3 much broader, that these are just two aspects of things that  
4 go on in home health and that the scope if the benefit is  
5 wider than these two activities.

6           After identifying best practices the next step  
7 then would be to move from best practices to process  
8 measures. We added a little bit more text here to explain a  
9 little bit of the science of moving from what we know to be  
10 good care to describing exactly what we mean. How do we  
11 make sure we're measuring it reliably? What's the  
12 denominator? Who should be excluded from it, et cetera.  
13 That would enable us to use these as measurements of quality  
14 of care.

15           The Commission said that it's important for all  
16 measure sets, not just home health, but all measure sets to  
17 evolve. And we know that CMS is engaged currently in some  
18 ongoing work to work on process measures and other measures  
19 for the home health setting.

20           So the chapter closes by urging CMS to consider  
21 the best practices that we identified with the help of our  
22 panel as they explore adding measures to the home health

1 set.

2 So with that, I'd like to open it up to make sure  
3 that the current draft has addressed your concerns.

4 MR. HACKBARTH: Any questions?

5 DR. SCANLON: I think it did 99 percent. I just  
6 want to raise was one small point, which is on 14 you talk  
7 about a validity test. I think this is one type of a  
8 validity test when there can be a correlation between what I  
9 might think of as an outcome measure and the process  
10 measures.

11 But if we have a desire for process measures  
12 because we can't measure outcomes, we need to think about  
13 other ways to validate those measures because if you do have  
14 an outcome measure that you can use to relate to the process  
15 measure, there's a question of why don't you use the outcome  
16 measure to begin with?

17 So expanding that a little bit to talk about  
18 validation may involve more things, would be very helpful.

19 MR. HACKBARTH: Okay, Sharon, well done. Nancy?

20 MS. RAY: This is the last of our 10 minute  
21 presentations. I'm here to get your comments on the draft  
22 chapter on Medicare's use of cost-effectiveness information.

1 The chapter focuses on the lack of standardization of  
2 methods and results across cost-effectiveness studies.

3 Recall last month that Peter Neumann and Josh  
4 Cohen presented the results of the review they conducted for  
5 us. They looked at cost-effectiveness studies for two  
6 Medicare covered services, ICDs and screening for colorectal  
7 cancer. The chapter summarizes the study's findings.

8 Despite some variation in the results across the  
9 studies, the literature provides an indication of the  
10 clinical effectiveness and value for colorectal screening.  
11 By contrast, the literature for ICDs does not provide a  
12 clear indication of the service's cost-effectiveness because  
13 the results vary substantially across studies.

14 The chapter then goes on to describe ways to  
15 improve the standardization of methods used in cost-  
16 effectiveness studies with the goal of improving studies'  
17 comparability and transparency.

18 Finally, the chapter points to future issues for  
19 Commission discussion, issues involved in Medicare  
20 developing the infrastructure to consider clinical and cost-  
21 effectiveness information, such as who would sponsor  
22 research, the public nature of clinical and cost-

1 effectiveness research, and the role of the federal  
2 government and private groups in standardizing and  
3 sponsoring this research.

4 We also raise other future issues for Commission  
5 discussion like who would fund the research and what  
6 services Medicare could focus on.

7 Again, we'd like your input as to whether or not  
8 the chapter addresses your conversation from last month.

9 MR. HACKBARTH: Questions or comments?

10 DR. KANE: My only comment was I thought it did  
11 actually. I read the whole thing and thought wow, they  
12 really did bring it -- so I thought it was a good job.

13 MS. HANSEN: Yes. I think, without a doubt, this  
14 whole area is always kind of dicey, the comparative  
15 effectiveness vis-a-vis the cost-effectiveness. I know that  
16 the state of Washington has really moved on this.

17 So I guess just some continued sensitivity that  
18 the cost-effectiveness side doesn't become kind of the  
19 larger numerator here, to make sure that the comparative  
20 effectiveness balance is just kept.

21 MR. HACKBARTH: Okay, thank you all.

22 Next up is hospital wage index.

1           MR. GLASS: This is a follow-up. We looked at  
2 some wage index issues in December and it's kind of an  
3 update of our progress. The wage index moves a lot of money  
4 around. Looking at the FY '07 proposed rule, the hospital  
5 in the highest wage index area gets a base payment of about  
6 \$6,600 and the one in the lowest wage index area gets a base  
7 payment of under \$4,000. So it's consequential to hospitals  
8 and other providers.

9           We think a new approach to the wage index may have  
10 some advantages, and particularly for the PPSs that now use  
11 a version of the hospital wage index rather than one that  
12 pertains directly to their sector.

13           The data we're going to present were developed for  
14 us by Abt Associates. They're historical data from 2002  
15 2004. So the results we're showing would be predictive but  
16 maybe not precisely what would be expected in the future.

17           The current approach to the wage index, we've  
18 discussed before and I'll just quickly go over, is the data  
19 comes from hospital cost reports. What they do is they  
20 calculate an average wage for each of hospitals. The  
21 calculation is kind of complicated because they have many  
22 pages describing what costs you're supposed to include and



1 what you're supposed to exclude for things like contract  
2 labor, home office, and all that sort of thing.

3 But essentially they use the average wages for the  
4 hospitals and then they take those and put them together and  
5 calculate an average wage for an area. The areas we're  
6 talking about are the metropolitan statistical areas, the  
7 MSAs, and the state-wide rural, which is all of the state  
8 that's not in an MSA.

9 You then take the area's average wage and you  
10 compare it to the national average wage and that produces  
11 the wage index for the area. So if it's a \$22 average wage  
12 in the area and the national average was \$20, your wage  
13 index would be 1.10.

14 They also make some adjustment for occupational  
15 mix and we'll get to how that works in a minute.

16 And then of course, there are the  
17 reclassifications and other adjustments that are made,  
18 things like rural floors and out-commuting and all that sort  
19 of thing. They are kind of exceptions but they change the  
20 wage index for about a third of the hospitals

21 The new approach we're talking about is based on  
22 using Bureau of Labor Statistics data. This is data that

1 the Bureau of Labor Statistics routinely calculates. It's  
2 used to calculate a relative wage for each area and we use  
3 what we call a fixed occupational weight technique and the  
4 data is for all employers in an area.

5           Basically what the BLS is in each area for each  
6 occupation in an MSA and in the state it shows the average  
7 wage for that occupation. That's for all employers of that  
8 kind of worker. And they also calculate, at the national  
9 level, what share each occupation makes up for each  
10 industry. So in hospitals 27 percent of the people are RNs  
11 in the hospital.

12           So they do that for each occupation. What we do  
13 is we take the national occupational weights, in other words  
14 what percentage each occupation is of the hospital's total  
15 labor pool, and we apply that vector of weights to the  
16 vector of wages that we have for each area, multiply it  
17 together and get the average hospital wage for the area.

18           We decided to take that a step further. That  
19 gives us a wage index for each area just like the regular  
20 process does. But then we took it another step further and  
21 we used census county level data to further adjust just  
22 within large MSAs. The objective here is if you have a

1 large MSA and the central area has higher wages than the  
2 outlying counties, this captures that. And that's using the  
3 census data.

4           A possible next step would be to further smooth,  
5 you could look at areas with large differences, say a rural  
6 area in the neighboring MSA. And you could further smooth  
7 there using other techniques such as blending the wage  
8 index. And our contractor, Abt Associates, is looking into  
9 how you might do that right now. And that could be used  
10 really with any wage index, with the current one or with the  
11 one we're proposing.

12           The differences between the approaches, just to  
13 summarize that, the current approach uses hospital data only  
14 as opposed to data from all employers under the new  
15 approach. That actually could be a profound difference  
16 because it kind of brings up what is the goal of the wage  
17 index. And we're going to talk about that more at the end  
18 of the presentation.

19           The basic question is should the wage index  
20 reflect hospital only data or the prevailing wage in the  
21 area for a specified mix of occupations? And it kind of  
22 goes to the question of do the hospitals compete with other

1 employers for their labor? Or do they exist in a pool to  
2 themselves?

3           The other difference is that the current approach  
4 uses one year data from the cost reports. So to figure out  
5 the 2004 data we're going to show you, they used the 2000  
6 cost report. The BLS number for 2001, which would be what  
7 would be available to set the 2004 index, is a three-year  
8 average of 2001, 2000 and 1999 data. So BLS is always a  
9 three-year average.

10           The current approach has to do an additional  
11 survey and then a further adjustment to the wage index to  
12 come up with an adjustment for occupational mix. The new  
13 approach you would just automatically adjust for  
14 occupational mix because we used that fixed weight approach  
15 where we're using the national weights. So we don't have to  
16 do anything more to it.

17           And finally, there is this question of all of the  
18 exceptions made to the current rule, reclassifications and  
19 that sort of thing. And the basis for the reclassification  
20 -- where there is one -- is the average wage. And since you  
21 wouldn't necessarily calculate that anymore on a hospital-  
22 by-hospital basis, that basis for reclassification is

1 removed. So you may end up with fewer exceptions under the  
2 new approach.

3 For some reason missing here is a slide on  
4 volatility. Basically, the new approach is less volatile  
5 over time than the current approach, depending on what level  
6 you do it, at the hospital level or the wage index area  
7 level. The volatility is about half, a couple percent less,  
8 in the 90th and 95th percentiles.

9 The occupational mix problem is that two hospitals  
10 could pay similar workers exactly the same kind of wages.  
11 So they could pay RNs \$30 an hour and LPNs \$15 an hour. But  
12 if they have a different mix of workers, if one uses more  
13 RNs and fewer LPNs than the other, they will have a  
14 different average wage. And since the point of wage index  
15 is to understand the underlying wages in the area, you don't  
16 want that choice of occupational mix being used by a  
17 particular hospital to be figured into the wage index.

18 So under the current approach they have to adjust  
19 it out. And the way they do that as they have an additional  
20 survey asking hospitals for their occupational mix and how  
21 many hours and now how many hours and dollars.

22 So FY '05 and '06 it was 10 percent adjusted.

1 They used that occupational mix adjustment to adjust 10  
2 percent of the wage index and 90 percent of it is not  
3 adjusted.

4 In FY '07 they're also proposing the 10 percent  
5 adjustment. But the problem is that they've recently lost a  
6 court case. And the result of that is that they are  
7 supposed to adjust for 100 percent occupational mix. It's  
8 not clear exactly what CMS is going to do with that problem  
9 at the moment. Either they have to use the old data, which  
10 the problem there and the reason it's only used 10 percent  
11 is no one is very happy with the current results, or they're  
12 going to have to use the new survey which they just put out  
13 there and it's not clear they're going to have result in  
14 time. So it's not clear what they're going to do.

15 Anyway, under the new approach, you'd  
16 automatically adjust, use the same fixed-weight vector, and  
17 you wouldn't have this occupational mix problem.

18 When we looked at the distributions that resulted,  
19 first of all the wage indexes from the current and new  
20 approaches are very highly correlated with each other. But  
21 the new approach has a slightly tighter distribution. There  
22 are fewer very high or very low values. The most salient

1 thing is that hospitals with very high wage index values in  
2 the current approach tend to have lower values under the new  
3 approach. So once you get above about 1.25 under the  
4 current approach, wage indexes of 1.25, those tend to come  
5 down under the new approach.

6 This is similar to earlier findings that we had  
7 in, I think, the June 2003 report which said that in high  
8 wage index areas the current index overstates possibly  
9 because of occupational mix.

10 Another thing we did is we tried to look at the  
11 explanatory power of the two indices. Here the objective is  
12 to test how much the wage index explains hospital cost. We  
13 used a multivariate regression model and the dependent  
14 variable was cost per case. On the right hand side we had  
15 payment like variables such as case mix index, wage index,  
16 DSH and that sort of thing.

17 Basically the result were very similar for the  
18 various wage indexes. We looked at the BLS index, we  
19 constructed two forms of that, and the CMS final wage index  
20 and the CMS pre-reclass index and it all comes out to be  
21 very similar.

22 If you look at a kind of marginal effect thing,

1 you might find there's a little bit of difference but  
2 results seem to be very similar.

3           The other issue we want to cover is using the  
4 hospital wage index in other sectors. Again, most other  
5 prospective payment systems, such as for SNFs and home  
6 health, use the pre-reclassification hospital wage index.  
7 What that is is that's the hospital wage index as calculated  
8 by area without any of those exceptions put in.

9           The concern is, first of all, it's not clear that  
10 wages for SNFs and home health agencies vary in the same way  
11 as hospital wages do. That would be one consideration.

12           The other is that when an hospital in an area is  
13 reclassified, the SNFs and home health don't get any change  
14 to their wage index, but the hospital they're competing with  
15 labor for, that hospital has a higher wage index than they  
16 do. And so those providers have raised this as an issue of  
17 equity.

18           The new approach would create a wage index for  
19 each sector. The area wages for each occupation would stay  
20 the same because they're from BLS data from all employers to  
21 begin with. The vector of occupational weights would differ  
22 by sector because remember that's the national occupational



1 weights for that particular sector. And so when you  
2 multiplied that occupational weight vector times the area  
3 wage vector, you'd get possibly slightly different results,  
4 but at least they'd appropriate to that mix of employees.  
5 So that may be more equitable. We're going to investigate  
6 how much of a difference it actually makes.

7           Because we're looking at relative wages between  
8 areas and it may be that that's relatively similar for all  
9 kinds of employers. But theoretically, it would be a better  
10 model and it does avoid the reclassification problem.

11           So in summary, the new approach is less volatile,  
12 it automatically adjusts for occupational mix, it would  
13 reduce administrative burden. The hospitals wouldn't have  
14 to produce the average wage data, and CMS could pick up the  
15 BLS data instead of calculating their own. It would  
16 eliminate the basis for the exceptions that are made now,  
17 though there may still be pressure for exceptions to be  
18 made, of course.

19           It would probably be more equitable for other  
20 types of providers, that is providers other than hospitals.  
21 And the data would represent the prevailing wages in a  
22 market.

1           On the other hand, the data would not be specific  
2 to hospitals, which can be thought of as a plus or a minus,  
3 and it would create new winners and losers, which of course  
4 would make this extremely political.

5           As I said we'd return to this question of what is  
6 the goal of a wage index. If it's role is to adjust  
7 payments for the difference in wages across geographic  
8 areas, then the question is should the wage index reflect  
9 average wages paid by hospitals in an area or reflect  
10 prevailing wages that all employers in an area have to pay  
11 to attract their particular mix of workers?

12           You can think of the difference between these two  
13 ideas. If you think that actually hospital wages are a  
14 perfectly good measure for every -- relative hospital wages  
15 would be a good measure for everyone else, then using the  
16 hospital wage index for all sectors is probably not a good  
17 idea. So the first one, if we think that's important to use  
18 exactly hospital wages, then we'd have to probably think of  
19 another way to the SNFs and home health and other providers.

20           The other assumption that we want to do the  
21 prevailing wages says that in these markets hospitals are  
22 competing with other employers for the same kind of labor.

1 So everyone's hiring office workers, everyone's competing  
2 for the same workers, so we should look at the prevailing  
3 wage. Everyone's hiring nurses, security guards, et cetera.

4 So the second assumption kind of says that  
5 everyone in that area is competing for workers and the  
6 hospitals don't have a separate pool of workers that they're  
7 looking at.

8 There are two different ways of looking at the  
9 goal and we would appreciate your discussion about which one  
10 of these we'd like to go with or if you think it's an  
11 important distinction.

12 And also, we would answer any other questions that  
13 you may have.

14 MR. MULLER: David, remind me again in many of the  
15 PPS areas we have the wage index, beyond the hospitals?  
16 Since that's one of the -- how many other --

17 MR. GLASS: There's SNF, home health, long-term  
18 health hospitals, IRFs, hospice. Almost everything but  
19 physicians.

20 MR. MULLER: To go back to the slide that we have  
21 in our packet but didn't get on the public screen, the one  
22 that says volatility. The way I'm reading it is under the

1 current approach versus the new approach, the changes are  
2 roughly twice as much. That is the change in the wage index  
3 from '03 to '04 is roughly twice as much in the current  
4 approach as the new approach. Am I reading that correctly?

5 MR. GLASS: Yes. I'm sorry, I don't know why the  
6 slide isn't here.

7 But anyway, what it says is that under the current  
8 approach the absolute percent change from 2003 to 2004 in  
9 the wage index for hospitals is 1.4 percent under the  
10 current approach and 0.7 percent under the revised approach.  
11 That ratio holds going up to the 90th and 95th percentile.

12 MR. MULLER: So in terms of how -- it roughly  
13 halves the increase in wages under the new approach versus  
14 the -- the old versus the new. What's causing that to  
15 occur? I can understand some of the technical measures that  
16 you referenced in your presentation but I'm just trying to  
17 figure out why it would have a -- halving of a wage increase  
18 is a big percentage.

19 DR. ZABINSKI: We're not halving the wage  
20 increase. This is just the percent that -- if you look at  
21 all of the areas in the country and you look at the wage  
22 index in 2003 and then you look at the same wage index in

1 2004, the wage index for the areas changed because the  
2 hospitals report different wage data and all that sort of  
3 thing. And sometimes that can change a lot and sometimes it  
4 can change a little. And we're saying at the median it  
5 changes by 1.4 percent.

6 DR. REISCHAUER: This is the absolute value. So  
7 there are pluses and minuses. This is just a volatility  
8 from year-to-year.

9 DR. STENSLAND: So on average it goes up by 1.4  
10 percent or down by 1.4 percent, on average.

11 MS. HANSEN: This is more of a question in terms  
12 of understanding this. Given the fact that whether BLS  
13 includes all employees for that area, as compared to looking  
14 at hospitals only, given the kind of targeted issues of  
15 again the nursing shortage and some of the areas of the  
16 medical technicians and physical therapists, that is  
17 addressed in this format? Or not?

18 MR. GLASS: Those occupations are in there, yes.

19 MS. HANSEN: But some of the unique issues of the  
20 pressures for this particular market, as compared to the  
21 market as a whole, is that factored in and considered in  
22 some unique way?

1           MR. GLASS: I guess I'm not quite following your  
2 question. In that area this will reflect the wages paid to  
3 all RNs, whether the RNs worked -- the BLS -- whether the  
4 RNs work in a hospital, in a doctor's office, in a SNF, in a  
5 home health agency, or whatever. So all that will be in  
6 there.

7           So if that particular area has a very tight market  
8 for RNs, then presumably all those wages will be lifted. So  
9 peculiar market conditions will be reflected.

10           What we're measuring is the relative wages of RNs  
11 in that market to RNs in other markets.

12           MR. HACKBARTH: Before I go to Bill, I just want  
13 to clarify where we stand in terms of the process on this.  
14 As you know, there was no paper in your notebook on this. I  
15 just want to be clear with the Commissioners and with the  
16 public audience that we are not at the point of reaching a  
17 conclusion on this work. Nobody is being asked to embrace  
18 this approach definitively as an alternative but rather  
19 we're more seeing guidance. Is this a tree that we want to  
20 bark up for a while and potentially come back with a  
21 recommendation next year. Is that right, David?

22           MR. GLASS: What we've been doing so far is just

1 to explore whether, in fact, this is even possible to do and  
2 then what the results look like at first glance and see if  
3 it seems like a practical feasible approach that might have  
4 some benefit. That's really where we are now. and then, as  
5 I say, we want to look at smoothing and we want to look at  
6 how this would work for other sectors.

7 MR. HACKBARTH: Okay, Bill.

8 DR. SCANLON: While I'm generally supportive, I  
9 guess I'm wondering, the problems we're trying to fix are  
10 reducing the burden on hospitals in terms of providing  
11 information, expanding beyond the hospital because we're  
12 concerned that the hospital may not be representative of the  
13 labor market. But there's a question of if all the  
14 hospitals in an area are having to pay higher wages than the  
15 rest of the labor market and in other markets they don't,  
16 which is the right measure? There's that difficulty.

17 You said there's a high correlation between the  
18 old measure and the new measure. And I guess I would be  
19 interested in knowing for the outliers what do we know about  
20 the outliers? Is there anything systematic about outliers?  
21 Because that might tell us something about -- that there are  
22 differences in market dynamics that may make that -- may

1 play a factor in terms of which we prefer.

2 I think the idea that -- is there an ease here to  
3 deal with occupation that is not -- I mean, this idea that  
4 we're having difficulty getting occupational adjustments  
5 into the wage index is troubling, given how long we've known  
6 that this has been a problem. And so it there's a fast way  
7 of resolving that, certainly we should be thinking about  
8 that. So the advantages with respect to occupation here  
9 argue in favor of the new method.

10 You just raised this last point, which to me is  
11 probably the most important two steps, which are on page  
12 three, which is what about the variations that exist within  
13 MSAs? That's a potential serious concern because some of  
14 these MSAs get extremely large and it's hard to think of  
15 them as single labor markets, though they may not be so far  
16 apart that there's a need for adjustment.

17 Secondly, our reclassifications are largely  
18 because of the cliffs. You move across a boundary and you  
19 say that you get everybody from the other labor market but  
20 maybe you don't. And I think we need to think about that  
21 smoothing process.

22 I guess the last part I would say would be the



1 issue of not only the variation within MSAs but the  
2 variation within the balance of the state. When GAO did  
3 some of this work a number of years ago, they distinguished  
4 between the larger towns, the medium-sized and then the  
5 other rural. A lot of that may have gone away in terms of  
6 being an issue because of the critical access hospitals, but  
7 still it may be that the balance of the state is not a  
8 homogeneous market or have the same wage levels, even though  
9 it's not a single market.

10 MR. GLASS: I think that's correct and that last  
11 problem, depending on how the smoothing worked out, might  
12 still remain. It also raises the issue of since they've  
13 taken critical access hospitals out of the data pool under  
14 the current system there's very little data to set that  
15 rate. Whereas in this system you'd have whatever BLS finds.

16 DR. REISCHAUER: A couple of questions. You  
17 talked about doing this for the various health sectors and I  
18 was wondering what kind of detail BLS had below hospitals?  
19 Is nursing homes a category and home health agencies?

20 MR. GLASS: Actually yes, health agencies and  
21 nursing facilities, which would not be SNFs per se, but the  
22 entire nursing facility is a category also. We're thinking

1 that we might jigger around some of those occupations within  
2 that that we know are more heavily used in a SNF than in the  
3 nursing facility, for example, or aren't used for Medicare  
4 home health patients and are used for other home health  
5 patients.

6 We'd have to play around. That's why we haven't  
7 done that one yet. We'd have to play around with that a  
8 little bit.

9 But yes, SNFs and home health exist, I don't think  
10 -- long-term care hospitals clearly is not a separate  
11 category.

12 DR. REISCHAUER: You said that there was a high  
13 correlation between the new measure and the old measure.  
14 But have you done any analysis of the fraction of hospitals  
15 that would have their index changed by more than 10 percent  
16 or more than 20 percent?

17 MR. GLASS: We don't have numbers on that yet.  
18 We've been working on that but we don't have numbers on that  
19 yet. As I said, the big differences -- the biggest  
20 systematic difference is when you get the hospitals with  
21 very high wage index values under the current system.

22 DR. REISCHAUER: The final issue, we're talking

1 about wages here and that's fine if wages are correlated  
2 with the other components of compensation. But my guess is  
3 they're not and it's systematic across employers. And here  
4 I'm talking about working conditions, fringe benefits, which  
5 might actually go in the opposite direction. Large  
6 institutions like hospitals probably have good fringe  
7 benefits, might have bad working conditions relative to an  
8 RN working in a doctor's office.

9           Are we collecting any kind of information to  
10 figure out total compensation just in one or two areas? And  
11 how it's broken down by institution type or employer, how  
12 much is wages, how much is fringe benefits?

13           MR. GLASS: The current system is wages and  
14 benefits, the current one. The average wage data they  
15 collect --

16           DR. REISCHAUER: The BLS is not.

17           MR. GLASS: The BLS is not. The BLS is strictly  
18 wages and doesn't include like self-employed, for example.  
19 Jeff, we were looking at this question of whether we could  
20 differentiate between strict wages and benefits using the  
21 hospital data and see if there's any pattern there, to see  
22 if it's a geographic pattern with wage index or what. So

1 we're looking into but I doubt that we'll get a really  
2 definitive answer.

3 DR. KANE: Just a question. How much variability  
4 is there in the occupational mix if you take a national  
5 average? Is there a wide liability in like 26 percent  
6 nurses versus 45 percent nurses? And then the second  
7 related question is if there is a lot of variability in the  
8 distribution of that in the proportions, why would you take  
9 the national average and not something like the most  
10 efficient or the best use of occupational mix? If you're  
11 going to go all the way you might as well go all the way.

12 I don't how much variability there is in these  
13 occupational categories across the hospital.

14 MR. GLASS: I guess I'm not quite following. The  
15 data we have is that at the national level we have what the  
16 occupational mix is.

17 DR. KANE: But by hospital, how much would a  
18 hospital deviate from that national average mix?

19 MR. GLASS: We don't know that. I suppose CMS's  
20 new survey may help answer that. The old one people were  
21 quite suspect of.

22 DR. STENSLAND: We looked at the old data and that

1 did imply a fair amount of variation in terms of who uses  
2 RNs and who uses LPNs. But there's also some question that  
3 CMS wasn't so comfortable with that data, so we don't want  
4 to place too much weight on it.

5 DR. KANE: Would this in any way create the  
6 incentives for the mix in the future, how the hospitals --  
7 what kind of labor mix they use? If you put a national  
8 average on there?

9 DR. REISCHAUER: Whatever you use, we'll pay for  
10 it; right?

11 MR. GLASS: Right now, yes. If you use the new  
12 approach, they'll have a wage index that relates to the  
13 national.

14 DR. KANE: That they can try to game.

15 MR. GLASS: They can't game it. It is what it is.  
16 But if they want to --

17 DR. KANE: They can game it by getting cheaper  
18 labor.

19 MR. GLASS: They'd have the correct incentive to  
20 optimize their mix.

21 DR. KANE: To go lower on their occupational mix.

22 MR. GLASS: Whatever incentive they have to lower

1 their costs, which they have now, of course.

2 MS. BURKE: Nancy raises though an interesting  
3 question. There is sort of an underlying discussion going  
4 on as to what the right occupational mix is, given the  
5 nature of the kinds of patients that you serve, and whether  
6 we want to encourage -- the whole question of RNs to  
7 patients, depending on the nature of the hospital.

8 There is an interesting question and whether or  
9 not we either mask that by simply saying do what you have to  
10 do and this is the average, or whether we want to encourage  
11 certain kinds of behaviors is, I think, an interesting  
12 question. Because there is wide variation for a variety of  
13 reasons. Certainly patient mix is one. The other might be  
14 locality.

15 We have, for years, tolerated lower rates of RNs  
16 to patient mix in certain areas of the country where  
17 recruitment has been very challenged and they are  
18 predominantly staffed by non-RNs. So there are big  
19 variances for lots of different reasons.

20 DR. KANE: So wouldn't you want to maybe do a  
21 quality adjusted labor mix or something? I don't know if  
22 that's even possible.

1           MR. GLASS: I think you'd prefer to look at the  
2 outputs rather than the inputs. If you were looking at  
3 quality you'd look at the output, not what mix they choose  
4 to use to get to it.

5           DR. KANE: You're going to do a national average  
6 mix of labor and perhaps you might want to base the mix on  
7 hospitals that have the highest quality or something. I'm  
8 just trying to get at how do you get at that? I don't even  
9 know.

10          MR. GLASS: Remember, this is just to get the  
11 relatively wages between areas, the relative underlying  
12 wages between areas. So which mix you chose, if you were  
13 reflecting it in all areas, I'm not sure that it would drive  
14 anyone to do one thing or the other. It wouldn't drive a  
15 hospital to hire one way or the other.

16          MR. HACKBARTH: The basic incentive would be the  
17 same as under the current system, which is to use the lowest  
18 cost mix of labor that you can, consistent with a quality  
19 product, with you defining the quality product that you want  
20 to produce right now. That incentive stays the same under  
21 either.

22           Other questions on this?

1 DR. SCANLON: I was going to say exactly the same  
2 thing Glenn did. Remember, what we're talking about here is  
3 taking an average for an area, which can be as big as an MSA  
4 and can maybe have 15 or 20 hospitals in it, and comparing  
5 that to the national average. So the individual hospital in  
6 the MSA has the incentive to be as inexpensive as possible,  
7 assuming that they're not thinking they're going to drive  
8 their wage index.

9 The occupational issue I think was more important  
10 in the past when we actually had to have a lot more rural  
11 hospitals that we were paying under the PPS because we had  
12 those hospitals which may be somewhat less intensive than  
13 some of the major urban area hospitals and that there was a  
14 bigger difference between the wage index because in the  
15 urban area hospitals we had more high-tech people, even  
16 beyond nurses, other kinds of ancillary personnel.

17 And again, as we've taken more of the rural  
18 hospitals out, that's become less of an issue. But why  
19 leave it as a lingering issue at all? Fix it by setting the  
20 occupational mix in setting weights for the overall index.

21 DR. MILLER: The only other thing, and this is  
22 just to think about, and we're still thinking about all of



1 this.

2 To your point about shouldn't we be encouraging  
3 the quality here as whether you want to actually pay that on  
4 the other end of the process, which is if you have good  
5 quality outcomes then I'll pay at that point, as opposed to  
6 trying to build it into the wage index. That would be the  
7 only other...

8 MR. HACKBARTH: I think that was David's point  
9 about paying for the outcome.

10 Thank you.

11 Next is physician geographic payment areas.

12 DR. ZABINSKI: In the Medicare program most  
13 physician services are paid under the physician fee schedule  
14 which has payment rates for over 7,000 services. These  
15 rates are adjusted for geographic differences and input  
16 costs.

17 In particular, under the physician fee schedule,  
18 CMS has created 89 payment localities. Each of these  
19 localities has its own set of geographic practice cost  
20 indexes or GPCIs that CMS uses to adjust the payments for  
21 the geographic difference.

22 Recently, the California Medical Association, the

1 CMA, has raised question about whether the structure of the  
2 payment localities causes the GPCIs to inaccurately reflect  
3 local costs of care, which can cause underpayments in some  
4 areas and overpayments in other areas, creating inequities  
5 among physicians.

6           The primary argument against localities is based  
7 on two points. First, they are often too large to account  
8 for geographic differences in the costs of care. And  
9 second, they are often based on geographic entities that  
10 were established as long ago as 1966 and consequently ignore  
11 changes in economic and demographic conditions that have  
12 occurred over the last four decades.

13           Because of the issues raised about the localities  
14 and because they have not been updated since 1996 we believe  
15 that they should be evaluated alongside alternative  
16 definitions. Today I'll discuss two alternatives.

17           One of these alternatives is what we'll refer to  
18 as the locality option and it was largely developed by the  
19 CMA. This alternative begins with the existing localities  
20 and then, within each locality, you calculate an index of  
21 local costs of care, a geographic adjustment factor or GAF  
22 for each of the counties in the locality. Then in each

1 locality you compare the GAF of the highest cost county to  
2 the average GAF of the other lower cost counties in the  
3 locality. Then if the GAF of the lowest cost county exceeds  
4 the average of the other counties by some preset threshold -  
5 - 5 percent is often used -- that highest cost county  
6 becomes a separate locality.

7           Then from there you go through an iterative method  
8 where in each step you compare the costs or the GAF of the  
9 highest cost remaining county to the average GAF of the  
10 other remaining lower cost counties. This iterative  
11 procedure stops at a point where the GAF of the highest cost  
12 remaining county does not exceed the average GAF of the  
13 other remaining lower cost counties by the preset threshold.

14           Basically in summary, the idea here is that within  
15 each locality if a county distinguishes itself as being  
16 relatively high cost to the other counties it becomes a  
17 separate locality on its own. And the other counties that  
18 do not distinguish themselves as high cost are collected  
19 into a single new locality.

20           The other alternative we looked at is called the  
21 MSA option. And this option is very similar to the locality  
22 option I just discussed, but a key difference between the

1 two is the starting point.

2           In particular, under the MSA option you eliminate  
3 all the existing localities and you start from scratch.  
4 Then in each state you collect the urban counties into  
5 metropolitan statistical areas or MSAs and the other  
6 remaining non-urban counties into a rest of state non-urban  
7 area. Then you calculate a GAF for each MSA and for the  
8 rest of state area. And then in each state you compare the  
9 GAF of the highest cost MSA to the average GAF of the other  
10 areas in the state. If the highest cost MSA exceeds the  
11 average of the other areas by the preset threshold, that  
12 highest cost MSA becomes a distinct and separate new  
13 locality.

14           Then you go once again through an iterative method  
15 where in each step you compare the GAF of the highest cost  
16 remaining MSA to the average GAF of the other remaining  
17 lower cost areas and you stop at the point where the GAF of  
18 the highest cost remaining MSA does not exceed the average  
19 of the other area by the preset threshold.

20           In summary, in any MSA that distinguishes itself  
21 by being high cost becomes its own locality. Those areas  
22 that are not high cost are collected into the rest of state

1 area.

2           Then, using a 5 percent threshold to identify  
3 relatively high cost area, we found that both the locality  
4 and the MSA options would increase the number of localities  
5 over what we currently have. As I mentioned earlier, we  
6 currently have 89 localities. The locality option would  
7 increase the number to 186 and most of these new localities  
8 would be single counties. The MSA option would increase the  
9 number of localities to 119 and most of these localities  
10 would have more than one county because MSAs are typically  
11 collections of multiple counties.

12           An issue to consider in any reconfiguration of  
13 payment localities is this: right now, under the existing  
14 localities, 34 states are what are called statewide  
15 localities meaning that have a single GAF or payment rate  
16 for the entire state. Two points to realize here is that  
17 the physician community chose this avenue in many these  
18 states and also that these states seem content with their  
19 current situation.

20           So this might raise the question of should the  
21 statewide localities be maintained and excluded from any  
22 reconfiguration of payment localities?

1           On the one hand, including those statewide  
2 localities in a reconfiguration would result in more  
3 accurate payments at the local level and consequently less  
4 incentive for physicians to avoid underpaid areas. Also,  
5 you would have a consistent method across all states for  
6 defining payment localities.

7           On the other hand, excluding the statewide  
8 localities from a reconfiguration would maintain continuity  
9 in the states that have decided to have equal rates between  
10 their urban and rural areas. Making changes in these states  
11 could be disruptive to existing position/patient  
12 relationships.

13           Also, excluding the statewide localities from  
14 reconfiguration would help minimize the administrative  
15 burden on CMS. For example, as I just mentioned, both the  
16 locality and the MSA options would increase the number of  
17 localities over what we currently have. This would give  
18 physicians greater opportunity to set up offices in more  
19 than one locality and then physicians could then game the  
20 system by submitting all their bills from their office that  
21 is located in the locality with the highest GAF. CMS would  
22 have to expend resources to counteract such gaming.

1           Then we went on and we applied both the locality  
2 and the MSA options using a 5 percent threshold to each  
3 state and found some interesting effects of both options.  
4 To start, we realize that both options are designed to be  
5 budget neutral nationally. But we also found that both  
6 options would be budget neutral within each state, meaning  
7 that the payments under the physician fee schedule going to  
8 each state would not change. But within states both options  
9 would shift money from some areas to other areas.

10           A second effect of both these options is that it  
11 would improve how accurately the locality GAFs, and  
12 consequently local payments, match local costs of providing  
13 care. Paying accurately at the local level can be important  
14 because it can reduce incentives for physicians to avoid  
15 underpaid areas.

16           Finally, both options would affect the differences  
17 in GAFs and payment rates between adjacent counties.  
18 Avoiding such large differences between adjacent counties  
19 can prevent perceptions of inequity between providers who  
20 might be in close proximity geographically but have very  
21 different payments because they are in different payment  
22 localities.

1           Then we went on and we used both the payment  
 2 accuracy at the county level and the differences in GAF  
 3 between adjacent counties as criteria for evaluating the MSA  
 4 and the locality options as well as the existing payment  
 5 localities. In particular, on this diagram we show how the  
 6 locality option, the MSA option and the current localities  
 7 would fare under those two criteria.

8           In the first column, it reflects the average  
 9 across counties of the absolute difference between county  
 10 locality GAFs and the county GAFs. In other words, this  
 11 column shows the average difference between county payments  
 12 and county costs. The smaller the number, the more  
 13 accurately county payments match county costs on average.  
 14 The average difference between county payments and county  
 15 costs would be about 1.5 percent under the locality option,  
 16 2 percent under the MSA option and is currently 2.2 percent  
 17 under the existing localities.

18           In the second column, we show the average absolute  
 19 difference in GAFs between adjacent counties. That is it  
 20 indicates the average difference in payment rates between  
 21 adjacent counties. Smaller numbers indicate smaller  
 22 differences on average. Here we see that the average



1 difference in payment rates among adjacent counties would be  
2 about 2 percent under the locality option, 1.4 percent under  
3 the MSA option, and is currently about 1.8 percent under the  
4 existing localities.

5           A key point to draw from these first two columns  
6 is that the results in those two columns show only small  
7 differences between what we would get under the locality and  
8 the MSA options versus what we currently have with the  
9 current localities. The purpose of the third column is to  
10 show why neither the MSA nor the locality option is much  
11 different from the existing localities.

12           In particular, the third column shows the average  
13 among counties of the change in payments from current policy  
14 to the payments that would occur under the locality and the  
15 MSA options. Smaller numbers indicate smaller changes. In  
16 particular, the average change in payments from current  
17 levels would be small under both options. It would average  
18 about 1 percent under the locality option and about 1.6  
19 percent under the MSA options.

20           On the next three slides we show the distributions  
21 of the three measures on this table. Here we show the  
22 distribution among counties of the difference between county

1 payments and county costs under the locality and the MSA  
2 options. The two main points here are that first, under  
3 both options the difference between payments and costs is  
4 less than 2 percent for a majority of counties. In  
5 particular, this occurs 64 percent of the time under the  
6 locality option and 56 percent of the times under the MSA  
7 option.

8           Second, only a small percentage of counties would  
9 have large differences between payments and costs of 5  
10 percent or more. That would occur 1.7 percent of the time  
11 under the locality option and 4.9 percent of the time under  
12 the MSA option.

13           The next diagram shows the distribution among  
14 counties of the difference in payment rates between adjacent  
15 counties under the locality and the MSA options. The main  
16 point here is that there is a large spike at zero, meaning  
17 that under both options the majority of counties have no  
18 difference in payment rates with their adjacent counties.  
19 This would occur 55 percent of the time under the locality  
20 auction and 74 percent of the time under the MSA option.

21           Finally, on this diagram, we show the distribution  
22 among counties of the change in payments from current levels

1 to payments that that would occur under the locality and the  
2 MSA options. The two main points here are first, that under  
3 both options the change in payments from current levels  
4 would be less than 2 percent for most counties. That is,  
5 that would happen about 82 percent of the time under the  
6 locality option and 67 percent of the time under the MSA  
7 option.

8           Also, only a small percentage of counties would  
9 have a large change in payments of 5 percent or more. Under  
10 both the MSA and the locality options, that would occur  
11 about 5.3 percent of the time.

12           To conclude this discussion, I'd like to consider  
13 two issues. The first is a question. Is a nationwide  
14 change in payment localities worth the costs of  
15 administrative resources that would be necessary and the  
16 potential disruption in services that could occur? I ask  
17 this because, as we just saw, the locality and the MSA  
18 options would both have small effects on the payments going  
19 to most counties.

20           Second, even though most counties would have small  
21 changes in payments, large payment errors are occurring in a  
22 few counties and these counties would see substantial

1 changes in payments under the locality and the MSA options.

2           Therefore, bringing these two issues together,  
3 because most counties would see small changes but a few  
4 would have large changes under reconfigured localities,  
5 perhaps the Commission would like to consider a method that  
6 addresses the situation of these counties that are facing  
7 large payment inaccuracies.

8           And now I turn things over to the Commission for  
9 discussion. In particular, we're looking for guidance on  
10 whether we should continue our analysis of this issue. And  
11 if so, advice on how we should proceed.

12           DR. REISCHAUER: Two observations. One is you  
13 keep referring to these changes as small, 1 or 2 percent.  
14 But let's remember, that's what the average update is or has  
15 been for the last four years. So from the perspective of  
16 physicians, it might not be so small.

17           The second observation is I wonder if we're  
18 opening up Pandora's box here with these thresholds. You  
19 say well, you look at the counties in this area and if  
20 you're 5 percent above, we regard that as justification for  
21 creating a new area. But we aren't doing it at the bottom.  
22 What if there's a county at the bottom? Or what if, among

1 all these counties, there's a gap somewhere between one  
2 group that's 5 percent lower than the next group up? We're  
3 providing a justification for a 5 percent differential that  
4 says you're different and we'll treat you differently. But  
5 we're only doing it for that differential when it occurs at  
6 the very top.

7 I think that's inviting problems in the future.

8 MR. HACKBARTH: So tell me what the alternative is  
9 to using some threshold?

10 DR. REISCHAUER: What we're doing right now, leave  
11 it alone. Most people find it's okay.

12 DR. CROSSON: I'm going to beg some indulgence  
13 here because I'm going to present a perspective from the  
14 left coast, which often requires indulgence in these here  
15 parts.

16 This actually has been a significant problem in  
17 California. It has been an issue that has created a lot of  
18 difficulty for the medical association. Obviously that's  
19 why they've been trying to find a solution. Maybe it  
20 shouldn't have, but it has.

21 There are in fact, as Bob mentioned, some counties  
22 where the physicians are receiving substantially less for

1 providing the same services. Some of those are really quite  
2 adjacent to other parts, particularly in the Bay Area.  
3 There are 10 percent differences.

4 In the current environment, and the problems  
5 created by the SGR, it just seems to have created more  
6 sensitivity than it might in an environment where the  
7 updates were more like the MEI. So when the food gets  
8 scarce, the table manners deteriorate, or something like  
9 that

10 So it is a real problem.

11 DR. REISCHAUER: What's the problem you're  
12 referring to? You have Marin County, then what's next to  
13 it, Humboldt?

14 DR. CROSSON: Hot tubs are very expensive.

15 DR. REISCHAUER: It's the gap going that way.

16 DR. CROSSON: You mean which counties?

17 DR. REISCHAUER: Isn't it a balance of the state  
18 problem which he's pointing out? How do you drift out of  
19 the San Francisco area into the more rural part of  
20 California? There's a cliff there you're talking about.

21 DR. CROSSON: For example, the difference between  
22 Santa Cruz County, which abuts with Santa Clara County where

1 I am, is about a 10 percent difference. So we actually have  
2 one medical group in Palo Alto, Palo Alto Medical Group,  
3 that has a branch in Santa Cruz which is about 35 minutes  
4 away. There's a 10 percent difference in the physician  
5 payment there.

6 DR. REISCHAUER: But are you in the same group or  
7 not? You aren't?

8 DR. CROSSON: Those are two different localities.

9 DR. REISCHAUER: But I don't how this is going to  
10 help that.

11 DR. CROSSON: Can I get on with it?

12 DR. REISCHAUER: I'm sorry, I didn't give you the  
13 indulgence that you asked for. I apologize.

14 [Laughter.]

15 DR. ZABINSKI: What would happen in this is that  
16 Santa Cruz would get carved out from what's called the rest  
17 of state right now and they would be carved out and their  
18 payment rates would go up by about 10 percent.

19 DR. CROSSON: But on a budget neutral basis.

20 DR. REISCHAUER: You're saying that Santa Cruz is  
21 10 percent under where it should be.

22 DR. CROSSON: That's correct.

1 DR. REISCHAUER: As opposed to there's a 10  
2 percent difference between these two. Those are two  
3 different facts.

4 MR. BERTKO: No, it's the same.

5 DR. CROSSON: As I was saying, so it seems to me -  
6 - and the next question is, as was part up, is this  
7 important enough to fix? It depends on the eye of the  
8 beholder. Overall, compared with some of the problems we  
9 face here, it's small. For the individuals and the dynamics  
10 that are taking place in that community -- and I think  
11 probably a few others in the United States -- it's not  
12 small.

13 There is a logic to the proposal that is to use  
14 the localities, and to use the 5 percent threshold for the  
15 ones that are at the top because that's the way the formula  
16 was created in the first place. That's how CMS created the  
17 localities in the first place.

18 So to do that and to, in a sense, open it up again  
19 for perceived problem areas is simply to use as the same  
20 mechanism that was used in the first place, not to invent a  
21 new one.

22 Or looking at it another way, you could say the



1 artificiality here was to freeze it and never change it,  
2 based on the calculations that were done in the past. So I  
3 think there's an argument there.

4           There's also an argument derived from the data  
5 that to do it that way would have less disruptive impact  
6 than for example to do the MSA model. So I think there's an  
7 argument there.

8           I think there's an argument to focus the fix  
9 initially on the 16 states that are multiple locality states  
10 because that appears to be where the greatest differential  
11 is, which is why there are multiple locality states in the  
12 first place. As opposed to necessarily opening it up  
13 immediately to all 50 states because, as was pointed out in  
14 the presentation, the majority of those states appear to be  
15 homogeneous and don't have the concerns that have been  
16 brought forward by -- as some would say -- the least  
17 homogeneous state we have in the United States.

18           I think the administrative resource issue is real  
19 and that is how many things do we want to adjust and change?  
20 I think that can be dealt with by doing this only  
21 periodically. There's no reason to do this every year. The  
22 dynamics which create larger expenses in different

1 geographic areas proceed slowly, not quickly.

2           So this adjustment, for example, could be made at  
3 one time soon, could be focused initially on the 16 multi-  
4 locality states. And then, for example, three years later  
5 or six years later that the next or the next to the next  
6 cycle of readjusting that goes on, the fix could be created  
7 again or states medical societies in this case could be  
8 given the option to propose a different way of doing it.  
9 Which changes the political dynamics within the association  
10 compared with the problem that we have now, which is they  
11 can't agree on winners and losers.

12           And in fact, in three or six years the issue of  
13 opening it up to all 50 states could be readdressed. So I'm  
14 actually suggesting a stepwise approach as a set of ideas  
15 that try to solve the problem and minimize the stated and  
16 real concerns.

17           I'm done.

18           DR. REISCHAUER: I'm being polite.

19           MR. SMITH: Jay, is what's driving the concern --  
20 you talked about the Santa Clara folks with a Santa Cruz  
21 office. Santa Cruz, I assume is in the balance of state and  
22 Santa Clara is in the SMSA?

1 DR. CROSSON: Yes, that's correct.

2 MR. SMITH: So is the different Santa Cruz costs  
3 or Santa Cruz payments? What is it that's got people  
4 aggravated? If Santa Cruz costs look more like balance of  
5 state costs, then why should the docs get Palo Alto money?

6 So it depends a little bit on how this issue  
7 shakes out in terms of real costs, not simply propinquity to  
8 a higher or lower cost place.

9 DR. CROSSON: My understanding of it is that the  
10 Santa Cruz situation was one thing in 1996, I believe it was  
11 when it was set. And now, in relative terms, it has changed  
12 over that time.

13 MR. SMITH: By Santa Cruz has gotten relatively  
14 more expensive than the rest of the state.

15 DR. CROSSON: I'm sorry, costs. And the same  
16 formula, the same process for determining whether a locality  
17 was put into the multiple locality larger group -- that was  
18 applied in 1996, if that was applied now then Santa Cruz,  
19 for the same reason, would have its own separate locality.  
20 But it was frozen and not updated.

21 DR. STOWERS: I'm going to stay a little bit out  
22 of the California question? The thing I'd like to talk

1 about a little bit would be whether we should include or  
2 exclude the statewides. Having been very involved in that  
3 at the time when we went around the nation and tried to get  
4 this statewide thing approved first and then implemented.  
5 We've got to remember the initial reason for that was the  
6 fact that there was tremendous payment between the rural and  
7 the urban physicians. And my payment, for example, was 30-  
8 some percent less for an office call in the rural than what  
9 my buddy was that was in Oklahoma City, and so forth.

10           What the physicians came together and found was  
11 there was very minimal change in those that were in the  
12 higher cost or urban areas and those type states that are  
13 very much rural to raise and to bring up an equal payment  
14 for those that were out in a rural area. And the state was  
15 facing tremendous problems of getting physicians out into  
16 the rural areas.

17           Since that time the rural implementation or supply  
18 of physicians in the rural counties is tremendously  
19 increased. A big part of that was this.

20           So by going to a more accurate payment, we would  
21 not solve the problem of getting more physicians into the  
22 needed areas. As the chapter kind of inferred, it would

1 actually do exactly the opposite and turn that whole process  
2 upside down again.

3 But the main thing that sold that argument that  
4 still exists today, and we don't go into it in this chapter  
5 and I think maybe we should before we go forward, is that  
6 there's a lot of problems in the way that this whole expense  
7 thing is calculated in the first place. And I think until  
8 those problems are corrected we're going forward with kind  
9 of funny numbers.

10 For example, what's local cost and what's national  
11 costs? I don't care if you're out in a rural area, if you  
12 buy your computers and those kind of systems, and especially  
13 as we go into high-tech areas of implementing IT and offices  
14 and that sort of thing, that's still figured on a local  
15 level.

16 So I'm just giving you one example of problems  
17 that are in there.

18 MR. HACKBARTH: I'm sure you're right that there  
19 are problems in the calculation. But let me just set that  
20 aside for a second.

21 If you have a system based on the principle that  
22 we ought to adjust for geographic differences and practice

1 costs and the payments ought to be adjusted correspondingly,  
2 it seems to me that you buy into periodic adjustments of  
3 that system.

4 Even though I think you're right, it could mean  
5 that in some circumstances, some states, it would work  
6 against the goal of encouraging physicians to practice --

7 DR. STOWERS: In fact, in the majority of the  
8 states in the nation.

9 MR. HACKBARTH: If that's the basic principle that  
10 your system is designed on, to say we're going to freeze it  
11 in perpetuity based on a snapshot that was taken in 19-  
12 whatever, just doesn't seem reasonable.

13 DR. STOWERS: I'm speaking to agree with Jay that  
14 I think that we should leave alone those that are agreeing  
15 to a statewide concept to meet the mission of that state to  
16 serve their rural areas. But I think it makes absolutely  
17 perfect sense in those where you're going to recalculate to  
18 do it with more current data and to update it and that kind  
19 of thing.

20 But I don't think the two necessarily have to go  
21 together. If the state believes in the purpose of a  
22 statewide, then let them do it. But if in fact a state that

1 has great variance needs to recalculate and has a different  
2 distribution of physicians, then it doesn't make sense to be  
3 on 1996 data and that kind of thing.

4           There's another number in here that would  
5 tremendously change things is that somehow in the original  
6 figuring of geographic costs, physician work was left in as  
7 part of the geographic -- this is not just based on practice  
8 expense. That geographic factor also applies to physician  
9 work.

10           So it makes sense to me that if we recalculated  
11 this and looked at it again just based on the practice  
12 expense, but right now there's geographic adjustments for  
13 work, practice expense and for the malpractice or  
14 professional liability. That is another number that a lot  
15 of people who calculate it say will change these numbers a  
16 lot.

17           It really doesn't make sense that somebody working  
18 in a rural area seeing the same patient, doing that same  
19 work piece, would be paid differently than somebody in a  
20 different setting. Although if in fact the state chooses, I  
21 think there should be a different geographic practice  
22 expense change in there.

1           So I think there is just things in that that  
2 really need to be looked at. With the minimal changes  
3 occurring here, especially with the statewide, I'm not sure  
4 it's time to move with it. That's all I'm saying.

5           DR. NELSON: We've always had, since I've been on  
6 the Commission, we've said that the payments should try and  
7 accurately reflect the cost of providing the care. And if  
8 there are reasons for giving additional payments to  
9 underserved areas, we ought to deal with that directly by  
10 having payments for physicians in underserved areas, as we  
11 do. If that isn't enough, we ought to make it more. That's  
12 a different issue.

13           I can't see why not to support this. The idea of  
14 well, CMS has got a lot of work to do, well that doesn't  
15 negate the principle that we've adhered to in the past. We  
16 tell them to do a lot of work on a lot of things and they do  
17 as much as they can.

18           So I'm with Jay. And I'm not with it just to  
19 solve California's problems. The bigger issue is to have  
20 payments accurately reflect the local cost of providing care  
21 to the degree that that's possible.

22           DR. MILSTEIN: Again holding California aside, I



1 want to second Alan's point. We have recommended  
2 adjustments in the payment system to improve its fairness  
3 for differentials and unfairness as we've calculated far  
4 smaller than these 10 to 15 percent levels of unfairness  
5 that we've uncovered in some areas.

6           So I think if you use our precedent of what degree  
7 of unfairness we previously used as a threshold for action,  
8 such as our recommendation to refine the hospital payment  
9 system, they have been at far lower levels of percentage  
10 imputed unfairness than we're looking at in some of the  
11 geographic areas described here.

12           MS. BURKE: I don't disagree with the ultimate  
13 goal of trying to be as accurate as we can and tracking as  
14 best we can a payment system that reflects the actual costs  
15 of doing business. I am reminded a bit of the debate that  
16 have taken place historically though around MSAs. And any  
17 time you begin to geographically break things up, people  
18 suddenly yearn to be in another county. We have lots of  
19 examples of statutes that moved people across lines to take  
20 advantage of difference in payment rates.

21           I am interested in the issue that Ray has raised  
22 and that is to try and get a better understanding of how

1 widespread this problem is and whether there is a way to get  
2 to a solution that makes sense without reconfiguring the  
3 entire system.

4 I'm also mindful of Bob's comment, that while 1  
5 percent seems small, it isn't small to the folks at the 1  
6 percent. And I am interested in the charts that show, in  
7 some cases, there's zero or less but in some cases there's 5  
8 and 10 percent. I can already imagine there are folks in  
9 the back of the room that are trying to figure out that map.  
10 And that is who's in which of those columns, in terms of  
11 what the impact would be.

12 I think it would be important to understand that,  
13 that is how widely distributed this problem is. As I  
14 understand it, as I recall from the paper, there are 20-  
15 something statewide currently. 26? I can't remember.

16 DR. STOWERS: 34.

17 MS. BURKE: 34 current statewide. And so the  
18 question is, as you begin to move around, do they rethink  
19 their position? Don't know that, whether anyone's asked  
20 that question or whether that would be a question that would  
21 need to be asked.

22 But I think that Dan has laid out for us the whole

1 series of questions and a couple of options that are  
2 certainly worth considering. And I think there should be a  
3 goal of trying to make sense out of what, in fact, is  
4 reality in today's market. These are quite dated.

5 But I would want to understand more clearly what  
6 the distributional impact might be, how widespread this  
7 problem is today. I know it can't possibly simply be  
8 California but I would interested in understanding how much  
9 dislocation there currently is. I think the goal ought to  
10 be to try to make more sense out of it but it is a quagmire  
11 once you get into it, once you start moving things around.

12 And I'm assuming, Dan, and I'm assuming in the  
13 course of this work that the expectation is whatever change  
14 would be made would be neutral to the area? Or are you  
15 talking about redistributing across the entire system?

16 For example, if you leave the states intact, those  
17 that have chosen to be statewide, and you start adjusting  
18 and fix the problems -- I mean we're not fixing the problems  
19 where people are being overpaid potentially. If you assume  
20 this is a zero sum game, you're going to be moving money  
21 around.

22 The question is you're moving around what area?

1 Is it the presumption that you only move it within a stat?  
2 Do you move it across the system so that you're taking from  
3 Mississippi to take care of Texas's problems? Or whomever  
4 it is that happens to play out.

5 What is the expectation in any of the scenarios  
6 that you've laid out?

7 DR. ZABINSKI: As it turned out, I don't want to  
8 say this was almost an accident, but both these alternatives  
9 I talked about are budget neutral within each state. So  
10 each state, the payments going to each state would not  
11 change from what they currently get. But there would be  
12 shifting, of course, within states.

13 MS. BURKE: And that's because we would construct  
14 it in that way or that's just the way the analysis worked  
15 out?

16 DR. ZABINSKI: Here's my take on how it happened  
17 is that the current localities are sort of self-contained.  
18 Each state has divided up into each locality. These  
19 localities never cross state lines. And both these options  
20 sort of do the same thing. They just take each state -- I  
21 mean, the locality option just takes the existing localities  
22 and draws out some high cost areas and leaves the rest of

1 them.

2 DR. REISCHAUER: Then you recalculate the GPCI for  
3 what's remaining there in locality and it goes down. So  
4 Santa Clara goes up and the balance of that locality goes  
5 down.

6 MS. BURKE: That is a policy position we're taking  
7 is that whatever we do --

8 DR. REISCHAUER: That's the way it works.

9 MS. BURKE: I'm just asking the question. That's  
10 the way we'd structure it? So it would be within the state.  
11 I just wanted to clarify that.

12 DR. MILLER: I guess I just want to clarify that  
13 you're saying a policy position we take. Generally the way  
14 people have thought about reconfiguring these localities and  
15 adjust them a little bit or work with the MSA, the  
16 arithmetic just basically falls that way. It's not like we  
17 set out and set up --

18 MS. BURKE: No, I understand. I understand.  
19 That's why I was asking the question as to what the impact  
20 would be, because any time you get into a redistribution,  
21 there are inevitably winners and losers. And so the  
22 question is how widely distributed are those wins and

1 losses? And the question is they are within that small  
2 venue.

3 But again, I think we'd want to understand more  
4 clearly, I mean to look at these things at a distance and  
5 see sort of the movement around of 1 percent, 2 percent,  
6 becomes much more real when you actually run these numbers  
7 out and you look at which counties are actually affected.  
8 And people become much more engaged in that when that  
9 becomes the case.

10 So again, I think we'd want to understand a little  
11 more clearly and query whether or not it is a solution that  
12 can be applied only to the areas that are identified as  
13 problems or whether this is something that we would want to  
14 put through the entire system. I think that Ray raises a  
15 good point.

16 MR. HACKBARTH: I think we are well short of a  
17 consensus on this, so I think the chapter that we write we  
18 need to be very careful not to imply that there is agreement  
19 on one option or the other. It has to be very much on the  
20 one hand, on the other hand.

21 My sense of this is that the "problem" is not  
22 widespread. It is relatively localized, which is good news.

1 All other things being equal I'd just as soon not have the  
2 whole system overturned and redone, although I guess that is  
3 sensitive to what you define as the threshold of a problem  
4 and the analysis that's been done here used 5 percent. I  
5 don't know why 5 percent is better than some other number.

6 DR. REISCHAUER: And only at the top.

7 MR. HACKBARTH: And only at the top.

8 DR. REISCHAUER: So by definition it's going to be  
9 small.

10 MR. HACKBARTH: So the basic issue here is if we  
11 have a system that adjusts for geographic differences, to  
12 whom does the right to fair payment belong? Is it a state  
13 association right? Or is it the right of the individual  
14 practitioner being paid under the system?

15 I think our general policy in Medicare is it's the  
16 right of the individual practitioner to fair payment. And  
17 so we need to set some threshold. We need to periodically  
18 readjust the system to reflect changes in underlying  
19 practice costs. And I don't think a state association or  
20 anybody else ought to be able to override that and say no,  
21 we want a different distributive policy.

22 To be very specific, I'm agreeing with Alan. If

1 we want to increase payments for rural areas because of  
2 shortage issues, we've got mechanisms in place to do that  
3 and we can use those and increase those payments more.

4 But to say that we're going to stop geographic  
5 adjustment as a way to accomplish that goal, I think is not  
6 fair, it's not consistent with our basic payment systems in  
7 Medicare.

8 DR. STOWERS: I may have misspoken there a little  
9 bit. It's not so much that it was just simply being used as  
10 a mechanism to get payments out. I think that this would  
11 have never happened in those states, the 34 or whatever, if  
12 in fact they felt that the system adequately represented the  
13 expenses in the lower cost areas. And those problems that  
14 were recognized nationwide, the distribution of what you  
15 have to acquire nationally and all of those things have  
16 never been corrected.

17 So what I'm saying going forward with this kind of  
18 thing, without having an accurate way to measure practice  
19 expenses in those areas, could do a lot more damage than  
20 could do good. I'm not against going back to it but what  
21 happened at that time, there was a policy decision made in  
22 Washington that rather than to go back and write the whole



1 way of calculating the thing, because everybody in the  
2 nation at that point agreed that the way that the practice  
3 expense was being figured in those areas was very, very  
4 inaccurate. So what do we do? We'll just allow the states  
5 to go to a statewide thing.

6           So I'm saying going ahead without now going back  
7 to Congress and fixing those other problems doesn't make  
8 sense. If we go that route and recommend doing that and  
9 then go to an accurate way of -- because I think you're  
10 going to find the practice expenses in those areas to be  
11 considerably higher than what was first believed to do just  
12 because of the old formulas that go back into the '80s that  
13 have never been changed.

14           That was my point. It was just the only mechanism  
15 at that time to fix a problem with the way it was  
16 calculated.

17           MS. BURKE: Following on it, it raises an  
18 interesting question. If in fact we take the position that  
19 we believe that there ought to be more accuracy in payment  
20 and that we ought to, by trying to solve this problem, move  
21 in that direction, one might wonder why we wouldn't then go  
22 back to those states that have chosen to essentially blur

1 those lines and take a position that in fact the answer is  
2 essentially a statewide. Why would they not want to come  
3 back and say well, if you've got a better way of figuring  
4 out things that are much more geographically specific, why  
5 aren't we back in the game? What makes us different?

6           It would be one thing to say let's fix the problem  
7 but it does ultimately raise the question if the presumption  
8 is that the statewide -- which was the blurring -- was to  
9 avoid having to deal with a problem they couldn't deal with,  
10 if you now have a way to deal with it because you're able to  
11 be more accurate, why wouldn't those same states come back  
12 and say we want to be back in play? Why are you leaving us  
13 essentially with this system that is, in fact, not as  
14 accurate as you're now able to do?

15           It would be difficult to explain, I think.

16           DR. REISCHAUER: Because they might legitimately  
17 want to pursue this other social goal, which is the  
18 redistribution of medical resources towards underserved  
19 areas. And they realize that the federal system is not very  
20 responsive to that need.

21           We have two conflicting objectives here, both of  
22 which are worthy.

1 MS. BURKE: Who's decision is that? To Glenn's  
2 point, whose decision is that to make? Is that a state  
3 society's decision?

4 MR. HACKBARTH: Potentially what you could have is  
5 a system that says the basic rule is that the right to fair  
6 payment belongs to the practitioner. And so when a locality  
7 exceeds a certain threshold, gets out of line by whatever  
8 the percentage is, we reconfigure. So do you take Marin  
9 County out and that means that all the lower cost counties  
10 in the locality are going to go down, just the arithmetic is  
11 going to work that way?

12 Now if California wants to come in and can develop  
13 consensus, including the physicians in Marin County, for an  
14 alternative financing mechanism that may be more compatible  
15 with their goals, they could do that. But Marin gets fixed.  
16 They have a right to get fixed. So if you can't reach  
17 agreement, Marin still gets fixed. But if you can reach  
18 agreement on an alternative statewide policy, CMS respects  
19 that.

20 MR. SMITH: [off microphone.] Why wouldn't that  
21 logically lead any practitioner to do that? If the  
22 practitioner's got a right to fair payment and an accurate

1 system provides them with that fair payment but her  
2 colleagues decide that they'd rather send the money a little  
3 bit further north, how do you square your principle which I  
4 think you've articulated well with not paying fairly?

5 MR. HACKBARTH: You're raising an important point  
6 about how you would operationalize all of this. Is it every  
7 individual practitioner? Is it a majority of the  
8 practitioners in Marin County? Point well taken.

9 Personally, I feel that the basic decision role  
10 needs to be fair payment for providers. I'm just trying to  
11 think imaginatively about a way that we could allow by  
12 consensus some alternative policy be pursued within a state.  
13 But that may not be workable.

14 Mar, do you have any --

15 DR. MILLER: I knew it was going to come to this.

16 MR. HACKBARTH: I'm trying to give you a lots of  
17 time.

18 DR. MILLER: I know and I've been using it, but I  
19 have a phone call so I have to step out. I can't answer the  
20 question.

21 We're left with the dilemma of trying to write the  
22 chapter here. I have been trying to think about this as you

1 were going around. There are a range of options that have  
2 been talked about here, including one early on of maybe you  
3 just leave it alone. Because if these principles are so  
4 much in conflict and there is not a clear way to break out,  
5 it does maybe mean that there is that.

6           There's a couple of things here. The chapter  
7 could try and set up this internal conflict, what is the  
8 guiding principle in this, and then try and talk about the  
9 different options because the different options basically  
10 fall along how you feel about these different principles.  
11 So you could have sort of an automatic adjustment if your  
12 principle is that every physician should be dealt with as  
13 accurately as possible. But if your principle is that the  
14 state has an overriding social goal, you could talk about  
15 allowing the state to come in and say, actually we don't  
16 want this to happen. We want it to happen this way, as long  
17 as there's a consensus in the state -- however defined.

18           The chapter could just simply go through that and  
19 in a very noncommittal way say these are the different ways  
20 you could think about it. Because that's the only way I can  
21 see drawing this together because there is no clear take on  
22 it.

1           The other thing is, if we think that there is  
2 still work to be thought about, if there's not enough  
3 consensus as to whether we're really ready to go forward  
4 with this.

5           MS. THOMAS: We had not intended for this to be a  
6 June report chapter, not wanting to roll this out in April  
7 and have this be your first time through. So we can return  
8 to it if you decide.

9           DR. MILLER: Maybe that's what we're doing here.  
10 I guess I should have taken that call. Oh, it was Sarah  
11 saying don't say what you're about to say. It happens a  
12 lot.

13           [Laughter.]

14           DR. MILLER: So I guess if this is not going to  
15 going into June, I think we can try and take another pass at  
16 some of these sets of questions and then bring it back to  
17 you and see if we cannot come to a consensus at least we can  
18 capture the degree of disagreement fairly among the  
19 commissioners. Is that fair?

20           DR. REISCHAUER: Is all the data collected on a  
21 county basis?

22           DR. MILLER: Yes.

1 DR. ZABINSKI: Yes.

2 DR. REISCHAUER: Because supposedly these are  
3 groups of counties that have homogeneous costs and there's  
4 really no reason why they have to be contiguous at all. And  
5 you could say there's going to be six categories in  
6 California and we're grouping these 22 counties that have  
7 costs around 84 together and these 16 counties that have  
8 costs around 97 together and treat them that way rather than  
9 the way we've done it in the past.

10 It might be that Santa Clara and Santa Cruz and  
11 Marin are one group.

12 MS. BURKE: Mark, in pulling that together I would  
13 be interested in seeing the list of states that are  
14 currently statewide. It would be interesting to understand.

15 DR. ZABINSKI: Figure 4 in your mailing material  
16 has a map. Any state that's one solid color is a statewide  
17 locality.

18 MS. BURKE: I'm sorry. That's my fault.

19 DR. MILLER: I'm glad we could respond to that  
20 request.

21 Bob, to your point, we certainly could devise a  
22 thing like that. But I think if I understand what you're

1 saying, that means two counties could be right next door to  
2 each other and paid very different rates. At least one of  
3 the things that people get excited about is that very  
4 phenomenon. So you would be saying --

5 DR. REISCHAUER: But they'd only be paid very  
6 different rates if their costs were very different.

7 DR. STOWERS: [Inaudible].

8 DR. REISCHAUER: That's a whole different issue  
9 that you brought up, that maybe we have flawed methodology  
10 to begin with.

11 DR. MILLER: Are we done? Say yes.

12 MR. HACKBARTH: I think we're past done, actually.  
13 Thank you, Dan.

14 Next up is a discussion of practice expense or one  
15 specific facet of practice expense.

16 MS. RAY: Last month Ariel and I raised some  
17 issues about data sources CMS uses to calculate practice  
18 expense payments. This work fits into our broad agenda to  
19 examine physician payment issues, including the SGR and the  
20 unit of payment.

21 Recall that in our March 2006 report we made a  
22 series of recommendations to improve CMS's process for



1 reviewing work RVUs. These recommendations address the  
2 concern about the mispricing of services in the physician  
3 fee schedule. The Commission and others have argued that  
4 inaccurate pricing may be leading to increased volume in  
5 areas such as imaging. We are now turning our attention to  
6 the other major component of the fee schedule, practice  
7 expense. Our analysis of practice expense also addresses  
8 this pricing issue. In today's session we are focusing on  
9 the practice expense RVUs for imaging services, MRIs and CT  
10 scans.

11 This is behind tab K of your mailing materials.  
12 This is a draft chapter for the June 2006 report.

13 MR. HACKBARTH: Thank you, Nancy.

14 MS. RAY: You're welcome.

15 Practice expense payments are important. They  
16 account for about half of the payments to physicians. Given  
17 the magnitude of the dollars involved in payments can boost  
18 volume for certain services inappropriately and undermine  
19 access to beneficiaries' access to care. Some of you have  
20 expressed concern that inaccurate payments can make some  
21 specialties more financially attractive than others. These  
22 are all points that were raised in our study on work RVUs.

1 CMS divides practice expenses into two categories,  
2 direct and indirect. For most specialties, indirect costs  
3 account for about 60 percent of total practice costs.

4 Recall last month I told you that CMS uses a  
5 micro-costing database of the direct practice costs incurred  
6 by physicians to provide nearly all of the 7,000 or so  
7 services paid for under the fee schedule. We are concerned  
8 that CMS overestimates the practice costs for certain  
9 imaging services -- MRIs and CTs -- because the equipment  
10 use rate may be too low and the interest rate -- that is the  
11 cost of capital -- may be too high.

12 So let's first address the equipment use rate. To  
13 derive the cost of a unit of equipment per service CMS  
14 multiplies the number of minutes it's used for that service  
15 by the cost per minute. The cost per minute is based on the  
16 equipment purchase price, how frequently it's used, the cost  
17 of capital, and other factors. The frequency of use  
18 assumption is very important. If equipment is used at full  
19 capacity, the cost is spread across many services and the  
20 cost per service is lower.

21 By full capacity we mean that the piece of  
22 equipment is used during all hours the practice is open for

1 business. If equipment is used at lower capacity, the cost  
2 is spread across fewer services and the cost per service is  
3 higher.

4 Right now CMS assumes medical equipment is used 50  
5 percent of the time.

6 Imaging services are diffusing. CTs and MRI  
7 machines are expensive and providers may have an incentive  
8 to use these machines, to the extent possible, to cover  
9 their fixed costs. This raises the question of whether  
10 CMS's 50 percent assumption is appropriate for MRIs and CTs.

11 It's important to note, I want to raise a  
12 technical issue, that the technical components of most  
13 imaging services are not currently valued using the direct  
14 inputs including the 50 percent assumption. Instead, right  
15 now CMS bases them on historical charges. However, CMS has  
16 given a strong indication that it will eliminate the charge-  
17 based approach and will instead use the direct inputs to  
18 value imaging services. Thus, it will be very important to  
19 make sure that the inputs, especially the equipment costs,  
20 are accurate.

21 We wanted to see whether it would be feasible to  
22 collect data on how frequently imaging machines are used

1 through a provider survey. We focused on MRI and CT  
2 machines because of the rapid growth of these services and  
3 the high cost of these machines. We surveyed providers in  
4 six markets listed on this slide who billed Medicare in 2003  
5 for MRI or CT scans. Ariel took the lead on this survey.

6 We chose these markets because they represent a  
7 range of geographic areas and a range of per capita Medicare  
8 spending.

9 Our survey had a high response rate, 72 percent.  
10 Based on the information we collected, we calculated the use  
11 rate for each provider. We then calculated both medians and  
12 means across markets.

13 We found that across all markets the median use  
14 rate for MRIs is 100 percent. That means that 50 percent of  
15 the respondents are at or below 100 percent and 50 percent  
16 of the respondents are at or above 100 percent. The median  
17 might be thought of as representing the typical provider.

18 At the other upper end of the distribution a small  
19 number of respondents had use rates above 100 percent. That  
20 is they used their equipment for more hours than the  
21 facility was open for business. Some of these providers  
22 said that they see patients with urgent needs outside normal

1 business hours or that they perform studies on urgent  
2 patients during normal business hours which causes delays  
3 for scheduled patients and forces the center to operate  
4 longer than usual.

5           The mean use rate across all markets for MRIs was  
6 91 percent and the 95 percent confidence interval on that  
7 value was 85 percent and 97 percent above CMS's 50 percent  
8 use rate assumption.

9           Let's move to CT use now. The median use rate for  
10 CTs is 75 percent. The mean use rate across all markets was  
11 very close to that, 73 percent. And the 95 percent  
12 confidence interval ranged from 65 percent to 81 percent,  
13 again above the 50 percent assumption rate.

14           This survey is a first step in examining the use  
15 of imaging equipment. It was not nationally representative  
16 and it was not designed to determine equipment use rates.  
17 Its intent was to assess the feasibility of getting use rate  
18 data from the survey. It shows that a the short survey  
19 instrument can be used to collect information on how  
20 frequently equipment is operated while achieving a high  
21 response rate.

22           It also raises questions about CMS's assumption

1 that MRIs and CTs are used 50 percent of the time.

2           Now let's look at another factor CMS uses to  
3 calculate the cost of medical equipment, the cost of  
4 capital. This refers to the interest rate on a loan or the  
5 opportunity cost of money spent to purchase equipment. In  
6 CMS's formula, they assume that providers pay an interest  
7 rate of 11 percent per year when borrowing money to buy  
8 medical equipment. The current assumption, developed in  
9 1997, is based on prevailing loan rates for small businesses  
10 which are used as a proxy for physician practices.

11           We were not able to locate a current source of  
12 data on small business loan rates. However the Federal  
13 Reserve Board collects quarterly information on commercial  
14 loans made to different types of providers. The information  
15 from the Federal Reserve suggests that CMS's assumption is  
16 too high.

17           Based on the Federal Reserve survey data for the  
18 first quarter of 2006 the highest risk loans of more than  
19 one year had an average annual interest rate of 8.5 percent.  
20 The lower risk loans were 7.7 percent.

21           So to sum up our presentation, we provided  
22 evidence from the survey that providers in at least some

1 markets, six markets, are using their MRI and CT machines  
2 more than 50 percent of the time. We found a more recent  
3 source of data on interest rates which suggests that CMS's  
4 current 11 percent interest rate assumption for loans to  
5 purchase equipment is too high. This evidence raises  
6 questions about CMS's assumptions in how they're calculating  
7 the medical equipment practice expense costs in their micro-  
8 costing database.

9 Consistent with CMS's statements of making payment  
10 for imaging services resource-based, changing the use rate  
11 and the interest rate would lower practice expense RVUs for  
12 MRI and CTs and these RVUs would be redistributed to other  
13 services, budget neutral.

14 We are interested in getting your feedback on  
15 today's issues, as well as the draft chapter.

16 Finally, Ariel and I will be continuing to work on  
17 practice expense issues throughout the summer, including the  
18 one that you raised, Ray, about the GPCI adjustment for  
19 national versus local.

20 MR. HACKBARTH: So this becomes an issue only for  
21 when CMS moves to a bottom-up calculation of practice  
22 expense; is that right?

1 MS. RAY: No. Well, partly yes.

2 This becomes an issue once CMS pulls these  
3 nonphysician work services out of -- when CMS eliminates the  
4 nonphysician work pool and treats these services as they  
5 treat all other services. So this will happen even if CMS  
6 keeps the top-down method.

7 MR. HACKBARTH: Okay.

8 On the issue of the utilization of equipment, you  
9 gave us a little survey data that suggests that the 50  
10 percent number at least it is not an accurate representation  
11 of this sample.

12 To me a question is whether this ought to be an  
13 empirical estimate of actually use or whether this ought to  
14 be a normative statement about what constitutes an efficient  
15 provider. I guess I would be inclined to the latter, as  
16 opposed to the former. I welcome reactions from Nancy and  
17 others on that.

18 DR. MILSTEIN: I agree with that principle and I  
19 think, in addition, I would comment that per this discussion  
20 and our prior discussion one of the things that the last two  
21 sessions have surfaced is the lack of regularity of updating  
22 things that bear directly on payment fairness.



1           In the last discussion we're looking at payment  
2 boundaries that were determined in 1966, unless there was a  
3 misprint on the slide. And here we're looking at an  
4 interest rate that was set in 1997.

5           If we're really interested in payment fairness we  
6 need some kind of -- cutting across all of our updates -- a  
7 rule that says we never let information be more outdated  
8 than X years before we update it.

9           DR. SCANLON: I'm certainly not against efficiency  
10 but I think that we have to recognize that the circumstances  
11 will vary. The fundamental goal of Medicare payment policy  
12 is making sure that you have access for Medicare  
13 beneficiaries at an efficient price. Depending upon the  
14 community, how densely populated it is, et cetera, maybe we  
15 should think about are we willing to pay for equipment to be  
16 used less frequently so that people don't have to go 50  
17 miles or 100 miles to get that kind of a service.

18           So we've used the actual experience and so far we  
19 haven't gotten into trouble with it.

20           We do need to think about how to become more  
21 aggressive about encouraging efficiency, but at the same  
22 time I don't know if we can use an arbitrary -- it's not

1 arbitrary -- a norm for efficiency because it's going to  
2 turn out to be conditional upon many things.

3 MR. BERTKO: To partly counter Bill's comment,  
4 particularly in area of imaging though, your normative --  
5 particularly where we know it's 100 percent, and if a  
6 community has 10 imaging machines and the 11th one going to  
7 be used 10 percent of the time, I'd still stay with the norm  
8 because that's maybe what's called for today.

9 DR. REISCHAUER: Nancy, did you break down these  
10 usage rates by physician offices versus imaging centers?  
11 You said the sample contains both. I didn't know if there  
12 was a big difference between those.

13 MS. RAY: We do have that information.

14 DR. REISCHAUER: Is it large? Significantly  
15 different? It couldn't really be because I think over half  
16 of them were physician's offices.

17 MS. RAY: I do want to caution that this survey is  
18 not representative anything.

19 DR. REISCHAUER: But it does suggest that 50  
20 percent is wrong, is way too low.

21 MS. RAY: What I can tell you is, for example, the  
22 IDTFs were open for more hours than the physician groups and

1 that the average hours that the MRIs and the CTs were used  
2 was lower in physician offices versus IDTFs. Does that  
3 help?

4 DR. REISCHAUER: It doesn't answer the question.

5 MS. RAY: But I don't have the equipment use rates  
6 by --

7 DR. REISCHAUER: You've given me the numerator but  
8 not the denominator.

9 MR. HACKBARTH: Bill, the point you raise is a  
10 reasonable one but it actually applies if we try to use an  
11 empirical estimate as well. The actual use rates may vary  
12 based on community conditions and the like. So if we use a  
13 single rate, whether it's empirical or a normative standard,  
14 we might have problems in unique circumstances.

15 So let me just focus on the normative idea for a  
16 second. If we were to go down that track in this particular  
17 area, would that implicate other areas of payment policy?  
18 Would we be breaking new ground that have ripple effects for  
19 other types of providers? And we'd need to think that  
20 through before we rush down this path? Any reaction, Mark  
21 or Nancy or anybody? Can you think of other places where  
22 this would have a ripple effect?

1 DR. MILLER: I'm more sympathetic to the second  
2 half of your comment in the sense of without being able to  
3 draw up specific examples I think we should think about  
4 this, because I do think it begins to ask questions about  
5 what is the underlying philosophy of these payment systems?  
6 Are getting prices accurate versus accurate for the  
7 efficient provider.

8 And I think to pick it in an area like this, it  
9 seems so clear and so it's easy to want to just go that way  
10 and say come on, this must be what we want to do. But I  
11 think I would caution that we think a little bit about it  
12 rather than state it as this is the principle and we're good  
13 to go, that we think about -- we think about holding off on  
14 that.

15 And here more the driver is that the data is  
16 suggestive that this assumption is wrong, raise that as a  
17 concept. But I wouldn't rush to it right off, for myself  
18 anyway.

19 DR. MILSTEIN: I certainly agree with the concept  
20 of looking a few moves down the chessboard before  
21 proceeding. But that said, I think we've gotten a pretty  
22 strong signal in the MMA that beginning to recalibrate our

1 recommendations to what's needed for efficient provision of  
2 health care is the direction that Congress wants to go. So  
3 obviously we need to -- this has implications throughout  
4 every -- that, in turn, has implications for almost every  
5 decision we make.

6           In many cases, as Glenn has pointed out  
7 previously, we're not in a position to implement that  
8 general concept. But where we come across opportunities to  
9 implement it, it seems to me we ought to tilt toward  
10 pursuing it.

11           DR. MILLER: Again, this is not to disagree. This  
12 is just to sort of think down the chessboard. I do embrace  
13 that principle and I think it's absolutely important. I  
14 think it's a question of where in your system you want it to  
15 happen. Just sort of harken back to the discussion about  
16 the quality. Do you want to build the metric on  
17 occupational mix based on the quality provider? Or do you  
18 want to build the metric to be relatively -- all right I'm  
19 just trying to get an accurate adjuster here, and then  
20 reward efficiency quality as sort of a separate transaction?

21           That's really what I'm trying to get it. Do you  
22 build it into each of your indexes as you're going through

1 your systems? Or do you really think about trying to incent  
2 that almost above this?

3 And that's not a yes or no. That's the three  
4 steps down the chessboard I would try and think.

5 DR. SCANLON: I would agree. In some respects, we  
6 aren't really operating even on the empirical level purely.  
7 We're operating on it to a degree and then there's a lot of  
8 slack that we've built into the rates and so far we've  
9 gotten along okay with that.

10 With Arnie's point, we do need to move towards  
11 better rates in terms of trying to be making the Medicare  
12 program an efficient provider, and efficient purchaser.  
13 That's somewhat different than saying we're going to look at  
14 what the efficient provider is doing because there are other  
15 circumstances that we have to take into account.

16 The prior discussion about physician areas, we  
17 brought up this idea of we've got the costs in areas but  
18 then we may have issues of trying to attract physicians to  
19 these areas. We may have two separate mechanisms, we may  
20 have the GPCIs and we may have the rural add-on.

21 But when we start to think about adjusting one,  
22 are we able to adjust the other one simultaneously in the

1 right way?

2 We've got so much built into our payments right  
3 now that are not quite perfect, to make want one part  
4 perfect may have consequences that we find very undesirable.  
5 And so it is thinking several steps down that chessboard,  
6 knowing what we can change to influence the bottom line so  
7 that we preserve the access that we want, that we then  
8 promote quality and we promote efficiency.

9 That's the only caution. It's not one that we  
10 can't improve but it's a difficult job of doing it.

11 As I remember when practice expense was first  
12 introduced and HCFA at the time had the bottom-up method,  
13 the assumption of 50 percent was challenged as being too  
14 high. Whether the challenge was valid is another issue but  
15 there were certainly people approaching the Congress saying  
16 we're being penalized here because we can't use our  
17 equipment that frequently.

18 Even in this, knowing the percentage is, in my  
19 mind, not enough. If you really want to do this  
20 appropriately, you need to think about what's the cost per  
21 use. So if people are operating different numbers of hours,  
22 we want to know how many units do they get out of this in a

1 day. That's what the cost is that we should actually be  
2 calculating.

3 There are many, many steps down the road that we  
4 need to think about before making big recommendations here.

5 DR. KANE: Might this be the same kind of problem  
6 as new services versus existing? That originally it was set  
7 fairly low because it would just be disseminating and now  
8 it's pretty established? I mean, how rare -- how hard is it  
9 in rural areas these days to find an imaging center? I've  
10 heard that that's the only thing people can afford now.  
11 It's so remunerative that everybody's got one and they're on  
12 every corner in rural areas, as well as -- that's probably a  
13 gross exaggeration.

14 Is this the same kind of problem as new services  
15 in the physician fee schedule versus ones that have been out  
16 for a while? And should we apply a similar kind of rule  
17 that after a while we should do revisit any capacity  
18 assumption and assume it's pretty well disseminated and then  
19 adjust it for the efficient provider at that point?

20 I can see where 10 years ago maybe 25 percent was  
21 asking for a lot. I just wonder now if it's all that hard  
22 to get an MRI or a CT scan anywhere.



1 DR. WOLTER: I think it's certainly true that many  
2 rural, even critical access hospitals, are now putting  
3 advanced imaging in because you really can get about a  
4 bottom line out of a relatively few studies per day, which I  
5 think would certainly support the fact that maybe 50 percent  
6 isn't the right number.

7 Sometimes I feel like were too cautious and I know  
8 we need data and we need to be able to justify what we're  
9 doing. But you look at the explosion of volumes in certain  
10 areas, whether it's specialty hospital or imaging or  
11 whatever, and we have a crisis that we're headed into just  
12 over the next few years. There are many reasons to fall on  
13 either sides of the argument.

14 The main reason I would put out that we have to be  
15 cautious with imaging is that it's one of the five or six  
16 profitable areas that both physicians and hospitals can look  
17 at. And if we're going to provide mental health and  
18 geriatrics and care for medical illness, all of which you  
19 lose money on, making changes in this without addressing  
20 those creates problems for providers.

21 But as a stand-alone issue, is there huge  
22 profitability in imaging? Is that driving behavior? Can

1 people make a lot of money with a fairly low volume per day?  
2 The answer to all of those questions is certainly.

3 MS. RAY: I just want to clarify a point. The 50  
4 percent assumption that CMS uses in its CPEP or direct input  
5 database, it uses that assumption for all medical equipment  
6 not just MRIs and CTs. We have focused on MRIs and CTs  
7 because that's where this assumption makes a big difference  
8 because these machines are so expensive, \$1 million to \$2  
9 million, versus a \$500 new table for example. The  
10 assumption doesn't have the same impact. But this  
11 assumption is used across all of the nearly 8,000 services  
12 that's in this micro-costing database, this 50 percent  
13 assumption.

14 DR. KANE: Do you know where it came from?

15 MS. RAY: I was looking to Bill for a little help.

16 DR. SCANLON: It appeared and was challenged.  
17 That's all I remember. But I think a key thing though is  
18 that in the top-down method what we're talking about is  
19 allocating the amount that's spent on equipment. So it's  
20 very different than if we're trying the true bottom-up,  
21 which is to make a set of assumptions and get a set of data  
22 and combine them and say this is what the relative value is.

1           Because to the extent that only certain  
2 specialists have CTs and MRIs, and we've got their pool of  
3 actual spending, we've got to control or we mitigate the  
4 role of the assumption. But again the true bottom-up method  
5 is going to eliminate that control.

6           DR. NELSON: The chapter makes the point that if  
7 we recalibrated the expenses as suggested, the savings would  
8 be redistributed. And to meet the concern that Nick  
9 expressed, I think we need to be pretty strong and make sure  
10 that those savings were redistributed, should be  
11 redistributed in a way that provides better support for  
12 those things that aren't currently paying for themselves.

13           MR. HACKBARTH: Okay. Thank you, Nancy.

14           Last for today we have our annual response to the  
15 CMS initial letter on the physician update.

16           DR. NELSON: Are we doing Part A tomorrow?

17           DR. MILLER: Tomorrow is the physician resource  
18 use, then the inpatient resource use and outpatient therapy.  
19 This is the physician update latter.

20           MR. HACKBARTH: He was asking about the inpatient  
21 resource use. That is the second --

22           DR. NELSON: The CMS proposed rule for acute

1 inpatient --

2 DR. MILLER: I'm sorry that that's confusing  
3 things. You should be looking at this thing that says  
4 review of CMS's -- with Kevin Hayes' name on it. That  
5 inpatient thing, that was just a summary of the rule.

6 DR. NELSON: So this is not a presentation. This  
7 is just a summary for our information.

8 DR. MILLER: Right, for your information.

9 DR. HAYES: As Glenn said, we're going through our  
10 annual process of reviewing this early estimate from CMS on  
11 the payment update for next year. Were required to include  
12 a review of this estimate in the June report.

13 From a staff standpoint, a conclusion for the  
14 review is that in calculating the update, CMS has used the  
15 best information available consistent with recent trends.  
16 Even if their estimates change between now and the fall it's  
17 unlikely that the update will be anything other than a  
18 maximum reduction permitted under law because of trends in  
19 spending for physician services that have played out over  
20 the last few years.

21 CMS's estimate is shown here. The bottom line is  
22 the number, an update of minus 4.6 percent. It's composed

1 of two things, change in input prices of 2.6 percent and an  
2 update adjustment factor of minus 7 percent.

3           The update adjustment factor, if not for a limit  
4 in law, would be much bigger. It would be a minus 28  
5 percent. And for that reason we feel like there's really no  
6 likelihood that the update would be anything other than the  
7 maximum negative update permitted under law. The numbers  
8 would just have to change too much in order to alter that  
9 update adjustment factor.

10           The reason for this negative update is the large  
11 gap that exists between actual spending for physician  
12 services and the target that's determined by a sustainable  
13 growth rate. Just to illustrate, in comparing 2004 to 2005  
14 the sustainable growth rate was 4.6 percent. Actual  
15 spending grew by 8.5 percent.

16           The reason for this disparity has to do with  
17 growth in the volume of physician services primarily. There  
18 is an allowance in the SGR for volume growth and that's  
19 growth in real GDP per capita, whereas actual volume has  
20 been much higher than that. If we look over the period  
21 since the inception of the SGR, the volume growth, actual  
22 volume growth, has been growing at an average annual rate of

1 5.3 percent. Real GDP per capita has been going up by 2.1  
2 percent on average per year.

3           Where is the growth occurring? As you know, the  
4 Commission has been looking at volume growth by type of  
5 service. And the information that we have from CMS is  
6 roughly consistent with what the Commission has been  
7 finding.

8           We don't have volume numbers by type of service in  
9 the information provided by CMS, but at least in terms of  
10 spending, particularly if we could look at these first three  
11 categories of services: evaluation and management -- which  
12 is mostly visits -- procedures and imaging, we see that the  
13 most rapid growth is in imaging.

14           I would make just one point about the drop in  
15 spending for Part B drugs that's shown here. That's  
16 composed of two things. One is an increase of volume of 23  
17 percent but a decrease in prices of 21 percent. We're  
18 looking here now at what happened in 2005 and that was a  
19 year when there was a transition from paying for Part B  
20 drugs at 85 percent of AWP and going to average sales price  
21 plus 6 percent.

22           Just to put all of this in some kind of

1 perspective, we can think now about what the Commission is  
2 doing in the area of physician payment and what we see.  
3 First, listed here is just this issue of mispricing as an  
4 area of emphasis for the Commission. What we've focused on  
5 here most recently is changes in the way CMS conducts the  
6 five-year review of physician work. Recall that you made  
7 some recommendations on that in the March '06 report.

8           We've just heard about couple of other physician  
9 topics, practice expensive and geographic adjustment of  
10 payment rates, all focusing on this question of whether  
11 Medicare is paying accurately for physician services.

12           In addition, you'll be talking tomorrow morning  
13 about measuring physician resource use and accounting for  
14 the efficiency with which physician services are furnished.

15           And lastly we are, as you know, working on a  
16 report for the Congress on alternatives to this SGR policy.  
17 The report is due in March of 2007. You will recall you  
18 heard a presentation on a work plan for that in January and  
19 in upcoming meetings we will be presenting parts of that  
20 report as they are ready.

21           That's it.

22           MR. HACKBARTH: Questions or comments for Kevin?

1 DR. MILSTEIN: Question. In our last meeting we  
2 discussed overall Medicare spending as a potential frame of  
3 reference. Can anybody remind me what the percentage point  
4 gap is more recently in annual growth between Medicare per  
5 capita spending and GDP growth?

6 Obviously, slide three shows a certain percentage  
7 gap, which I'm going to infer is larger than the gap that  
8 I'm referring to. It's a potential frame of reference on  
9 whether or not -- I understand.

10 MR. HACKBARTH: You're asking for total Medicare  
11 as opposed to just Part B?

12 DR. MILSTEIN: Right, if physician activity  
13 influences total Medicare spending growth in addition to  
14 spending growth across this narrow market basket of  
15 services.

16 What I'm asking for is -- if it's not available  
17 now at some point along the way -- some frame of reference  
18 on how physicians as a group are doing in rate of growth  
19 relative to GDP on total Medicare spending rather than just  
20 the subset of services that are currently in the basket.

21 MR. HACKBARTH: So the total figure in recent  
22 years has been just about GDP plus 2 percent or slightly



1 under that, 1.8 percent.

2 MR. BERTKO: I believe that the National Health  
3 Expenditure stuff has accounts that would do that and that's  
4 the stuff that gets poured into the Trustees report which,  
5 as we've heard, may be coming out sometime.

6 MR. HACKBARTH: Rachel presented on that if not at  
7 the last meeting, two meetings ago, and it was about 2  
8 percent, GDP plus 2 percent.

9 DR. MILSTEIN: 2.5 points for all spending, for  
10 Medicare spending.

11 MR. HACKBARTH: For overall Medicare spending  
12 relative to GDP.

13 DR. MILSTEIN: And what annual rate of growth is  
14 implied in slide number three? What's that gap? Is that  
15 more or less than two points?

16 MR. BERTKO: It's about the same. It's five  
17 versus two.

18 DR. MILSTEIN: Five versus two.

19 MR. HACKBARTH: The growth rate for Part B has  
20 been faster than Medicare overhaul so the gap would be  
21 larger for -- do you know what's the number, Kevin,  
22 underlying the graph?

1 DR. HAYES: No, I don't know.

2 DR. MILSTEIN: As we cast about for alternatives,  
3 which I guess will be on our agenda in the fall, I think  
4 it's a frame of reference that would be useful because in  
5 many cases there is an increasing on average shift away from  
6 inpatient care. And in some ways the old SGR formula does  
7 not take that into account. In fact, it penalizes  
8 physicians in that way.

9 MR. HACKBARTH: Okay. Anything else on this?  
10 We'll have a brief public comment period.

11 MR. FENIGER: If I may, I know you've missed me.  
12 Randy Feniger with the American Surgical Hospital  
13 Association, and I'd like to just take a few minutes to  
14 comment on some of the observations during your discussion.

15 I certainly appreciate the quality of the second  
16 analysis that was done with a larger database and also  
17 appreciate the time the staff had spent with us earlier to  
18 discuss some of the issues that were dealt with in greater  
19 detail today.

20 Just quickly, the question of the relative costs  
21 of specialty hospitals versus other hospitals is kind of a  
22 conundrum. You have talked about that. We have talked

1 about it among ourselves. I think more answers came out in  
2 this analysis, but quite frankly we really don't know why  
3 that data shows what it does.

4 We'd like to see a little more focus on the length  
5 of stay since it is so significant. And perhaps that might  
6 be an area for further exploration. Perhaps there are some  
7 lessons that could be learned and applied to a broader array  
8 of facilities. Why do we have that length of stay? Is it  
9 the staffing? What else could be learned?

10 Medicaid came up, and I would like to comment on  
11 that. There was, I think, some excellent points made about  
12 that. But one I want to add to that, in many states  
13 Medicaid, as you know, has moved to a managed-care model.  
14 So there are selected contracting with hospitals in those  
15 states.

16 If you don't have a contract with the state  
17 system, you're not going to get Medicaid cases. It may make  
18 sense from the states point of view to contract primarily  
19 with full general community hospitals as opposed to  
20 specialty facilities. That's certainly the case that we've  
21 seen in California where they have just bypassed all of the  
22 specialty hospitals and gone to larger community hospitals.

1           So I think that's an additional reason to think  
2 about on the Medicaid distribution, in addition to the  
3 points that we're already made. I don't want over those  
4 because I think this is an issue that just keeps recycling.  
5 But there are many reasons, as was discussed, why Medicaid  
6 distribution is the way it is among all hospitals.

7           Size and occupancy, as you probably know, CMS  
8 Administrator McClellan has identified this as a specific  
9 issue, really the definition of a hospital. We expect that  
10 they are going to be coming out with a report, probably May  
11 or perhaps in the summer, I don't know if the time frame is  
12 terribly firm, that will address that specific question. It  
13 may shed some light on how the department intends to respond  
14 if they feel a response is necessary. But I wanted to add  
15 that that is very much underway and on their radar screen.

16           On the competitive response that was discussed, I  
17 would be interested in how hospitals compete with each other  
18 when there is no specialty hospital in the community. If we  
19 find the same kinds of responses, for example hospital A  
20 hires away the cardiovascular team of hospital B, what does  
21 hospital B do to make up that difference? They probably  
22 have the same set of options that they have to respond to a

1 specialty hospital. But I would be interested if that is an  
2 area of concern to the Commissioners that perhaps looking at  
3 some other areas in competitive response might be helpful in  
4 addressing that more completely.

5 And finally we would ask, as an industry, to allow  
6 the DRG changes that are now underway to be fully  
7 implemented and fully absorbed. I would like the record to  
8 reflect that we are not the organization who is trying to  
9 shut down competition and opposing those recommendations.  
10 In fact, we have supported the recommendations of MedPAC  
11 specifically on the DRG changes and refinements.

12 We would simply ask that you allow time for those  
13 to be fully implemented before coming back and addressing  
14 this issue again. Because I think, as was pointed out, it  
15 could have a significant impact on the behavior of  
16 physicians, investors, hospitals of all kinds, and we think  
17 that needs to play out before we go any further with that  
18 issue.

19 Thank you.

20 MS. McNEIL: Hello. My name is Elizabeth McNeil.  
21 I'm with the California Medical Association. As Dr. Crosson  
22 said, I have flown out from the left coast to be with you

1 here today.

2 I just wanted you first thank the Commission for  
3 looking at this Medicare geographic payment issue. We are  
4 very grateful to you for doing this. It has plagued the  
5 California Medical Association for about eight years now and  
6 we have taken numerous proposals to CMS and to Congress to  
7 try to get this problem fixed.

8 Many of those proposals were budget neutral.  
9 We're trying to proactively solve it ourselves. So we are  
10 very appreciative of your willingness to look at it and  
11 study it further.

12 I would like to just tell you that we believe that  
13 this is a national problem and it's a large problem.  
14 Physicians in 32 states are inaccurately paid. So this is  
15 not just a California problem. It's New York, Texas,  
16 Illinois, Missouri, Ohio, North Carolina. I can go on and  
17 on and name you those states, but it's a significant problem  
18 in 32 states.

19 It is also a problem if you are in one of these  
20 counties that is underpaid. It is a significant problem for  
21 those physicians. The payment inaccuracy rate in these  
22 counties is up to 14 percent.

1           Now there are only 30 counties in the country that  
2 have a 10 percent to 14 percent problem. But in those  
3 counties that's very significant and many, many other  
4 counties are underpaid by 5 to 10 percent.

5           I will just give you an example. In California  
6 our Santa Cruz County, which was mentioned earlier, they are  
7 underpaid -- they have a Medicare cost factor that is  
8 assigned to them. And they are paid 10 percent less than  
9 that cost factor. They are paid 25 percent less than the  
10 Palo Alto physicians across the border. And their cost  
11 factors are only differentiate between 2 or 3 percent. So  
12 it's a major difference in payment when their cost factors  
13 are very similar.

14           Santa Cruz County, I will just tell you, we think  
15 there are access problems appearing in these underpaid  
16 counties. Just for an example, in our Santa Cruz County,  
17 all of the physician groups there over the last couple of  
18 years have not taken new Medicare patients. The last group  
19 that has agreed to take them as of June 1 this year, none of  
20 the physician groups in Santa Cruz County will be taking new  
21 Medicare patients. So we're going to see some significant  
22 excess problems appear there this summer.

1           I just want to also mention that we believe these  
2 problems were created largely by the overhaul that HCFA did  
3 in 1997 by consolidating the localities and creating this  
4 larger payment error.

5           But I would like to leave the Commission with  
6 three thoughts about going forward. Because we have had  
7 extensive conversations with our members of Congress and are  
8 delegation -- so has Texas and New York -- and with CMS  
9 about this issue. I think Congress, CMS and certainly the  
10 physician community are really seeking guidance from MedPAC  
11 on, first of all, a validation of a methodology. I think  
12 there's a great deal of interest in Congress in solving this  
13 problem in CMS. They're interested in doing it on different  
14 levels. But, I think they need someone other than the CMA  
15 to say we like this 5 percent threshold idea. They would  
16 like some validation from MedPAC to say what they think an  
17 appropriate methodology would be.

18           We have steered away from the MSA approach, I will  
19 just tell you, because it has changed things for counties  
20 and physicians where there is not a problem. It's a major  
21 overhaul in the country and we have considered if it ain't  
22 broke there, don't fix it. But we're certainly open to that



1 idea.

2           If you did move to an MSA approach though, I think  
3 we would recommend that you look at just moving to a strict  
4 MSA, not using the 5 percent iterative approach. If you  
5 want to move everyone to MSAs, just move them to an MSA. I  
6 don't think you need use the 5 percent approach to do that.

7           But we have obviously preferred the 5 percent  
8 county-based threshold.

9           The second issue is an issue of budget neutrality.  
10 This becomes a very difficult problem because if you help  
11 these underpaid counties and move them out to new  
12 localities, you then inflict payment reductions on basically  
13 suburban mostly rural counties. And in California, the  
14 payment reduction would 4 to 6 percent in our rural  
15 counties. That's been very significant.

16           And we, as an association, have not been able or  
17 willing to want to inflict these kind of payment reductions  
18 in the rural areas.

19           So most recently we had talked to Congress about a  
20 budget supplement. The cost of fixing all the counties  
21 across the country is \$300 million. The cost to only fix  
22 the multi-locality states is \$115 million. So the cost is

1 very minor in the scheme of things. I think that's an issue  
2 that you, as a Commission, will have to wrestle with is  
3 whether you want to do this on a budget neutral basis or  
4 not. I understand you much prefer budget neutrality but it  
5 becomes a very difficult issue when you look at the rural  
6 counties.

7           And finally I just do want to mention that the  
8 process to this date has been a political process. And so  
9 I'm very encouraged by the discussion to look at setting up  
10 a process for updating the localities that is formula driven  
11 and that is automatically updated. CMS not by law, not by  
12 regulation, but by their policy have put the state medical  
13 associations in the middle and wanted our approval before  
14 any change could occur. Of course, that's been very  
15 difficult to do that.

16           And so we would much rather see a process that is  
17 formula driven than a political process in order to achieve  
18 payment accuracy in the system.

19           so thank you very much for your time today and for  
20 studying the issue.

21           MS. McILRATH: I'm Sharon McIlrath. I'll try to  
22 be brief since it's late.

1           I just wanted to second the comment that as you go  
2 forward and do your volume report that you try to look at  
3 the total pot of money and see whether some things that are  
4 happening on the physician side may be driving some  
5 reductions over on the hospital side. Certainly last year  
6 they did comment that the increases on the hospital side  
7 were lower than had been anticipated.

8           I also would encourage you to drill down. When  
9 you look at the total SGR pot, the utilization of the drugs  
10 is driving the number up. So if you were looking only at  
11 the fee schedule services you would see lower growth. And  
12 when you wiped out the things that were legislative and the  
13 legislative pay cuts then you would find that the growth on  
14 the physician services themselves is closer to -- and this  
15 would be the volume and intensity, not the spending -- would  
16 be closer to 4 or 5 percent. So take that into  
17 consideration when you're making decisions.

18           Also, remember that these are preliminary numbers  
19 and they do change. If you read that letter that CMS sent,  
20 last year at this time they said the increase in  
21 expenditures was 15.2 percent. In the end they decided it  
22 was 11.4 percent. And it was particularly off on certain

1 kinds of services.

2           For instance, they had said that the growth on the  
3 E&M services was about 15 percent. It actually turned out  
4 to be 8 percent. So when you're looking at which services  
5 are growing and what sorts of things you ought to be looking  
6 at, keep that in mind.

7           And I will just say that our numbers guy, and his  
8 track record is very good, and it was closer last year than  
9 the CMS estimate, is finding that the imaging, while it's  
10 still growing, has sort of trailed off a bit from where it  
11 was. That doesn't mean that anybody shouldn't  
12 be looking at imaging. It just means that you need to maybe  
13 go back and do a look back.

14           And then finally, to keep in mind that a big part  
15 of our problem is not just the volume. As much of the  
16 problem, at least up through 2005, was due to the unfunded  
17 congressional fixes. That is that basically they increased  
18 the payment rates for 2004 and 2005 but they didn't increase  
19 the target. So essentially it wasn't that they gave  
20 physicians money. They loaned physicians money and they're  
21 to get it back by longer, bigger cuts in the future.

22           So that was, through 2005, about 36 percent of the

1 problem, whereas something somewhat less than that was due  
2 to volume increasing by more than the target.

3 MR. HACKBARTH: Okay, thank you very much.

4 We'll convene tomorrow morning at 9:00 a.m.

5 [Whereupon, at 5:12 p.m., the meeting was  
6 recessed, to reconvene at 9:00 a.m. on Thursday, April 20,  
7 2006.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, April 20, 2006  
10:15 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair  
ROBERT D. REISCHAUER, Ph.D., Vice Chair  
JOHN M. BERTKO  
SHEILA P. BURKE  
FRANCIS J. CROSSON, M.D.  
AUTRY O.V. DeBUSK  
DAVID F. DURENBERGER  
JENNIE CHIN HANSEN  
NANCY KANE, D.B.A.  
ARNOLD MILSTEIN, M.D.  
RALPH W. MULLER  
ALAN R. NELSON, M.D.  
WILLIAM J. SCANLON, Ph.D.  
DAVID A. SMITH  
RAY E. STOWERS, D.O.  
NICHOLAS J. WOLTER, M.D.

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

2 MR. HACKBARTH: We begin this morning with two  
3 presentations on measuring resource use, starting with  
4 physicians.

5 MR. BRENNAN: Thanks, Glenn.

6 Good morning. Today we'll be presenting our  
7 latest findings related to our assessment of two  
8 commercially available episode groupers and how they perform  
9 on Medicare claims and their suitability for measuring  
10 physician resource use.

11 To briefly review, the two of groupers we're using  
12 are episode treatment groups created by Symmetry Data  
13 Systems and the Medstat episode grouper created by Medstat.  
14 In addition to the resource use component of the analysis,  
15 we are also calculating a set of claims-based quality  
16 indicators for the same population.

17 At the March meeting and today we'll be presenting  
18 the results of our analysis using a 5 percent sample of  
19 Medicare claims. Once this report cycle concludes, we'll  
20 begin analysis of 100 percent of claims in selected  
21 geographic areas, permitting us to build on the lessons we  
22 have learned from the 5 percent analysis and begin to

1 construct physician-level caseloads, resource use scores and  
2 quality scores.

3           At the March meeting we presented some results  
4 which I've quickly recapped here. There were a high  
5 proportion of claims and dollars that grouped in both  
6 groupers. We found broad agreement between the two  
7 groupers. We examined the composition of episodes by type  
8 of service and we tested a variety of attribution methods  
9 for both the resource analysis and the quality analysis.

10           The next area we wanted to examine was variation  
11 in resource use by MSA. As you all know, previous research  
12 -- most notably that performed by researchers at Dartmouth -  
13 - has found that there is a large variation in per capita  
14 Medicare costs in different parts of the country.

15           One thing to note here is that to date, as these  
16 tools have been used in the private sector, they have rarely  
17 if ever been used to compare resource use across wide  
18 geographic regions. Because of the fragmented nature of  
19 health insurance coverage for the non-elderly, many  
20 different private insurance companies can cover the  
21 population of any given MSA. Therefore, in using these  
22 tools, most plans are merely trying to assess the relative



1 performance of physicians in their network in a given area,  
2 not to other non-network physicians in the same market area  
3 or broader regional comparisons.

4           So one of the things we will be examining is  
5 whether the groupers can control for regional differences in  
6 patterns of care or volume.

7           This table highlights relative resource use scores  
8 for several MSAs on some of our selected conditions. If you  
9 recall our presentation from last month on the types of  
10 services within each episode, you can think of these five  
11 episodes as falling into two groups: chronic conditions that  
12 tend to have low levels of acute care usage, hypertensive  
13 and diabetes, and those that have higher levels of inpatient  
14 usage, CHF and CAD.

15           If you look at the first row the table, we present  
16 the national average cost for each episode: \$423 for high  
17 blood pressure, \$833 for Type I diabetes, and so on.  
18 Remember that these dollars have all been standardized so  
19 they are comparable across regions. We've also shown the N  
20 there, the total number of episodes for each group.

21           The remaining rows detail for each MSA their  
22 average cost for these episodes relative to the national

1 average. These represent relative resource use scores for  
2 all beneficiaries with a given episode in each MSA. You can  
3 see that for high blood pressure Minneapolis has a relative  
4 resource use score of 0.87 compared to 1.2 for Houston and  
5 Miami. This means that per episode costs for high blood  
6 pressure episodes in Minneapolis are 13 percent less than  
7 the national average, whereas they are 20 percent higher in  
8 Miami and Houston. Minneapolis also has lower relative  
9 resource use scores compared to other MSAs for Types I and  
10 II diabetes.

11           However, the pattern of relative resource use  
12 changes significantly for coronary artery disease, CAD. If  
13 you look at the less column of the table, both Miami and New  
14 York City have relative resource use scores of considerably  
15 less than 1.0 while Minneapolis has a relative resource use  
16 score of 1.28.

17           We were a little surprised at this finding so we  
18 decided to delve a little deeper into the data.

19           [Laughter.]

20           MR. BRENNAN: What we found was that it may help  
21 to look at more than just per episode costs in order to get  
22 the fullest picture of resource use. This table presents a

1 number of statistics that may or may not be helpful in  
2 parsing exactly what to make of the large gap in relative  
3 resource use scores for CAD between Miami, which has been  
4 identified in the past as a high resource area, and  
5 Minneapolis, which has been identified in the past as a low  
6 resource use area.

7           One of the first things we found was that Medicare  
8 beneficiaries in Miami were more likely to have a CAD  
9 episode than beneficiaries in Minneapolis: 11 percent of  
10 Medicare eligibles in Miami had a CAD episode compared to 6  
11 percent in Minneapolis.

12           We also looked at the total number of episodes for  
13 beneficiaries with a CAD episode in each MSA and again found  
14 that beneficiaries in Miami when CAD tended to have more  
15 total episodes than beneficiaries in Minneapolis. Further,  
16 beneficiaries in Miami had more other heart-related episodes  
17 than beneficiaries in Minneapolis

18           However, when we looked at the total dollars  
19 associated with these episodes, the total episodes, the  
20 relative resource use scores were quite similar between the  
21 two MSAs. So while CAD patients in Miami have more  
22 episodes, they have similar levels of resource use to CAD

1 patients in Minneapolis.

2 Now I'm going to move from focusing on CAD to  
3 focusing on all patients, all episodes. And again,  
4 comparing these two MSAs on a per episode basis, Miami is  
5 again lower in terms of relative resource use than  
6 Minneapolis. Across all episodes Miami has a relative  
7 resource use score of 0.98, whereas Minneapolis has a  
8 relative resource use score of 1.03.

9 However, when we move to a per capita notion you  
10 can see that the result changes quite dramatically. On a  
11 per capita level Miami's relative resource use score is  
12 1.32, whereas Minneapolis' is 0.88.

13 MR. SMITH: The total dollars per beneficiaries,  
14 is that all Medicare dollars or all Medicare dollars related  
15 to episodes?

16 MR. BRENNAN: Are you talking about the fourth row  
17 on the table?

18 MR. SMITH: Yes.

19 MR. BRENNAN: That's total Medicare dollars for  
20 all beneficiaries with a CAD episode.

21 MR. SMITH: So it's all dollars for anybody with  
22 an episode?

1 MR. BRENNAN: With a CAD episode, yes.

2 MS. BURKE: In the course of reading the chapter,  
3 I thought one of the comments made was that there were  
4 certain things that we couldn't easily track to a particular  
5 episode, certain expenditures. Is that not the case? Or  
6 was that just with respect to docs? Pharmaceuticals, as I  
7 recall, and there was one other. Is that related to docs?

8 MR. BRENNAN: We don't have any data on drug  
9 claims because there's no drug benefit. But everything else  
10 should be in there and is relatively easy to track. You  
11 know, you would just identify the beneficiary and then  
12 identify all the other care that they have. Perhaps there's  
13 something in the chapter that we miswrote.

14 MS. BURKE: I thought there were two. Drugs was  
15 one and I thought there was a second that you couldn't  
16 capture by episode. But go ahead, everything but drugs.

17 MR. BRENNAN: We also didn't look at DME claims,  
18 for example. But we covered the majority of things,  
19 hospital inpatient, physician, hospital outpatient, home  
20 health, SNF, et cetera.

21 So these results raise many interesting issues in  
22 using episode groupers to measure resource use. At a first

1 glance, if you just focus on the per episode relative  
2 resource use scores you might conclude that Miami is more  
3 efficient than Minneapolis in the treatment of CAD.

4           However, what seems to be happening is that  
5 beneficiaries in Miami are much more likely to have a CAD  
6 episode in the first place. So one thing that may be  
7 happening is that there are more low-cost CAD episodes in  
8 Miami, which combine to drive Miami's average for CAD down.

9           Additionally, beneficiaries in Miami are more  
10 likely to have more total episodes in addition to CAD  
11 episodes, particularly other heart-related episodes.  
12 Meaning that perhaps the prevailing coding patterns or  
13 supply of physicians in Miami are such that beneficiaries  
14 who in Minneapolis would remain in a CAD episode and  
15 continue to drive up costs in that episode are being  
16 classified into other episodes in Miami.

17           So perhaps a solution would be to combine a per  
18 episode approach to resource use with a per capita approach  
19 in order to control for differences in volume across  
20 regions. It's also possible that the grouper software  
21 packages could be further refined to adjust for episodes  
22 that are low in severity and have very low levels of

1 resource use.

2 We'll continue to explore this issue in our 100  
3 percent analysis.

4 Another important factor that we have to deal with  
5 in using episodes of care to assess physician resource use  
6 is risk adjustment. From our experience in talking with  
7 people who have used these tools in the private sector a  
8 common reaction from physicians is that their per episode  
9 costs are higher because their patients are sicker. In  
10 order for these grouping tools to have face validity with  
11 practitioners, you have to be able to show that the groupers  
12 do not unfairly reward or penalize physicians based on the  
13 underlying health status of their patients.

14 Both groupers employ risk adjustment techniques.  
15 ETGs uses an approach known as episode risk groups or ERGs  
16 while the MEG grouper uses the diagnostic cost grouper  
17 method, DCG. Using these methods you can calculate a risk  
18 score for each episode and eventually build an overall risk  
19 score for a physician's panel of patients. In the next few  
20 sides we'll provide some examples of the MEG DCG risk  
21 adjustment approach.

22 This table is based on our current analysis and

1 illustrates how the use of risk adjustment can further  
 2 refine how you look at a given episode. As you know from  
 3 our presentation in March, the MEG grouper employs a disease  
 4 staging approach which classifies most episodes into three  
 5 severity stages based on the clinical severity of that  
 6 episode. What the DCG adjustment does is create five  
 7 overall patient severity categories for each stage of each  
 8 episode, meaning that you can now look at 15 cells within a  
 9 given episode.

10 This table headlights the risk adjustment of CAD  
 11 episodes from our analysis and presents the average cost per  
 12 each complexity level and each stage of CAD. If you look at  
 13 the bolded and underlined and yellow cells in the table you  
 14 can see that the average costs for a CAD episode range from  
 15 a low of \$564 for a stage 1 patient complexity level 1  
 16 episode to over \$11,000 for a stage 3 complexity level 5  
 17 episode. Obviously you don't want to compare a physician  
 18 who predominately treats the former with the latter.

19 You'll also notice that at higher complexity  
 20 levels the values in certain cells can be the same. That's  
 21 because some cells have their values merged in order to  
 22 maintain an appropriate sample size.



1           This next table provides an illustrative example  
2 of how risk adjusted episodes can be used to adjust  
3 physician scores. For this hypothetical episode the average  
4 costs are a little over \$2,000. That's the predicted cost  
5 in the bottom left-hand corner of the table.

6           Looking at the last two rows on the table you can  
7 see that physician number six has actual costs of \$2,032  
8 while physician number seven has actual costs of \$2,405,  
9 resulting in relative resource use scores of 1.01 and 1.20  
10 respectively.

11           However, when you incorporate information on risk  
12 adjustment you can see that the average risk score for  
13 physician number seven's patients is almost doubled that of  
14 physician number six's. When we incorporate this  
15 information into each physicians' predicted cost the  
16 relative resource use score for physician number six  
17 increases from 1.01 to 1.15, while the score for physician  
18 number seven decreases from 1.2 to 1.06.

19           With that, I'll turn it over to Karen for a  
20 discussion of our quality findings.

21           MS. MILGATE: We also looked at quality across  
22 MSAs using a set of claims-based indicators. We have over

1 30 indicators in the set so we grouped the indicators by  
2 condition to look at the MSAs. There's two types of  
3 indicators in this set. One type is the necessary care  
4 indicators, and just to refresh your memory on what that  
5 means it's using, for example, for diabetics whether over  
6 the course of a year they got the appropriate tests that  
7 they needed.

8           We also have some potentially avoidable  
9 hospitalization indicators in there. Again, using the  
10 example of diabetics, there the measure looks at whether  
11 someone who had been identified as a diabetic had been  
12 hospitalized for either short or long-term complications due  
13 to diabetes.

14           In the table below here we're only using the  
15 necessary care indicators and I'll describe why that is in a  
16 moment.

17           We found when we ran the indicators on the 5  
18 percent sample that in general there was quite a bit of room  
19 for improvement on the indicators. You can look at the  
20 first row there in the table, that's the national average  
21 across all these indicators. So we have a composite  
22 diabetes score, a composite CHF score, and you can see the

1 numbers leave room for improvement on all of them really  
2 except COPD, which is fairly high, that there's 20 to 40  
3 percent of beneficiaries -- at least in our 5 percent simple  
4 -- not getting appropriate care.

5           So then what we did is take that national average  
6 and compare it to MSA composite scores on the conditions.  
7 And so the rest of the table shows some examples of the MSA  
8 scores relative to the national average.

9           So for example if you look at the row for Chicago  
10 on the first condition, diabetes, you see that Chicago had a  
11 score somewhat lower than 71 percent. So their ratio is  
12 0.95. But then for the next four indicators they were  
13 pretty close to the national average, slightly above in a  
14 couple of them. But still again, this is a ratio to a  
15 fairly low number.

16           Our analysis also provided information on several  
17 technical issues. Before we grouped the indicators by  
18 condition we considered whether each MSA scores were based  
19 on sufficient sample size and we ended up removing some  
20 indicators from the analysis based on low incidents and  
21 others based on low eligibility. Let me explain what I mean  
22 by that.

1           We removed all the potentially avoidable  
2 hospitalizations because at the MSA leveled by condition  
3 they occurred so infrequently. However, we are  
4 experimenting with creating an overall composite across  
5 condition of the potentially avoidable hospitalizations and  
6 may decide to add that back in when we look at the 100  
7 percent analysis, depending upon what we see as the  
8 incidence level at the individual physician level.

9           Further, we removed any indicators with fewer than  
10 30 beneficiaries who were eligible to counted. That would  
11 be the denominator for each MSA by indicator. We have heard  
12 from our expert panel, as well as others we've spoken with,  
13 that in fact that's a fairly conservative estimate, a fairly  
14 conservative threshold that's often used for these types of  
15 analyses.

16           So that meant that some of our indicators are not  
17 included by condition at the MSA level.

18           Because we began with over 30 indicators we needed  
19 to create composites and we created them by condition, as  
20 you saw in the previous table. We applied two different  
21 weighting methods to try to do that. When I talk about  
22 weighting methods, what I'm describing basically is how we

1 added up the indicators to create a composite score for the  
2 condition.

3           The first way we did it we called a straight  
4 average. There we just added up the specific indicator  
5 scores and then divided the scores by the number of  
6 indicators we had. So if we have a score of 71, 65, 50, we  
7 would add those up and then divide those by three, or  
8 however many indicators in the condition.

9           But this method weights equally indicators that  
10 apply to a lot of beneficiaries with the indicators that  
11 apply to a few beneficiaries. So what we did was also apply  
12 what's being called an opportunity model.

13           This method basically the concept is you're trying  
14 to look at all the opportunities a physician had to actually  
15 provide necessary care. And there, for each condition you  
16 sum the denominators or all the beneficiaries that are  
17 eligible. You sum the numerators, all of those that got the  
18 right care, and then divide the sum of the numerator by the  
19 sum of the denominator.

20           That does control for the number of beneficiaries  
21 that are actually eligible for something to happen to them  
22 that's considered high-quality care.

1           We did find that on the indicators that had very  
2 different denominators that certainly did move the scores  
3 around. So it would be important to consider that when we  
4 look at the weighting methods when we look at physicians  
5 individually.

6           One important caveat is that claims-based process  
7 indicators may move in the same direction as resource use.  
8 Both count whether services were provided. We found in our  
9 analysis because the scores group so closely and are  
10 relatively high in our MSAs it was hard to know how this may  
11 have affected our scores.

12           What we did then is add in then another outcome  
13 measure to see if, in fact, the relative rankings would  
14 change if we added in another indicator. So we used the  
15 combination of potentially avoidable hospitalizations across  
16 conditions, which actually would move in the inverse  
17 direction that the process measures would move. For  
18 example, if you had high process measures you'd also have  
19 high quality. Well, if you had high resource use on process  
20 indicators, you'd also have high quality. If you had high  
21 potentially avoidable hospitalizations you, in fact, would  
22 have low quality. So it moves in the opposite direction and

1 we wanted to see if, in fact, that would change the  
2 rankings.

3           And it did, for quite a few MSAs but not all of  
4 them. For example, Miami, if you just looked at necessary  
5 care, ranked 1.02. So around the national average, slightly  
6 above. Whereas if you looked at potentially avoidable  
7 hospitalizations they had 0.81, meaning that they looked  
8 lower on quality rather than higher. So it does change the  
9 rankings of the MSAs.

10           So in conclusion, just to sum up kind of all of  
11 what Niall and I have said here, we find that per episode  
12 resource use in the aggregate, particularly at the MSA  
13 aggregate, should be used alongside information on per  
14 capita spending as well as per capita number of episodes.

15           We will continue to look at this variation in the  
16 100 percent analysis to see if, in fact, we see the same  
17 type of variation patterns within MSAs that we saw across  
18 MSAs.

19           We also find that a broader set of quality  
20 indicators, such as those the Commission recommended for pay  
21 for performance, may be necessary to ensure that quality is  
22 measured somewhat independently from utilization.

1           We'll continue to assess the use of these  
2 indicators but additional information on lab values,  
3 prescriptions and some of the discussion we had on care  
4 management processes would also be beneficial if the  
5 Medicare program intends on measuring efficiency using  
6 claims.

7           With that we open it up for your discussion.

8           MR. BERTKO: A number of comments. First of all,  
9 Niall and Karen have done an amazing amount of work here so,  
10 as somebody who's plugged through the data, let me just  
11 congratulate them on getting this much done for us.

12           Secondly, I think where they're headed next with  
13 the 100 percent file on looking within MSAs as well as  
14 across MSAs is pretty important. The across MSAs, to me,  
15 there are some surprises there. And they tell us that --  
16 and not being a clinician, I'll just use the term  
17 generically -- best practices, that there may be a number of  
18 best practices that would affect the Medicare plan as a  
19 whole. Then within MSAs, to be actionable, you may need to  
20 roll it up on individual docs or within individual  
21 specialties to see where the issues are.

22           In fact, I guess I'd looked to Arnie for



1 confirmation but many of us who are doing this on the plan  
2 side are rolling up within specialties. So we take a number  
3 of episodes that a cardiologist would do, roll them all up  
4 together, balance them somehow, and then see what's going on  
5 there.

6           Because ultimately I think if we're going to help  
7 people identify what they should be doing, if this comes  
8 from here some normative data, then you need to be able to  
9 do -- for lack of a better term -- report cards or at least  
10 some reporting back on all of this.

11           The last comment here is the quality measures that  
12 Karen just talked about. This is, I think, a really  
13 important finding. We had done our quality efficiency  
14 comparisons mainly off the claims data, saw strong  
15 correlations, and in fact the insight that you have of  
16 looking at non-activity based type of quality measures, I  
17 think, is really important in order to get the best possible  
18 idea of how quality and efficiency are correlated.

19           DR. NELSON: I found this as interesting as John  
20 did.

21           I wondered, since a third of the claims that you  
22 subject to analysis had to be excluded because you couldn't

1 identify start and stop date makes you concerned about  
2 whether this technique is ready to be used, particularly in  
3 performance evaluation of individuals or small groups. Do I  
4 make myself clear?

5 If you can't tell when an episode started and  
6 stopped on one-third of the claims how confident are you  
7 that this is a useful tool? And then I have another  
8 question.

9 MR. BRENNAN: In terms of the clean starts and  
10 clean finishes, by eliminating an episode that you can't  
11 identify as having a clean start or a clean finish, in a way  
12 you hopefully make it fairer in comparison because you're  
13 not comparing a potentially very low resource use episode  
14 with one that has a full year of claims or whatever.

15 So I think, and this is just my personal opinion,  
16 sort of methodologically you could look at it as  
17 strengthening the analysis because it's fairer. You are  
18 losing sample size but in a lot of these things losing  
19 sample size is just a fact of life.

20 MS. MILGATE: I would presume what you're getting  
21 it is you might not be looking at really the whole of what a  
22 physician was doing because you're missing some part of it.

1 Is that where you're going?

2 DR. NELSON: Or whether there were particular  
3 conditions that were excluded that would skew your analysis  
4 when it came to any particular physician or group of  
5 physicians. I'm satisfied with the response, that that  
6 doesn't particularly shake your confidence in the  
7 applicability of this tool for performance measurement.

8 MR. HACKBARTH: Where they randomly distributed,  
9 the ones that are excluded because there's not a clean start  
10 or a clean finish?

11 MS. MILGATE: They should be.

12 MR. BRENNAN: They should be. We can check that.

13 MS. MILGATE: The other thing to note, Alan, it  
14 doesn't get at whether there's particular conditions that  
15 may be left out. But when we get to the 100 percent, we're  
16 going to have to make -- and everybody who uses these tools  
17 make some assumptions about how many episodes that you need  
18 to say that you've actually fairly measured a physician.

19 So what Niall is saying is we're only going to use  
20 those that we really know are episodes and then we'll have  
21 another threshold where we say and do they have enough to  
22 really feel that we've gotten a good picture of the

1 physician?

2 MR. BRENNAN: And by using clean episodes, you  
3 hope that you'll have the fullest picture of care for a  
4 given condition. And then every physician is going to have  
5 clean episodes that were kept and unclean episodes -- for  
6 want of a better word -- dirty episodes that were...

7 DR. NELSON: That satisfies me.

8 My second question has to do with potentially  
9 avoidable hospitalizations. As I understand your  
10 presentation, you were using that in comparing one MSA with  
11 another. That is, you were examining geographic variations  
12 around this particular factor, which would be -- which would  
13 be okay in my view. If you were using potentially avoidable  
14 hospitalizations in performance evaluations of individual  
15 physicians, that would worry me because over the course of  
16 20 years of diabetic treatment who in the hell do you pick  
17 to attribute that potentially avoidable hospitalization to?

18 Reassure me that my interpretation of where you're  
19 going with this is correct, that you're using it for  
20 regional variation comparisons and not thinking in terms of  
21 nailing a potentially avoidable hospitalization on an  
22 individual as part of their performance evaluation.

1 MS. MILGATE: We have only, yes, used it at the  
2 MSA level. We've actually been discussing that very issue  
3 with an expert panel we pulled together to advise us on  
4 these very topics. And had a discussion actually on that  
5 exact issue in our last meeting.

6 There were actually varying opinions on that with  
7 the one physician on the panel suggesting that well,  
8 physicians did have some role, and others saying exactly  
9 what you're saying, that perhaps it's not something you  
10 should hold an individual physician accountable for.

11 DR. NELSON: I think you could but it would depend  
12 on the condition. You'd have to be very selective in terms  
13 -- and if there's a potentially avoidable hospitalization  
14 based on whether or not you treated a pneumonia in the  
15 outpatient setting appropriately, that would be an example  
16 where yes, you should assign credit or discredit.

17 MS. MILGATE: So you think that it's more specific  
18 to the condition which would argue against combining them.

19 I'm not sure because we haven't looked at the  
20 data, but given what we found at the MSA level it seems like  
21 it would be difficult at the individual physician level to  
22 get enough sample size on the potentially avoidable

1 hospitalizations by condition. So we were thinking of  
2 looking at -- and I don't know exactly what we'll find --  
3 combining them altogether at the 100 percent to see what we  
4 find.

5 But your caution is definitely in play about then  
6 suggesting that this is a measure you should actually hold  
7 individual physicians accountable.

8 DR. NELSON: Yes, I think you would have to  
9 consider the degree to which a chronic condition that  
10 extends over a long period of time -- I mean the amputation  
11 on a diabetic is an example. Who do you blame when that  
12 person has had this condition for 20 years?

13 MS. MILGATE: Okay.

14 DR. CROSSON: I think I have two impressions and a  
15 question. The first impression was it seems that there's  
16 more here than I might have thought anyway when we first  
17 started down this path. And this may be a lot more useful  
18 than some of the other avenues that we've been exploring.

19 The second one, in connection with Alan's  
20 comments, is that it's probably more complex than it might  
21 have appeared to be and that we're going to have to spend  
22 some time on the modeling assumptions and that perhaps even

1 think it through -- I hate to say this -- but think it  
2 through almost on a disease specific basis to make sure that  
3 the logic works for the collected clinical conditions.  
4 Because they may, in fact, have different drivers, different  
5 logic behind them.

6           The question was, in terms of separating the  
7 resource use from the process quality measures, is it  
8 conceivable that you could take the resource use required  
9 for the process measures out of the resource use  
10 denominator? Trying to separate inappropriate from  
11 appropriate resource use.

12           In other words if you extracted from the resource  
13 use denominator, let's say mammography screening, the  
14 resource inherent in mammography screening, et cetera, and  
15 then did the analysis would that help to pull apart --

16           MR. BRENNAN: I think it would be a little  
17 difficult only because then you'd have to make some  
18 assumptions regarding what an appropriate level of care was  
19 and then that starts -- I mean I know there are benchmarks  
20 and clinical guidelines for certain conditions. But then  
21 you get into the every patient is different and this patient  
22 needed two of this instead of one of that.

1 I'd be a little hesitant, but...

2 MS. MILGATE: Beyond the technical issues which,  
3 as Niall expressed would be difficult, I don't know that  
4 you'd see anything difficult because what many of these  
5 quality indicators measure are pretty small dollars. And so  
6 the pattern is more if in a particular -- at least this is  
7 how I'm interpreting it -- in a particular MSA physicians  
8 are just generally doing more, they're just potentially  
9 doing generally more of the stuff we measure for quality  
10 indicators as well as everything else.

11 So if you took it out I don't think you'd see a  
12 real different pattern because they're not expensive and  
13 because they're probably just going to be doing more claims-  
14 based process indicators.

15 It's not like you're not measuring something  
16 that's real. They are doing more of the claims-based  
17 process indicators but it's unclear whether, in fact, the  
18 outcomes of those are as good on other measures.

19 DR. REISCHAUER: First of all, let me congratulate  
20 the two of you. This is really a tremendously interesting  
21 analysis, and I think sheds light where there's been  
22 darkness, at least outside the halls of individual health



1 plans that have done some of this kind of work.

2           Karen, you talked about creating these composite  
3 scores and the two different weighting mechanisms, the  
4 simplistic average and the opportunity-based one. But what  
5 worries me about weighting systems is we really should be  
6 weighting by clinical significance or financial importance  
7 to Medicare. Even in your opportunity-based one you're  
8 taking some things which we think are indicative of high  
9 quality but they're really small throwaway items and others  
10 which are life and death, and sort of saying they're of  
11 equal importance.

12           Is there any way we can sort of move down the  
13 track of developing weighting systems that I think are more  
14 reflective of what really is important?

15           I mean, there's a tendency in all of these  
16 weighting systems to pretend if we just do a simple average,  
17 or even the opportunity thing, we aren't weighting. But in  
18 fact, we are weighting and we're weighting in a way that is  
19 really bizarre when you sit down and think about it from the  
20 standpoint either of fiscal resources or significance to  
21 health outcomes.

22           MS. MILGATE: I have a couple of thoughts.

1 DR. MILLER: That's all I have. too.

2 Here's the good thing. We knew someone was going  
3 to ask this question and we talked about it among ourselves  
4 and we don't have a very good answer for you. One of the  
5 things I almost was going to say in the presentation is when  
6 Karen was going through and saying I'm putting these  
7 composites together, this is not to say that we forgot -- I  
8 know. I know. We had this conversation among ourselves.  
9 We know that this issue has surfaced. And you have spoken  
10 to it very directly and very strongly, that this may be more  
11 important than that.

12 I think that this is one that -- and so we're  
13 doing this just as an exercise to kind of go through and  
14 really just kind of feel our way through the data. I think  
15 you have raised the question and it may be that we just have  
16 to define that as a project in and of itself to crank  
17 through as we go down this track. I think you'll continue  
18 to see exercises where we're saying take a look at this  
19 analysis, we're just trying to get a feel for it, but we're  
20 going to have to approach that question.

21 And I really don't know the answer, and I think  
22 Karen, we've had conversations about this. I don't think

1 there's a lot of consensus out there and I think a lot of  
2 people come back to simple averages because there isn't a  
3 lot of consensus.

4 MS. MILGATE: Just to add a couple of things right  
5 off of that point, we have again talked to quite a few  
6 people about how do you do it. Actually the most  
7 sophisticated example that I know of is a process AHRQ went  
8 through to figure how to develop composites at the state  
9 level. And they had some that they did averages simply  
10 because there was too many component moving pieces and some  
11 that they thought were really more appropriate for the  
12 opportunity model.

13 Then I can't remember if they also perhaps had  
14 some weighting, the kinds of factors that you're talking  
15 about.

16 But many of the projects actually use some of  
17 those criteria to decide even measured in the first place.  
18 So if it's an important conditions to the population, if  
19 it's high dollars that might actually cut off some of what  
20 you might look at in the first place, and then after that do  
21 more of their well, are you going to do a straight average  
22 or not?

1           Specific to -- and I think Mark's right, that it's  
2 really a bigger issue and it doesn't mean we shouldn't take  
3 it on in this project or think about it, but that it may  
4 need to have a broader look because we need to look at it  
5 for hospitals as well, for example.

6           But in this particular analysis on these  
7 indicators, just looking at the necessary care indicators, I  
8 don't know that the problem is quite as large because  
9 they're not outcomes. They're all basic services that  
10 should be provided. You could say some have more bang for  
11 the buck than the others, but in fact they're I guess a  
12 little more even than some of the sets that you see in part  
13 because they're a limited set.

14           I don't know in this analysis if I would be as  
15 concerned if we're primarily looking at the necessary care.

16           MR. HACKBARTH: Arnie, you have a comment on this  
17 particular issue?

18           DR. MILSTEIN: On this point, having been down  
19 this road on the private sector side, I know it's tempting  
20 to weight clinical process measures for their impact on  
21 outcome.

22           One of the things I can report back is you do run

1 into some of the problems that Peter Neumann articulated at  
2 our last meeting where almost all advocated process measures  
3 do have -- they are advocated because there is some evidence  
4 they impact outcomes. But when you then look at the  
5 outcomes that they've been shown to impact, what you find is  
6 sort of a non-uniform currency on which they're measured.

7 I mean ideally they'd all be measured on impact on  
8 quality adjusted life years, ideally for the Medicare  
9 population. But when you get to the end of the road for  
10 most of these process measures what you find are facets of  
11 favorable outcome that are not easily compared. And I think  
12 there, as Peter Neumann was suggesting last meeting, there  
13 are things we could do nationally to begin to address that  
14 issue.

15 And I think that this suggestion would then less  
16 be valuable because even with the imperfect information  
17 better to have weighted process measures than proceed on the  
18 assumption that they're all equally valuable. But at the  
19 end of the road it's unfortunately a little bit murkier than  
20 we want it to be.

21 DR. WOLTER: I agree, this was very well done and  
22 a complicated work and was not light reading either.

1           It got my wheels spinning in quite a number of  
2 directions, and in particular connecting the dots to some of  
3 the other work we've done around coordination of care. I  
4 noted that there were some high attribution episodes that  
5 tended to be around things like hypertension and Type II  
6 diabetes which got me thinking about some of the Alan's  
7 comments in exec session yesterday and are there areas where  
8 we can identify that it makes a lot of sense to create  
9 attribution and ultimately accountability at the individual  
10 physician level in terms of coordination of care? Whereas  
11 as we moved into the high hospitalization dollar areas  
12 attribution was more difficult.

13           I think that that's where, if there's an  
14 implication here that we're going to be able to ultimately  
15 tie most episodes to an individual physician for  
16 accountability, I think given the fragmented underlying  
17 delivery system that's going to be unlikely in the long run.

18           I was even wondering if case studies, because one-  
19 third of E&M codes means there's a lot of care being  
20 provided outside the province of an individual physician,  
21 would a few case studies to see what is the actual  
22 relationship between that physician who has one-third of the

1 E&M codes to the rest of care that's provided? It may be  
2 that there's not much coordination or relationship between  
3 that physician and all of the other care that's provided,  
4 particularly in the high hospitalization areas.

5 I think that when you look at the chapter on  
6 coordination of care and care in a couple of models you  
7 proposed for those more complex high cost patients, clearly  
8 some approach to the organization of care has to be put in  
9 place. And ultimately, in looking at attribution, do we  
10 also want to incent that accountability is placed more at a  
11 team level for some of these things in addition to finding  
12 those places that Alan pointed out yesterday could be placed  
13 at the level of the individual physician?

14 I think it's going to have to be both or we really  
15 won't tackle the problems of accountability that can  
16 successfully take care of complex high-cost patients well.

17 It really got me thinking about that because  
18 ultimately we are trying to find a way to create some  
19 accountability to create improvements.

20 I also think that the claims-based quality  
21 measures can only take us so far. Some of the key quality  
22 process measures just don't come off of claims. As we have

1 looked at trying to tee up with the voluntary physician  
2 measure reporting, we found that many of the measures we  
3 really did have to go to chart reviews for and that sort of  
4 thing. Many physicians have commented too, that for them to  
5 comply with these measures really requires does the hospital  
6 they work at participate in collecting some of the measures,  
7 depending on the disease state. Which again points to the  
8 issue of at some point, with the more complex patients,  
9 creating incentives around how the delivery system is  
10 organized is going to be important.

11 I'm probably jumping way ahead of the game. We  
12 have a lot of work to do on this data to start with. But I  
13 don't think the end game can be that we find a way to  
14 attribute all complex cases to one physician. I just don't  
15 think that that's going to be successful.

16 MR. BRENNAN: Just very quickly, I think that's a  
17 very good point. And where we've been going internally, I  
18 don't know if it actually made it into the paper, but there  
19 may not be a one-size-fits-all approach to attribution. For  
20 certain conditions you might want single attribution with a  
21 50 percent threshold for other conditions. You might want  
22 multiple attribution with a 30 percent threshold. So we're



1 still exploring that. As you pointed out, it does differ a  
2 little depending on whether it's a chronic condition that  
3 doesn't have a lot of acute care usage versus a condition  
4 that has a lot.

5 DR. WOLTER: To be real specific, over the last  
6 couple of years we've had presentations that have come at us  
7 from different places, even the insurance industry, that has  
8 pointed out that ultimately creating accountability at more  
9 of a group level may be necessary for certain high cost  
10 complex issues. And that's really one of the important  
11 themes, I think, that we could connect to this eventually.

12 MS. BURKE: Just on this point, following up on  
13 Nick's comment, one of the things that occurred to me around  
14 the issues of attribution is the extent to which the change  
15 in practice, the development of the hospitalist for example,  
16 and the movement to essentially transfer authority over a  
17 patient during periods of time, during limited periods of  
18 time, whether that will add to the complexity of ultimately  
19 tracking and dealing with this question of attribution. Who  
20 ultimately is responsible for decisions and certain kinds of  
21 behaviors?

22 I do think it will vary by condition potentially.

1 And so whether it's a percentage of whatever it happens to  
2 be in terms of trying to figure that out, I think Nick  
3 raises a very good point. I think it is going to become  
4 more complicated rather than less as these sort of methods  
5 for delivering and the site of delivery and whether it's a  
6 team or not come into play, I think will vary by condition.

7 So I think the point you make, Niall, is that it  
8 may not be a single method that applies to all, I think is  
9 exactly right.

10 MR. HACKBARTH: I think the point that Nick made  
11 is a really important point and raises one of the basic  
12 issues facing not just Medicare but the broader system.  
13 Does organization drive payment? Or does payment drive  
14 organization? There's sort of funny very important  
15 interaction between the two.

16 We've got a fragmented delivery system, in part  
17 because the payment system reinforces that, tolerates it,  
18 accommodates it.

19 Now if we say well, we've got a fragmented  
20 delivery system, we have to continue to pay in ways that  
21 reflect that, we will always have a fragmented delivery  
22 system.

1           On the other hand, if you have a payment system  
2 that is totally disconnected from the reality of practice,  
3 it's a nonstarter politically, and in a lot of other ways.  
4 It's a very difficult problem to get out of.

5  
6           MR. MULLER: Just briefly along those lines, the  
7 chart that we had on five, which shows not a total  
8 consistency, as you pointed out in the elaboration of the  
9 Minneapolis and Miami example, in terms of practice style  
10 and patterns, and we all know that's true inside settings as  
11 well, even in a complex place like ours. You can't  
12 necessarily infer at a certain place in cancer therapies  
13 what that means for cardiovascular or neurosurgical.

14           I think it's important in terms of the weightings  
15 that we also keep trying to remember, in terms of the  
16 comments earlier about the financial aspects of this, what  
17 proportion of the total delivery system is measured by these  
18 various conditions. I'm trying to remember from last month,  
19 when you start adding up especially coronary artery disease  
20 and congestive heart failure and diabetes, I'm trying to  
21 remember the number you had of what proportion of Medicare  
22 spending you captured by those three. I don't know if you

1 remember off the top of your head?

2 MR. BRENNAN: Off the top of my head, I don't  
3 remember but it's a pretty sizable chunk.

4 MR. MULLER: Wasn't it pushing 60 or something?

5 DR. REISCHAUER: 61 percent of the inpatient.

6 MR. BRENNAN: I guess there are different things.  
7 For CAD, 61 percent of CAD dollars are inpatient dollars.  
8 Is that what you mean? Or do you mean of our selected  
9 episodes how much of Medicare spending did they represent?

10 MR. MULLER: The latter.

11 So obviously the inpatient is perhaps more  
12 clustered. But if one goes down the attribution argument I  
13 think one would want to look at our we covering 40, 50  
14 percent of the care provided, to Nick's point, in a delivery  
15 system, in some kind of responsible unit? Or are we just  
16 looking at a low number, 10 percent? Because obviously the  
17 extent to which you do a lot of measurement of 10 percent,  
18 10 percent, 10 percent, you may decide you want to add them  
19 up. But it doesn't tell you a lot if you add them up if  
20 you're very superior in one area and inferior in another  
21 area.

22 So I think these questions of how much of the

1 total care are we measuring, and as you pointed out in your  
2 response, what one measures on an inpatient scale can be  
3 considerably different than what one measures on the  
4 physician scale if you look at four or five conditions.

5           So I think thinking a little bit about what we're  
6 trying to get to in attribution -- I mean one of the  
7 discussions we had going back two or three years is what  
8 kind of accountable units are we looking at? And a lot of  
9 people around this table have, over the years, argued for  
10 bigger, more organized systems.

11           And to do that I think it's helpful for us to keep  
12 reminding ourselves whenever we're looking at this kind of  
13 analysis what proportion of the clinical pie are we looking  
14 at?

15           Just the fact that the physician -- if you add up  
16 these conditions as to what proportion of the physician  
17 services there are, if they are considerably different than  
18 the proportion they are of inpatient services, one goes in  
19 different directions. As some people have said the  
20 weighting of how you weight this, what proportion of the  
21 clinical care you're looking at, is I think of major  
22 importance.

1           MS. HANSEN: I just want to preface that this is  
2 probably even a further stretch but it has to do with not  
3 even large organized systems but to take some opportunities  
4 to use -- perhaps some of the findings from all the PACE  
5 sites that do have both an organized delivery system, as  
6 well as an integrated financing system and take a look at  
7 some of these conditions that are not just singular, since  
8 the average elder person has about eight diagnostic  
9 conditions, and perhaps take a look at some of the data sets  
10 because all of the ICD-9s are collected on that.

11           Going back to the whole attribution of  
12 accountability, the unit of accountability is actually the  
13 whole provider. With a physician you can cull out obviously  
14 the diagnoses. But the distribution of services which moves  
15 beyond unfortunately Medicare, but when you're dealing with  
16 this population there are other services that come in  
17 oftentimes on the Medicaid side. But to be able to just  
18 understand the patterning and the diagnostic coding that  
19 comes about with this kind of comorbid population that goes  
20 perhaps with all three categories and taking a look at the  
21 cost elements that come out.

22           MS. MILGATE: When you say they're collected, the

1 ICD-9s, in what way?

2 MS. HANSEN: They're submitted to Medicare.

3 MS. MILGATE: They are, so even though they get a  
4 capitated payment, they keep track of their claims?

5 MS. HANSEN: Yes, so all the claims are there. So  
6 the practice patterns can then be looked at relative to  
7 about 35 sites across the country.

8 DR. MILSTEIN: A number of the measurement issues  
9 that have been raised over the last few minutes have come up  
10 in prior similar efforts over the last few years, NQF, IOM,  
11 et cetera. Let me just sort of share a few insights that I  
12 pulled from those activities.

13 First, one of the things that you realize is that  
14 there are multiple windows that are equally valid with  
15 respect to individual and group, for example efficiency  
16 measurement. And in some cases, they are related to what  
17 condition you're trying to evaluate.

18 So even something as narrow as a per visit cost  
19 might be the right longitudinal unit of accountability for a  
20 physician's management of a cold, a patient with a cold,  
21 whereas for a broken arm a per episode framework intuitively  
22 makes more sense. And for congestive heart failure maybe a

1 year's worth of illness makes more sense as a denominator,  
2 or even two years as others have suggested.

3           The second insight that one pulls out of -- at  
4 least I pulled out of these discussions -- is that there  
5 also can be multiple units of accountability for the same  
6 measure. To say that, for example, a complicated asthma  
7 patient it's not reasonable to hold a physician accountable  
8 for that, I think that's absolutely true. One appropriate  
9 unit of analysis for a complicated asthma patient is not  
10 just the physician but the group of physicians and other  
11 team members that are involved in managing that patient.

12           But that said, holding team constant, there is  
13 such a thing as better performance, better results by some  
14 physicians within a group than others. And we don't want to  
15 lose that signal and that basis of performance distinction.

16           Let me now jump to a related topic but a different  
17 topic, and that is that over the last three or four years  
18 the private sector has satisfied itself that there is a  
19 reasonable ratio of signal to noise on physician efficiency  
20 measures and has, in some ways, put their money on the line.  
21 That is you now can find in a variety of places around the  
22 country insurers who, based on physician networks that



1 they've narrowed, based on efficiency measures, or that  
2 they've tiered based on efficiency measures, they now are  
3 able to offer the public a significantly lower premium  
4 associated with networks that have been narrowed or tiered  
5 based on these measures.

6           Now if actuaries -- and John can override me on  
7 this -- but if actuaries are willing to bet on this and bet  
8 their careers on this, and indeed in subsequent years this  
9 has turned out to be a good bet, that tells me that there is  
10 signal here. This can't purely be due to unaccounted for  
11 differences in patient morbidity if, after narrowing the  
12 network based on these measures you get a substantially  
13 lower PM/PM and curl.

14           That said, many private payers struggle as they  
15 attempt to assess physicians on the efficiency measure but  
16 also on the quality measures with borderline levels of  
17 claims experience with an individual physician. I think  
18 both of these two facets of physician performance, both  
19 effectiveness and efficiency, which are the two domains that  
20 have been presented today, could be much more effectively  
21 rewarded by the private sector if the private sector was  
22 able to boost their claims experience with individual

1 physicians via access to the beneficiary anonymized version  
2 of the Medicare claims database.

3 I think this week's New York Times editorial,  
4 speaking in favor of this as a Medicare policy option, I  
5 think was well argued and I hope it's something that we  
6 would consider here at MedPAC.

7 DR. CROSSON: Just one last comment Glenn, going  
8 back to your chicken and the egg analogy. I think we've  
9 talked about this once or twice before. But if you think  
10 about how we could see over time evolution of delivery  
11 system into more accountable organizations, the question is  
12 what could bring that about?

13 One thing that could bring it about overtime is  
14 the performance measurement process. So for example, the  
15 issue of attribution, I think, over time could convince at  
16 least some physicians and hospitals that rather than be  
17 subject to something that they may view as unfair that it  
18 would be better to be part of an organized system.

19 And secondly, to the extent that over time the  
20 measurement process uses information that either has to come  
21 from charts or from clinical information systems, to the  
22 extent that it's easier, more accurate, more efficient to

1 derive that information that is needed to be reported, for  
2 example, if you were going to do it that way from a clinical  
3 information system, and developing that capability is easier  
4 as part of an organized system, then the management and the  
5 performance accountability process may be a driver.

6           So I think as we go about this it might be useful  
7 to think about that. And perhaps, and I've said this  
8 before, even mark out that that goal -- that is greater  
9 organization of the delivery system might, in fact, be an  
10 explicit goal over time of the performance measurement and  
11 accountability work.

12           DR. NELSON: I'm not sure how much of the IOM  
13 deliberations are confidential but I feel comfortable in  
14 identifying a point that I made because I've made that point  
15 in other arenas. And that is that restructuring becomes  
16 feasible if the rewards, if the awards for doing so are  
17 substantial. You don't have to have a stick if you've got a  
18 big enough carrot.

19           The incentives for solo and small groups to get  
20 together and form virtual groups to pool their resources so  
21 they can afford the information technology to do the kind of  
22 reporting that allows resource use and performance on

1 quality indicators to be easily obtained. They don't have  
2 to be a group within one wall. They can be a virtual group  
3 tied together by information technology and pooling  
4 resources so they can hire ancillary personnel and so forth.

5           It seems to me that the natural resistance and  
6 inertia within the system, and it certainly is present in  
7 health care more than many systems, we have an opportunity  
8 to help break that down if we are fairly forceful in urging  
9 the kind of incentives that can make it happen.

10           MR. HACKBARTH: I think that you probably need a  
11 mixture of the carrots and the sticks. I could imagine that  
12 you might say okay, we will provide certain tangible  
13 benefits, rewards, that will draw people into more organized  
14 forms of care. They'll say oh, I'm maybe only going to be  
15 eligible for that reward if I'm in a certain type of  
16 organizational framework, or at least I'll only have a  
17 reasonable chance of obtaining that level of performance if  
18 I'm in a more organized system.

19           If you finance those rewards and you keep the  
20 whole system budget neutral by saying okay, that means we  
21 have to constrain payment for people who aren't producing  
22 that level of performance, you've got negative pressure on

1 one side and positive opportunity on the other. To me  
2 that's the broad direction we need to move.

3 Obviously the rub is where do you start? What's  
4 the magnitude? And those are the issues we're wrestling  
5 with.

6 DR. KANE: I just have a quick question, actually.  
7 Pharmaceutical data is not in this yet. What's  
8 the timing on when it might be includable?

9 And then are the private plans producing data in  
10 such a way that it will be easily incorporated into these  
11 kinds of things? I just wanted to know more about how the  
12 pharmaceutical part might come into play, because it seems  
13 on some of these conditions that's going to be fairly  
14 critical.

15 DR. MILLER: Let me bounce the second half of the  
16 question to you. My sense is that the private firms do use  
17 the pharmacy data in these things now. Right?

18 MR. BRENNAN: Yes. And for certain episodes  
19 pharmacy costs can be -- like diabetes it can be about one-  
20 third of the cost of a diabetes episode.

21 DR. MILLER: I think it's going to be a while. If  
22 you consider that the claims data for that drug benefit have

1 just started on January 1 -- and I'll take any kind of  
2 advice from anyone on the staff -- but I'm thinking we're  
3 not going to start seeing that into well into next year,  
4 would be my sense, that there will be some lag. We might be  
5 able to see things sooner.

6 And then to move it into this process, we have to  
7 work through this as well. I think this could take a while  
8 to show up.

9 DR. KANE: Is the sense that before you have that  
10 information you would want to start using this as a payment  
11 incentive or performance measurement device for payment  
12 purposes? Or are you going to wait until you have the  
13 pharmacy data before you -- or I guess it's more of a  
14 question. Should the pharmacy data be in there? Because to  
15 me that's fairly critical to some of these conditions that  
16 we're looking at in terms of how well a patient is handled.

17 DR. MILSTEIN: On this point, and Karen maybe you  
18 can fill in here, I know that the leader in the research  
19 community in physician efficiency research, Bill Thomas, has  
20 analyzed whether or not -- appreciating that pharmacy is a  
21 significant percentage of total spend -- but he has taken a  
22 look at whether or not the deletion of pharmacy claims

1 significantly affects physician ranking.

2 And correct me if I'm wrong, but I believe that  
3 his conclusion was that it did not.

4 MR. BRENNAN: I'm not entirely sure. He actually  
5 gave me a draft paper the day before yesterday that I  
6 haven't had a chance to read yet. The points I do remember  
7 is for certain conditions like AIDS, pharmacy costs are a  
8 huge, huge component. And I'm not sure, he also did a paper  
9 recently that said that using risk adjustment didn't affect  
10 relative physician ranking. So I'm not sure if he also  
11 found that the inclusion or exclusion of pharmacy costs  
12 affected the rankings.

13 DR. MILSTEIN: This is knowable.

14 MR. BRENNAN: We can check that and get back to  
15 you.

16 MS. HANSEN: Just as a follow-up when I brought up  
17 the data that's available, and I've left On Loc PACE as of  
18 about a year-and-a-half ago. But we actually had collected  
19 both diagnostic and reportable to Medicare. Plus we have  
20 collected all of our pharmaceutical data, as well, online.  
21 So we have even as a small base.

22 Again I'm not in an authority position to offer

1 that you directly, but I can certainly make that connection  
2 for you. But we do have it all online so that it can be  
3 pulled out.

4 DR. REISCHAUER: But you're saying you have  
5 diagnostic data for individuals. But if it's not tied to  
6 cost information --

7 MS. HANSEN: But we have cost information, as  
8 well. We have cost, we have pharmaceuticals, we have DME.  
9 But again, it's a population of about 1,000, but we've  
10 tracked them over 12 years.

11 MR. HACKBARTH: Okay, good work. Thank you very  
12 much.

13 Next we turn to inpatient resource use.

14 MS. MUTTI: This presentation focuses on our  
15 framework for considering hospital efficiency and, more  
16 specifically, hospital resource use. Our goal in pursuing  
17 this topic is to see whether there is a way to hold  
18 hospitals accountable for both the quality of their care and  
19 the resources used to deliver that care, so that ultimately  
20 we can encourage greater efficiency.

21 We introduced the framework back at the November  
22 meeting but wanted to come back to it so we could get more



1 specific feedback on a design issues as well as any  
2 additional general thoughts you have on our overall  
3 framework.

4           This slide may refresh your memory about the  
5 framework we presented in November. As you can see we  
6 consider hospital efficiency to be a function of both  
7 quality and resource use. As you might recall at the last  
8 meeting, Sharon broached the subject of quality measures as  
9 well as the challenges of creating a composite measure.

10           On the side of resource use we have begun our work  
11 by identifying three distinct yet complementary dimensions.  
12 The first are hospitals costs during an inpatient stay.  
13 This refers to the costs incurred by the hospital in  
14 delivering care that is paid by Medicare under PPS.  
15 Hospital costs are influenced by their propensity to use ICU  
16 care, the patient length of stay staffing decisions and  
17 other factors. And although Medicare does not spend more in  
18 the short term if hospitals use more resources of this type,  
19 over the long term hospitals collective cost growth  
20 increases pressure for higher annual updates for Medicare.

21           Our second dimension is the volume and intensity  
22 of care around an inpatient stay, particularly physician

1 visits during the stay as well as all other care after  
2 discharge. Our literature review suggests that hospitals  
3 are in the position and often do influence care during this  
4 period, and I'll elaborate more on this in a minute.

5           The final dimension is the propensity of  
6 physicians on the hospital's medical staff to admit  
7 patients. Some hospitals have physicians who choose to  
8 treat on an inpatient more readily than other physicians.  
9 Hospitals can influence their affiliated physicians'  
10 admitting practices by, for example, offering outpatient and  
11 chronic care management services then prevent the need to  
12 hospitalize, as well as by maintaining a bed supply that is  
13 well-matched to the community's need. As we discussed  
14 yesterday, physicians tend to admit more if there are more  
15 beds available.

16           For the remainder of the presentation I'll focus  
17 on dimension two, the volume of services around an  
18 admission. Hopefully this diagram will help clarify our  
19 concept. As you can see we are on a time continuum, as the  
20 line at the bottom indicates. This box here represents the  
21 hospital stay itself, which reflects dimension one, the  
22 hospital's costs during the stay.

1           Dimension two specifically refers to the physician  
2 visits during the hospital stay as well as care after  
3 discharge. That includes physician visits, post-acute care  
4 such SNF and home health care, outpatient visits and  
5 readmissions.

6           In the next three slides I'll discuss the possible  
7 motivation for measuring this dimension. First, I'll discuss  
8 whether hospitals can and do influence Medicare spending on  
9 other health care services. Presumably, it is only worth  
10 holding them accountable if, in fact, they can influence  
11 that care. So what are their opportunities and constraints?

12           Second, I'll briefly review the literature on  
13 variation in Medicare spending and care patterns around an  
14 admission. The logic here is that to the extent that there  
15 is variation with no differences in quality, there may be  
16 room for resource conservation.

17           Then I will switch gears a bit and address one of  
18 the central questions concerning how one would proceed  
19 measuring this dimension, and that is how long an episode  
20 could a hospital be held accountable for? Are hospitals  
21 able to influence care just during the stay, a short time  
22 afterwards, something like 15, 30, 60 days? Or are they

1 able to influence care even years after the admission?

2           Research findings suggest that hospitals are able  
3 to influence resource use, as I mentioned earlier. Among  
4 the prime leverage points are their ability to control  
5 complications and infection rates. Success in this area  
6 means fewer intensive services during the hospitalization as  
7 well as fewer readmissions and other post-discharge  
8 services.

9           Managing the transition home is another way that  
10 hospitals can influence episode spending. I'll give two  
11 examples here so that it also illustrates sort of the  
12 merging of that care coordination issues that we've talked  
13 about as well as resource use measurement.

14           One example is a hospital found that it was able  
15 to increase appropriate use of medications known to prevent  
16 complications if a checklist of medications was reviewed by  
17 nurses just prior to each patient's discharge.

18           Another hospital found that by having nurses  
19 repeatedly meet with patients at high risk for poor outcomes  
20 after discharge, patient needs were better met and  
21 readmissions reduced. Home visits were scheduled 48 hours  
22 after discharge and seven to 10 days after discharge. Those

1 who needed more received more. Visits were also made during  
2 the hospitalization.

3           The nurses provided written instructions and  
4 medication schedules, addressed patient and caregivers  
5 questions and interfaced with physicians to obtain needed  
6 services and adjustment to therapies. The result was a 62  
7 percent decrease in the readmission rate after six weeks of  
8 the study.

9           A hospital's culture and work environment also  
10 seem to matter. A recent study that looked at physicians  
11 practicing in two different hospitals found that physician's  
12 patient's length of stay, after controlling for differences  
13 in health status, varied depending upon which hospital the  
14 patient was admitted to. This suggests that a physicians'  
15 judgment about length of stay, a key aspect of practice  
16 style is not uniform or constant but instead is influenced  
17 by either colleagues at a given hospital or that hospital's  
18 management approach.

19           As several of you commented in November, the  
20 opportunity to influence care may vary among hospitals.  
21 Factors that potentially constrain hospitals are their  
22 relationships with physicians, affiliated physicians, the

1 culture, the presence of competitors in the marketplace, and  
2 financial arrangements between hospitals and physicians, for  
3 example, may influence whether some hospitals are able to  
4 positively influence the care after discharge.

5           Since physicians are the ones performing the  
6 surgery, signing discharge orders, prescribing drugs, their  
7 cooperation is key.

8           Another constraining factor is the uneven  
9 diffusion of clinical IT. Hospitals that have invested in  
10 clinical IT may be in a much better position to identify  
11 problems such as complications and then implement effective  
12 interventions.

13           Uneven supply and mix of health care services and  
14 professionals is a third potential constraint. For example,  
15 the mix of post-acute care options varies across markets and  
16 we might want to be mindful of that.

17           On the question of variation, research shows that  
18 there is wide variation across hospitals in the number of  
19 services provided around a given type of hospital stay.  
20 Again, this is important because variation suggests that  
21 there is a possibility that resources could be safely  
22 conserved.

1           Some researchers have focused on variation in the  
2 volume of physician services provided during the hospital  
3 stay. They found that, after adjusting for price and case  
4 mix, payments to physicians for inpatient care per admission  
5 ranged twofold across MSAs.

6           Other research has looked at variation in resource  
7 use six months to five years following the hospitalization  
8 in some 300 hospitals. That study found that Medicare  
9 spending on hospital and physician services in high  
10 intensity hospitals was 11 to 16 percent higher than in low  
11 intensity hospitals six months after discharge. Over the  
12 five-year window that it looked at they found wider  
13 variation, 49 to 58 percent higher spending in some  
14 hospitals than others.

15           Another study found that patients in the last six  
16 months of life getting care from the seven best hospitals  
17 for geriatric care, as rated by the U.S. News & World  
18 Report, received very different amounts of care. For  
19 example, the number of physician visits was more than twice  
20 as high at Mount Sinai Hospital and UCLA than at Duke  
21 Hospital.

22           Now to our design issue. How long an episode

1 could hospitals reasonably be held accountable for? As I  
2 mentioned, it could run that spectrum from none to just a  
3 little bit after the stay to years after the stay. This  
4 question challenges us to define the notion of longitudinal  
5 efficiency. How encompassing should our longitudinal  
6 measure be? We hit on this subject in the last  
7 presentation, too.

8           The answer may depend on the degree of  
9 responsibility that you think the hospitals should have  
10 here. For discussion, I'll offer three examples of  
11 different degrees of responsibility and the implication of  
12 that responsibility.

13           If you think that the hospital's responsibility  
14 should be limited to its role in direct patient care and its  
15 consequences only during the stay, then the hospital could  
16 be held accountable only for the stay.

17           If, on the other hand, you feel that the  
18 hospital's responsibility extends to the direct consequences  
19 of its care, such as the complications and the infections  
20 that I talked about before, as well as the efficacy of its  
21 discharge plan, as well as the type of culture that it  
22 creates in the environment, then a hospital could be held



1 accountable for care delivered immediately after the stay.

2           And lastly, if you think that hospitals should  
3 have a responsibility as conveners of physicians influencing  
4 them both in their hospital-based care as well as in their  
5 office-based and primary care, then a one to five year  
6 window may be appropriate. The longer episode here  
7 addresses also the propensity of the physicians to admit,  
8 which we also try and pick up in our third dimension that I  
9 discussed earlier.

10           Each of these approaches entails a host of policy  
11 and logistical questions. How do you align the incentives  
12 between the physicians and the hospitals so that there is  
13 the cooperation that we need? How do you risk adjust  
14 appropriately? A whole range of questions. But at the  
15 moment we were hoping to get your feedback on this broader  
16 question.

17           So with that, we look forward to your comments.

18           DR. WOLTER: I suppose you could cut my comments  
19 from the last section and paste them into this one. But I  
20 do think that we should be thinking more about what is the  
21 accountable unit. And just to connect the dots again, if 61  
22 percent of inpatient costs are related to three diagnoses,

1 either alone or in combination, there's a tremendous amount  
2 of gain to be made by tackling those areas where we also  
3 know the quality measures are not adequate.

4           And so the whole issue of coordination of care, I  
5 mean one of the IOM's key principles is patient centered but  
6 we're proposing hospital-centered and physician-centered  
7 approaches to accountability, whereas if we're looking at  
8 congestive heart failure or diabetes clearly the appropriate  
9 time is not four days in the hospital or 30 days after.  
10 It's a year or two, or whatever the case may be. And if we  
11 were to design incentives that took a little of Part B and a  
12 little of Part A and said for the appropriate physicians in  
13 hospitals that want to work together -- these could be  
14 formal groups, these could be virtual networks as Alan has  
15 pointed out. But we will take accountability for the care  
16 of these patients and the costs of these patients. Then we  
17 can design ways of looking at the care of these patients  
18 that go beyond just the hospital stay or just the care in  
19 the physician's office.

20           And then if you connect some of the other issues  
21 we've dealt with over the last few years, the diffusion of  
22 IT is very critical to this. And yet there clearly are

1 barriers now to hospitals and physicians putting the same IT  
2 systems together. Some of those have to do with Stark and  
3 kickback regulations. The gainsharing that we recommended  
4 in the past could come into play here if we really wanted to  
5 look at how we tackle this in a different way.

6           So I hope we can maybe try to bring some of this  
7 thinking into these chapters, even though you're right  
8 Glenn, it's the chicken and the egg. How do we build this  
9 on top of what we have? But on the other hand how do we  
10 create some direction where over five or 10 years we might  
11 end up in a different place?

12           MR. MULLER: My comments are along the lines of  
13 Nick's, so I won't repeat his excellent exposition of them.

14           The question of the payment incentives, just to  
15 build on one of them, obviously if the big payment incentive  
16 right now is inside the inpatient episode, in those three or  
17 four or five days, there are not payment incentives right  
18 now in the same way to take care of the care after the  
19 hospitalization except insofar as there's a complication  
20 that causes somebody to be readmitted, and so forth. So how  
21 one thinks about payments have to be changed within a more  
22 bundling approach, as I think is what Nick was suggesting

1 there, is obviously a critical part of this.

2           Also in terms of point two, on the accountable  
3 unit, in some ways in the Modernization Act it strikes me  
4 there's a big policy statement there that the accountable  
5 unit becomes the health plans. And so the kind of  
6 innovation that will go on inside those health plans and  
7 their relationships to doctors and hospitals and so forth is  
8 a critical thing for us to keep watching because I think, in  
9 many ways, that was the philosophical statement as I read it  
10 in the elaboration of Medicare Advantage.

11           So the extent to which that becomes a set of  
12 accountable units that then works with the hospitals to get  
13 that kind of longer-term longitudinal responsibility for  
14 care is something I think we should keep watching. Because  
15 in some ways it's not CMS as an agent, sitting here in D.C.  
16 or Baltimore. That's going to be individually doing all of  
17 this with all the hospitals and the physicians of America  
18 strikes me we've made a major statement that it's going to  
19 be the health plans who are doing that.

20           Like Nick and Alan and others, I think we should  
21 keep focusing on how to get organized delivery systems more  
22 incentivized to be created. As we've said, that Jay's had

1 one for 50-plus years, we need to keep evolving in that kind  
2 of direction.

3 But right now I would say, in terms of MedPAC,  
4 having the payment system more fully reflect what we want to  
5 do in terms of accountable unit is an important thing for us  
6 to do because right now we have all of this evidence that  
7 the payment system cuts against the kind of themes that  
8 we're stressing.

9 DR. MILSTEIN: Outside of the HMO environment one  
10 of the interesting phenomena over the last 20 years is no  
11 one wanting accountability for either longitudinal cost or  
12 longitudinal quality. It's sort of like -- if someone were  
13 here representing health plans, they would say no, not me,  
14 it's the hospitals and the doctors. And Nick is saying no,  
15 it's the plans.

16 And that's the problem is that you have -- okay,  
17 sorry. I really think that returning to this notion of  
18 multiple units of accountability for the same outcome is the  
19 only solution in a non-organized system of care on a prepaid  
20 basis.

21 And so I think I yes, for longitudinal both  
22 economic and quality outcomes, the plan has to be

1 accountable. But so does the physician group, the  
2 individual physician, and the hospital. And we need units  
3 of measurement and forms of accountability at each of those  
4 levels. Because they all can have a significant influence  
5 on longitudinal both cost and quality.

6           Let me go down to a very narrow point now and ask  
7 -- one of the facets, if we were just looking purely at a  
8 relatively narrow inpatient unit of analysis, thinking  
9 either way on the inclusion or non-inclusion of  
10 prehospitalization for elective admissions,  
11 prehospitalization work-up activities, that can obviously  
12 unfairly reflect upon a hospital if those are done on an  
13 inpatient basis. Yet they are part of, certainly for  
14 surgeries, part of the necessary services incident to the  
15 surgery itself.

16           MS. MUTTI: I think we've thought about that. We  
17 just didn't tackle that first, in this presentation.

18           DR. MILLER: Arnie, some of the reason that we  
19 wanted to have this conversation and take this piece of the  
20 hospital inpatient or the hospital resource use is that  
21 there has been this repeated theme of longitudinal  
22 accountability that you brought up.

1           And so we're trying to get a feel, and I'm sure  
2 other people will comment. But from your perspective, if  
3 this was a tool that we were building and one that we're  
4 using, what is your sense? I don't mean to pin you down so  
5 much, but 30 days? Two years? Those are big differences.  
6 And I think hospitals could reasonably come back and say  
7 there's a big difference and my ability to influence a  
8 patient a couple of years out could be very limited.

9           So could you talk a little more about that?  
10 Because I think a lot of your comments are driving some of  
11 this question.

12           DR. MILSTEIN: I think per my earlier comment, the  
13 answer is for some conditions multiple windows, multiple  
14 longitudinal windows of measurement and accountability for,  
15 for example, a hospital would all be appropriate. That is  
16 there may be some hospitals that are truly distinguished on  
17 their Eliot Fisher, you know, initial hospitalization event  
18 and five years subsequent. There may be other hospitals  
19 that substantially outperform that particular hospital on  
20 this more narrowly defined window that we heard about this  
21 morning.

22           I think what's important would be for us to

1 essentially build out multiple longitudinal windows for a  
2 particular provider and recognize the fact that some  
3 providers may excel in some facets of efficiency. And  
4 others may excel at others.

5 I don't think there is any one -- there may be,  
6 for many conditions, no single unit of longitudinal --  
7 single longitudinal frame that's appropriate for measuring  
8 efficiency. There may be multiple that are applicable.

9 MR. MULLER: But Arnie, the payment system gives  
10 you a clear answer. It's the stay only, is the answer right  
11 now.

12 DR. MILSTEIN: Today.

13 MR. MULLER: Aside from some bundling on the  
14 surgical side. So if you want the answer in the payment  
15 system, the answer is the stay. If you want to change the  
16 policy, as I said, then you need to have some modifications  
17 in the payment system to both pre- and post-bundle the stay  
18 if you want more longitudinal accountability. But right now  
19 the hospital basically, the payment in terms of the costs  
20 that go into the DRG, they end on the day of the stay except  
21 for some very modest exceptions.

22 DR. MILSTEIN: The consequences of only using that



1 window are ones that we're all familiar with.

2 MR. MULLER: Oh, yes.

3 DR. NELSON: I come at this from a little  
4 different direction. I think if we're talking about the  
5 hospital saying how long after the patient leaves do I get  
6 blamed for, that's one thing. If you're talking about the  
7 hospital saying how long after the patient leaves am I able  
8 to receive a reward for good management, then that's a  
9 different breed of cat.

10 As a long-term strategy, I think that we ought to  
11 have as a principle that we would like to break down payment  
12 silos when it comes to rewarding performance.

13 Now I'm suggesting that we break down the payment  
14 silos that pays for the services that are received. I'm  
15 saying that if we are talking about rewarding performance we  
16 ought to be looking at a commingled reward pool that  
17 acknowledges that hospital efficiency may increase as a  
18 product of outpatient, better outpatient management, both  
19 before the hospitalization and after the hospitalization.  
20 And that the reward pool should be commingled so that where  
21 the benefit is attributed gets adequately recognized.

22 This again is something that has had some

1 discussion at the IOM and other places. And I don't think  
2 that it is helpful to retain indefinitely independent silos  
3 of reward pools that ignore how interconnected they may all  
4 be when it comes to improving performance.

5 MR. HACKBARTH: I think that's been as clear a  
6 theme as we've had over at least the last couple three  
7 years. We keep coming back to that. I think that, in terms  
8 of vehicles Nick mentioned concerning that in some of these  
9 chapters and I think that's important to do.

10 I think potentially our report on the SGR is  
11 another important vehicle for pulling together some of these  
12 ideas in a coherent way, and at least pointing to potential  
13 paths to pursue. We need to get from the conversation,  
14 though, to a much more concrete level of discussion on this.

15 DR. STOWERS: I think my comments are almost  
16 redundant from Arnie to Ralph to Alan, but it initially  
17 struck me when I saw the physician visits during the  
18 hospital stay and after the hospital stay that it would be  
19 very interesting to track them back six months to a year  
20 prior to the hospital stay, which would show initial care  
21 for congestive heart failure, diabetes, that sort of thing.  
22 Because certain integrated health care systems the hospital

1 has a lot of responsibility in running that.

2           And I think the correlation between the hospital  
3 rate and whether or not they are being seen on a regular  
4 basis, getting what they need, I know some previous work has  
5 been done on that that was really pretty fascinating. So it  
6 might be interesting to do both pre- and post. And I think  
7 I've heard that here before.

8           MR. SMITH: I don't have a lot to add to what  
9 colleagues have said but a couple of things strike me.

10           Arnie, I think it's very hard to have complex  
11 overlapping intervals of responsibility without beginning  
12 with bigger episode defined bundles of payment. I think it  
13 will be the contractual relationship between the hospital  
14 and the post-acute care setting or the clinical relationship  
15 between the hospital and physician visits during the  
16 setting. That is where efficiencies as well as quality  
17 improvement can be affected by the hospital. We've got to  
18 somehow give them the capacity to utilize financial  
19 resources in order to try to drive those outcomes.

20           What we can't do is look back at a fragmented  
21 payment system and say now we're going to adjust payments  
22 for quality in an imputed time frame where nobody was in

1 charge during that time frame.

2           Outside of the coordinated system part of the  
3 delivery apparatus, I don't know how we get it without  
4 bigger bundles. I think Ralph described it correctly.  
5 We've tended to, and we do in the care coordination  
6 discussion and the post-acute section, we tend to focus on  
7 the post-acute stay part of the bundle. But Ray beat me to  
8 it.

9           An awful lot of what isn't getting done is not  
10 getting done in the pre-acute stay either badly or unmanaged  
11 physician and other practitioner services. And figuring how  
12 to get that back into the bundle, assuming we can't or don't  
13 want to put everybody into a plan setting, we need to go  
14 both board and backward as we think about what these  
15 episodes look like.

16           MR. HACKBARTH: I'm trying to pull together some  
17 of these comments.

18           Right now we've got our fragmented fee-for-service  
19 system. At the other end of the continuum we've got a  
20 complete capitation model. One approach to addressing some  
21 of these issues would be to create a third option which  
22 voluntarily allows groups of physicians and providers to

1 assume responsibility for broader bundles of care that  
2 bridge the Part A and Part B. If it's done on a voluntary  
3 basis I think we're addressing one of the issues that Alan  
4 has raised, the rewards versus it all being penalties. You  
5 can say you can stay as you are, but if you go into an  
6 organized relationship with other providers you may have an  
7 opportunity to improve performance, both quality and  
8 efficiency, and be rewarded for that.

9 Now conceptually that's easy to say. It's much  
10 harder to devise the policy. But that's one potential path  
11 that I hear us wanting to explore it. There are some other  
12 ways you can approach it as well. Bob?

13 DR. REISCHAUER: There's a problem with this and  
14 that is there are there the providers and there are the  
15 beneficiaries. And what's different about the coordinated  
16 care model, the Kaiser or whatever, is the beneficiary has  
17 said I'm going to be in this regime. That's the missing  
18 agreement when you go to virtual groups or other things  
19 because you then have to ask yourself does the beneficiaries  
20 still have the ability to walk, in a sense. That makes it  
21 more complicated because you then don't know how to  
22 attribute accountability to those who don't stay where they

1 started.

2 MR. HACKBARTH: That is a very important point.

3 DR. REISCHAUER: It may turn out that that's a  
4 very small situation.

5 MR. HACKBARTH: Politically it's a huge point, but  
6 in design terms it's a huge point. Are we talking about  
7 options within the free choice traditional Medicare and new  
8 paths there? Or are we talking about lock-in models?

9 I was talking about a free choice system but it  
10 raises the question of will providers step to the plate if,  
11 in fact, beneficiaries have the opportunity to go wherever  
12 they want?

13 DR. REISCHAUER: But you can also have the virtual  
14 group or the accountable group and the beneficiary  
15 voluntarily saying I'm agreeing to have this as my care  
16 management group or my coordination group, and give them  
17 some kind of an incentive, you know, smaller Part B, smaller  
18 co-payment, whatever.

19 DR. NELSON: Right, for identifying the care  
20 coordinator and staying with them.

21 DR. SCANLON: On this point, we have, in some  
22 respects, in the Medicare health support, something where

1 the beneficiary is being asked to participate without some  
2 kind of formal obligation. There is an organization that is  
3 doing something -- not quite a virtual group -- but trying  
4 to do something to bridge some of the gaps that we have. We  
5 may see from that how influential our organizations on  
6 beneficiary's behavior in terms of influencing their choices  
7 are.

8 DR. KANE: I'm going to sound like a broken record  
9 but have we thought about the fragmented Part D and how that  
10 will be brought into these incentives, and making sure that  
11 the formularies and the incentives and the drug benefit  
12 match the incentives in the payment of the primary care  
13 doctor and the hospital?

14 I'm just concerned that you've got a cohesive  
15 Medicare and then you've got this Part D out there that's  
16 privatized and fragmented.

17 So do we need to also be thinking about how do we  
18 make sure that the incentives are going on? And by what  
19 vehicles are those going to happened?

20 I don't think we can just keep ignoring that there  
21 is this other thing going on out there that I think has a  
22 lot of influence over certainly congestive heart and

1     diabetics are managed.

2                   How can we make sure that -- is Medicare going to  
3     review the plans every year with regard to whatever you're  
4     trying to do with Part A and B or not? What is the  
5     integration and policy here? And have people thought about  
6     it? Should we be thinking about it? Because I just can't  
7     see this really working without having the whole package  
8     under some kind of single goal oriented system or it will  
9     get pretty complicated.

10                  MR. HACKBARTH: It's an important point. I can  
11     imagine clinicians saying yes, I'm willing to step up to the  
12     plate to do this. And now you've got beneficiaries  
13     volunteering to do it. But now I've got six different  
14     formularies that I have to deal with as a clinician. That's  
15     another added complication.

16                  DR. REISCHAUER: But in the stand-alone drug plan  
17     the stand-alone drug plan has no incentive to design a  
18     formulary or a cost-sharing agreement that saves money on  
19     hospitalization or something else. And so the real issue  
20     will be whether the MA PDP plans look a whole lot different  
21     from the stand-alone ones a few years from now.

22                  MS. BURKE: The other thing, and this goes back to



1 Ralph's earlier point, I think one of the other areas of  
2 complexity -- and I've raised this drug issue repeatedly and  
3 I agree with everything Nancy has said. I remain deeply  
4 concerned that there isn't that type of anticipation or  
5 coordination going on.

6           But on the broader question of how one tries to  
7 move in this direction, I think Glenn is right that this  
8 ought to be a theme that we begin and have begun to state  
9 throughout a variety of our papers in terms of the desire to  
10 look at the patient throughout the entire period of their  
11 life, not simply sort of in an episode, which is what we  
12 have traditionally done.

13           But I think the issue that Ralph raises is exactly  
14 right, which is -- and this is not suggesting it's right.  
15 But the payment system in everything we have done has, in  
16 fact, encouraged these kinds of silos in a variety of ways.  
17 And we have tried to understand the silos more clearly and  
18 what goes into the silos.

19           In some cases you have more traditional  
20 relationships. The physician-hospital relationship is one  
21 that there is a history to and there is a partnership there  
22 that you could more easily imagine trying to get those two

1 pieces to work, although there are a variety of problems  
2 that arise and issues around gainsharing and a variety of  
3 other issues that we'd have to deal with.

4           But I worry that, in looking both at sort of the  
5 lead-in, the early as well as the late period of time of  
6 care, as David suggested, that it is at the end where there  
7 has been the least amount of collaboration historically in  
8 some respects. And that is with the sort of non -- I mean,  
9 the other institutional providers, the skilled nursing  
10 facilities and other partnerships that move on.

11           And we know that the experience with the discharge  
12 planning has been one of the great conundrums that we've not  
13 yet figured out how to manage, which is really making sure  
14 that there is great thought. I mean, it's sort of the tail  
15 of the dog. It doesn't quite get done right and there isn't  
16 the kind of attention to how important that is in terms of  
17 making sure that there are services available.

18           But I worry that that's where the least amount of  
19 relationship traditionally has occurred in terms of  
20 organized systems of care unless it is an organization that  
21 is completely controlled by the hospital, where they own the  
22 home health agency, they own the skilled nursing facility or

1 whatever it happens to be.

2           So I think again, as we look at how we expand that  
3 episode, I think that may be a very difficult thing to think  
4 of conceptually is how you force that relationship that has  
5 not existed. People tend to go long distances. They want  
6 to go closer to home, rather than if they're in an acute  
7 care facility they go back someplace else.

8           Those relationships might be the more difficult to  
9 manage in terms of trying to encourage or incentivize some  
10 kind of a partnership, potentially. I don't know the answer  
11 to that question. But it would seem to me that it is that  
12 broader group, as Ralph suggests. It is trying to get the  
13 beginning and the end, as David suggests. I think some of  
14 those partnerships are less easily understood or there's  
15 less history there than there might be in some of the areas.

16           MR. MULLER: Let me just speak to that. To  
17 paraphrase the old John Mitchell phrase, don't look at what  
18 we say, look at what we do.

19           We're basically spending a lot of time now in CMS  
20 in the new rule making the episode much more sophisticated,  
21 the re-weightings, but it doesn't deal with the coordination  
22 of care issue in that sense.

1           Excuse me one second.

2           MR. HACKBARTH: Pardon us while we say goodbye.

3           This is been a fruitful discussion but we are  
4 running behind time, so we're going to have to close it for  
5 right now. Thank you, Anne.

6           Our last session of the day is on outpatient  
7 therapy and Carol's going to lead us through that.

8           We are, right now, roughly a half-hour or 20  
9 minutes behind, so I apologize for that.

10          DR. CARTER: This year we undertook a study of  
11 outpatient therapy. Program spending almost doubled between  
12 2000 and 2004, yet we know very little about the value of  
13 this purchasing. There is little information about who  
14 receives services and no information about their outcomes.  
15 This makes it hard to evaluate program spending.

16          For example, we know that there are more users and  
17 that the average user received more services. We also know  
18 that there is a lot of variation in the spending per  
19 beneficiary. But we don't know whether the care needs of  
20 beneficiaries were increasing, and we have little  
21 information about the comorbidities of patients to know if  
22 spending was targeted at those with the greatest care needs.

1           Last, we can't evaluate whether increased spending  
2     resulted in better outcomes.

3           Today I'm presenting information about two  
4     approaches used by private payers and providers to manage  
5     therapy use that might be considered by CMS. I'll also  
6     outline what data are needed and how they could be used to  
7     design a new payment system.

8           We have discussed before the need for a new  
9     payment system that does not encourage therapists to furnish  
10    services. Combined with spending trends presented in  
11    January, this information will be a chapter in the June  
12    report, and you have a draft of that.

13           This winter MedPAC convened an expert panel and  
14    consulted a variety of experts to learn about and consider  
15    alternative ways to manage therapy use. We also asked the  
16    experts to evaluate the evidence basis for identifying who  
17    needs therapy and how much therapy is effective. We  
18    gathered information from over 40 people.

19           Of the strategies examined, two seemed promising  
20    for CMS to pursue: developing guidelines for practice and  
21    tracking resource use and patient outcomes.

22           Some payers and providers use practice guidelines

1 to approve continued therapy provision or to compare a  
2 therapist's practice to such norms. Service provision that  
3 is unusually high or low is flagged for review. The experts  
4 we spoke with had mixed opinions about applying guidelines  
5 to beneficiary service use. They differed in the assessment  
6 of the quality of the evidence underlying the guidelines but  
7 agreed that if guidelines were to be used they would need to  
8 be tailored to an elderly population.

9 Guidelines are generally written for a younger,  
10 healthier population and typically do not consider  
11 comorbidities and other factors that may increase the  
12 beneficiaries' care needs. If guidelines for the elderly  
13 were developed, CMS could use them to flag unusual service  
14 use for further review and to educate therapists and  
15 referring physicians about best practices.

16 Another promising strategy is the tracking and  
17 reporting of service use and patient outcomes and using this  
18 information to establish benchmarks. By comparing their own  
19 practices to averages, clinicians can reduce both the number  
20 of services billed during a visit and the number of visits.  
21 One integrated health system told us that it had lowered  
22 therapy use by 8 percent by tracking resource use and

1 patient outcomes together with standardizing their  
2 practices.

3 Another integrated health system told us that it  
4 uses vendor software to estimate the number of visits a  
5 patient is likely to need to improve and then pre-approves  
6 that number of visits. Using estimates of resource use and  
7 outcomes, the system focuses on ensuring that services  
8 continue to be beneficial to a patient.

9 Tracking resource use and patient outcomes is key  
10 to establishing practice norms and to evaluating program  
11 spending. In addition to flagging aberrant practice,  
12 benchmarks could be used to vary the therapy caps by patient  
13 condition. Spending limits could be lower for beneficiaries  
14 with modest care needs and higher for beneficiaries with  
15 extensive care needs. Limits that vary by condition would  
16 encourage therapists to be mindful of the amount of services  
17 furnished to all patients, not only the high end users  
18 constrained by the current therapy caps.

19 Private plans generally did not offer innovative  
20 approaches to paying for therapy. Most pay on a per service  
21 basis and limit the number of days or visits of care. One  
22 exception to this was a health system that plans to pay

1 therapists for the resource used and the outcomes their  
2 patients achieve. By comparing a therapist's practice to  
3 benchmarks, payments will vary according to the therapists'  
4 relative resource use and their patient outcomes.

5 To increase the value of its purchasing, CMS needs  
6 two types of information. First, it needs better  
7 information so it can accurately identify the care needs of  
8 beneficiaries. And it needs to gather functional status  
9 information at admission and discharge so that it can assess  
10 patient outcomes.

11 In this table I've outlined the data requirements  
12 and you can see that the majority of this information is  
13 currently not collected. To gather these data CMS must  
14 select a patient assessment tool that it would require  
15 therapists to use.

16 There are currently two functional measurement  
17 tools that can assess patients with varying clinical  
18 conditions and put all of these different assessments on a  
19 common scale. These are the Patient Inquiry tool and the  
20 Activities Measure for Post-Acute Care, the AM-PAC. Both  
21 been tested for their reliability and validity. The Patient  
22 Inquiry tool is used in many outpatient settings and has



1 primarily been used to assess patients with orthopedic  
2 conditions. The Patient Inquiry tool has a built-in  
3 reporting feature that links resource use to patient  
4 outcomes. CMS has explored the use of this tool at two  
5 clinic sites.

6           The AM-PAC was developed to assess patients across  
7 post-acute care settings. As such, it can assess patients  
8 with chronic and multiple comorbidities, including patients  
9 in nursing homes. HealthSouth has selected this tool to use  
10 across its post-acute and outpatient sites and Kaiser  
11 Permanente of Northern California is currently piloting the  
12 use of this site in a rehab clinic that specializes in  
13 neurological patients.

14           One advantage of the AM-PAC tool is that it can be  
15 used to assess the functional status of beneficiaries across  
16 the post-acute care spectrum. CMS is required to do a  
17 demonstration beginning in 2008 in which a common assessment  
18 tool must be used to assess patients across post-acute  
19 settings. If CMS decides use the AM-PAC tool for this  
20 demonstration, and then used this same tool to assess  
21 outpatients, it would be able to compare patients across the  
22 post-acute care continuum.

1           One way for CMS to test its selection of a patient  
2 assessment tool and to gather data quickly would be to  
3 conduct a short pilot. The pilot could test the feasibility  
4 of the data collection method from a representative mix of  
5 providers before all therapy providers were required to use  
6 it. In the near term, data gathered from the pilot could be  
7 used in many ways.

8           First, representative data could be used to  
9 develop and test an accurate risk adjustment method so that  
10 valid comparisons across patients can be made. CMS could  
11 also use the data to establish benchmarks for therapy  
12 provision and review aberrant practice patterns. As  
13 mentioned before, benchmarks could be considered for varying  
14 the therapy caps by patient condition. Also, better  
15 information could also be used to evaluate if the exceptions  
16 process is currently correctly identifying patients with  
17 high care needs.

18           Finally, the information from the pilot could be  
19 used to design a payment system. One option is to pay for a  
20 bundle of therapy services that varies by patient condition.  
21 Another is to develop an incentive payment system that  
22 encourages therapists to both provide high-quality care and

1 be conservative in furnishing services. Yet until better  
2 information is available, and adequate risk adjustment  
3 methods are available, efforts to design a better payment  
4 system will be hampered.

5 I'd be glad to answer your questions and take  
6 comments on the draft chapter.

7 MS. BURKE: This is really not truly a question,  
8 but it occurs to me, having just completed the conversation  
9 on this sort of broader approach to patients, whether there  
10 is anything as we look at this particular chapter or as we  
11 look at what kinds of tools ought to be available and  
12 information in terms of tracking the patient and  
13 anticipating their needs based on prior use as well as  
14 subsequent use, whether some thought ought to be given to  
15 whether there is a way to state this broader goal in the  
16 context of this chapter? And that is trying to understand  
17 the full nature of services and the collaboration that  
18 occurs.

19 I mean, as we look at the risk factors -- and the  
20 chapter is very well done in terms of looking at these  
21 issues -- in identifying what we don't know and how  
22 difficult it is to anticipate or to look at use based on a

1 variety of issues, severity and things of that nature,  
2 whether there ought not be given some thought to what our  
3 ultimate goal is and whether it should be reflected in terms  
4 of information that we want or tools that we need to  
5 develop.

6 DR. KANE: I have a question about whether it's  
7 also possible to tell who's providing the service? Because  
8 some states, I guess, have licensed therapists and others  
9 have these doctor's offices where the masseuse could be -- I  
10 mean whoever is in there, some states allow them to bill,  
11 too.

12 It would be interesting, I think, to get a sense  
13 of who's providing these services because the physician  
14 office, in particular, seems to be one of the fastest-  
15 growing areas. It is not really clear whether this is an  
16 extension of physician income, as opposed to a true physical  
17 therapy practice.

18 And I don't see any of the recommendation here  
19 that acknowledge that we should be trying to capture data on  
20 who's doing the actual services within the office.

21 DR. CARTER: There is a little bit of information  
22 that maybe I should highlight in the chapter. Therapists

1 need to be licensed in order to bill for services under  
2 Medicare.

3           Assistants can provide services but they must be  
4 supervised. It is very difficult in the claims data, when  
5 services are being provided in a physician's office we can't  
6 tell, first of all, which of those practices they are.  
7 Because if they are billing using a therapist's ID, we can't  
8 tell whether that therapist is actually practicing on their  
9 own or in a physician's office. The group ID just doesn't  
10 even tell you -- you can't tell therapy groups from  
11 physician groups. All we know is it's a group.

12           And so both the setting is really hard to tease  
13 apart. But also we won't know whether the therapist is  
14 licensed or someone being supervised. So there are  
15 limitations to what we can do there.

16           DR. KANE: I understand we don't know yet. I'm  
17 just wondering if we shouldn't recommended that that be part  
18 of what we collect --

19           DR. CARTER: A piece of information that we  
20 gather.

21           DR. KANE: Yes. Because your footnote here  
22 explains that you don't have any idea who's billing for some

1 of these things. And that's one of those areas where it  
2 could just explode with all kinds of people doing whatever,  
3 sports therapist and things like that.

4 MR. HACKBARTH: Okay, thank you, Carol.

5 We'll now have a brief public comment.

6 MR. MASON: Thank you Mr. Chairman. I know you're  
7 anxious to wrap up and a little behind schedule.

8 Dave Mason with the American Physical Therapy  
9 Association and we want to thank Carol and the staff for the  
10 Commission's efforts to explore the reasons for increasing  
11 beneficiary use of therapy services.

12 I think, as Carol just noted, there is little if  
13 any evidence available that indicates that the increased  
14 rehabilitation is not beneficial or appropriate for  
15 patients, and it possibly also reflects previously unmet  
16 needs or potentially more cost effective interventions. So  
17 I think those are all areas that you will want more  
18 information on.

19 The letter from CMS on the physician fee schedule  
20 that you reviewed yesterday refers to some of the  
21 improvements in chronic patient care and that is one of the  
22 areas we think you'll look further into.

1           We do appreciate the Commission's recognition to  
2 proceed cautiously in this area, especially in making  
3 changes in payment systems without a sufficient  
4 understanding of which services are appropriate to meet  
5 patient needs. And I think you've just have a good  
6 discussion about the concern that the codes that are  
7 commonly used by physical therapists are also commonly  
8 billed by many other providers and you don't have a lot of  
9 information on what's going on in that area, which I think  
10 you'll need to design a better system.

11           I'll point out once again also that APTA and the  
12 other professional associations have developed some  
13 guidelines and are working on practice patterns to assist  
14 therapists in both assessing patient needs and providing  
15 more effective interventions. Staff of the Commission has  
16 seen some of the work that we're working on there and we  
17 welcome the opportunity to talk more about those activities.  
18 We are working to develop and improve and standardize the  
19 collection of information of the type you're looking for  
20 related both to specific diagnoses and conditions.

21           We certainly support the idea that the staff  
22 report includes about additional research and piloting of

1 the assessment and evaluation systems and we would encourage  
2 you to consider APTA and the other professional associations  
3 as resources in that effort, a lot of expertise among our  
4 members who might be able to inform and assist in your  
5 activities.

6           So I thank the Commission once again for looking  
7 into this area.

8           MR. HACKBARTH: Okay, we are adjourned.

9           [Whereupon, at 11:02 a.m., the meeting was  
10 adjourned.]

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