MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
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Washington, D.C.

Thursday, October 6, 2005
11:23 a.m.

COMMISSIONERS PRESENT:

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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.

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

2 MR. HACKBARTH: Good morning everybody.

3 I apologize for the late start, so we will get

4 right to the business at hand.

5 Our first discussion today is on the context

6 chapter. Rachel, whenever you're ready.

7 DR. SCHMIDT: Good morning. My job over the next

8 few minutes is to try to put the topics that you make

9 recommendations on in their broader economic and policy

10 context.

11 I'm sure you know that Medicare is right at the

12 verge of some very big changes. For example, Part D is

13 about to begin on January 1st. You know that the baby

14 boomers are about to begin to retire. and that's going to

15 increase the ranks of Medicare beneficiaries pretty

16 significantly. And both of those are going to put a lot of

17 upward pressure on the spending of Medicare at a time we're

18 already experiencing pretty big increases in program

19 spending.

20 I'm sure you also know that the Medicare

21 Modernization Act put in place a warning system with regard

22 to the financing of the program that could kick in in as few

1 as a couple of years from now. That could prompt
2 policymakers to consider some rather big changes to the
3 program.
4 This presentation is aiming to help you, as a
5 commission, keep the long-term goals in mind as you make
6 recommendations and consider some of these policy changes
7 ahead.
8 Just to review those again, the long-term goals of
9 the program, are to ensure good access to appropriate high
10 quality care for beneficiaries without undue burden on
11 beneficiaries and taxpayers.
12 To do that let's take a look at this slide. This
13 summarizes a lot of what I hope you will take away from this
14 talk today.
15 As I mentioned, we're likely to see some big
16 changes to the program soon, and a lot of those changes are
17 going to be aimed at trying to improve the financial
18 sustainability of the program over time, even though this is
19 going to be occurring at the same time that there are
20 competing demands to expand Medicare's coverage and to
21 increase payment rates, those sorts of things.
22 The Commission has tended to focus on this first

1 sub-bullet. These are categories of policy options in these
2 four sub-bullets. We've tended to focus on trying to
3 improve efficiency without lowering access or quality and,
4 in fact, trying to improve quality.
5 These are, in essence, the most desirable set of
6 changes. You can understand why. We'd like to provide
7 better incentives through our payment systems in order to
8 get more bang for the buck out of spending Medicare's
9 resources.
10 The other approaches, as you can see, limiting
11 benefits, constraining payments, increasing financing, are
12 all very painful. For example, imagine raising the share
13 that beneficiaries pay in premiums in the near term,
14 especially right now when beneficiaries are about to
15 experience their third year in a row of double digit
16 increases in the Part B premium. So as you can see, that's
17 just one example. All of these are painful options.
18 The effectiveness, however, of the more desirable
19 approach is less certain than the more painful approaches.
20 And so for that reason -- well, we're probably going to need
21 some of each of these approaches. For that reason, we'd
22 like to try our hand at trying to improve efficiency first.

1 And if we're successful at that, we might need fewer of the
2 more painful options.
3 As we try to make better use of Medicare's
4 resources, it's important to keep in mind that the Medicare
5 program is just part of a broader system with lots of
6 providers and lots of payers. The ability of the program to
7 carry out effective changes is likely to vary across
8 different sectors and depend on factors that are shown in
9 the sub-bullets on the next part of the slide.
10 For example, if Medicare was a small payer for
11 certain services and tried to clamp down on provider
12 payments, that may not work so well. In fact, it could
13 backfire and beneficiaries might have access problems.
14 Medicare might be able to initiate change in some
15 sectors where it has greater market power or where other
16 payers are looking to it to lead or coordinate change. But
17 the point is here that I think it's probably important for
18 the Commission to be strategic in picking areas for change
19 where success is more likely and perhaps provide some
20 guidance to policymakers along those lines.
21 Let's spend a moment reviewing the long-term
22 financing situation. This chart reminds us of the details

1 about that. Just to remind you, you've seen this chart
2 before but the overall height of those layers reflects the
3 combined spending on all parts of the Medicare program, A,
4 B, C, D and the protections over time of how much that could
5 cost. These are based on OACT protections.
6 The sources of financing are shown by the layers
7 themselves. My comments are focusing primarily on the green
8 and red portions, but that's not to dismiss, for example,
9 the pink area, beneficiary premiums, which you can also see
10 is growing fairly rapidly over time. And that's something
11 to be mindful of.
12 The vertical bar shows where we are today in time.
13 Just to walk you through it, you can see that the yellow
14 portion or payroll taxes make up most of Medicare's
15 financing at the moment, along with beneficiary premiums,
16 the pink area, and the green area which is general revenues.
17 To remind you, general revenues refer to overall
18 federal taxes that just are not dedicated to any particular
19 use. So those are the revenues that are used for all sorts
20 of public spending unlike, for example, payroll taxes that
21 are dedicated to Part A.
22 Notice how the green area bumps up after Part D

1 starts in 2006. That's because Part D is financed in a very
2 similar manner to Part B, about 25 percent of the program
3 spending is through beneficiary premiums and the rest
4 through general revenues.
5 The MMA has a warning system in place that kicks
6 in when projections show that the green area will make up 45
7 percent or more of total program outlays. Under the
8 Trustees' latest projections, that's due to happen around
9 the year 2012.
10 Under this warning system, the way it works is
11 based on future projections. So it could be the case that
12 the President and the Congress need to begin considering
13 broad changes to the Medicare program in as few as two years
14 from now. There's a lot of uncertainty there, of course,
15 but it could be that quick.
16 I think the MMA included this to trigger a debate
17 among policymakers on national priorities for this general
18 revenue spending. Do you want to continue to spend a larger
19 increasing share of this tax revenue on the Medicare program
20 versus other national priorities that may be of great value
21 to us as well?
22 The red area you can see shows you the Part A's

1 trust fund deficit over time. As you probably recall,
2 there's no authority to pay for Part A services once that
3 trust fund is depleted and that Trustees' latest projection
4 is that will happened in 2020.
5 So at risk on this slide we have the red area,
6 which is funding that we haven't yet identified to continue
7 the Part A program as it is today, and the green area where
8 Part B and Part D program spending is taking up an
9 increasing share of general revenues that otherwise might be
10 spent on other priorities.
11 As I mentioned before, it's also important to be
12 mindful of the pink area, beneficiary premiums, that are
13 also growing over time.
14 Let's take a look at how Medicare fits within the
15 broader U.S. health care system. In 2003 we spent $1.7
16 trillion out of an $11 trillion economy or about 15 percent
17 on health care. That's shown in the red line, again where
18 the vertical line is hitting.
19 The yellow line shows you that just under half,
20 about 46 percent of the $1.7 trillion was financed publicly
21 through big programs like Medicare and Medicaid, but also
22 other federal programs like VA and DOD and also state and

1 local health care spending. This publicly funded portion is
2 projected to reach about half in a decade or so, and that's
3 largely because of Part D.
4 The Medicare program is shown in the green line at
5 the bottom. It currently makes up 2.6 percent of GDP
6 growing to about 4 percent over the next decade.
7 I'd like to point out in particular the upward
8 trajectory of all these lines and that's simply telling us
9 that health care spending is growing faster than national
10 income for all payers. So what this is telling us is that
11 society has been choosing to spend more on health care over
12 time. This is been true for quite awhile and it's likely to
13 continue for a while.
14 On the one hand, this is a very good thing because
15 it's probably lengthened our lives and generally improved
16 the quality of our lives. But there's also substantial
17 literature out there saying that some of this spending is
18 inappropriate, wasteful and sometimes even harmful. So it's
19 important for us to try and use these resources as
20 efficiently and effectively as possible because otherwise it
21 might be spent on other priorities that are also very
22 important to us.

1 I mentioned that that the ability to make
2 effective changes to Medicare could be different across
3 sectors and that's what this chart is trying to get at it.
4 This is displaying data from the National Health
5 Expenditures. Down the left-hand side you can see various
6 sectors, health care sectors. But be a little bit careful
7 in interpreting these numbers because these sectors are
8 defined by where the service is provided. So for example,
9 for hospital care it's referring to inpatient, outpatient,
10 pharmacy, SNF, home health, all of those combined so long as
11 it's provided in a hospital setting.
12 These categories are also very broad aggregate
13 groupings that mask some important detail. For example,
14 Medicare may be by far the largest payer for end-stage renal
15 disease services and hospice care but that's not going to
16 show up in these aggregate categories. The same would be
17 true for certain specialties of physician.
18 Certain payers are listed across the top, as you
19 can see. And for Medicare you can see that Medicare pays
20 for about 30 percent of hospital care, 20 percent for
21 physician and clinical services and so on. The largest
22 market shares for Medicare are for hospital, freestanding

1 home health, and retail durable medical equipment. For
2 these categories it may be the case that Medicare will be
3 able to initiate broader change more successfully because it
4 has a relatively more influence. For other sectors, like
5 maybe physician clinical services, Medicare may need to work
6 more in concert with other payers in order to be effective.
7 Your mailing materials included a lot of data
8 comparing the U.S. health care system to member countries of
9 the Organization for Economic Cooperation and Development,
10 other industrialized countries. In presenting this analysis
11 we weren't arguing that any country's particular way of
12 doing things is better. It was more an attempt to
13 understand how we are different and help us think about
14 improving.
15 However, having said that, it's also important to
16 note that we spend much more in the United States than every
17 other country in the world. The data displayed here are for
18 2002, and you can see that the United States spends on
19 average about $5,300 per person. This is across all people
20 in the U.S., not Medicare beneficiaries, or about 15 percent
21 of our GDP.
22 The next closest country, I should mention, is

1 Switzerland which spends about $3600 per person.
2 Some people argue that these sorts of comparisons
3 aren't quite fair because they don't, for example, include
4 the value of waiting time that some patients may have in
5 countries that don't have as immediate access to visit
6 specialists or have certain procedures done. That's a fair
7 comment. Nevertheless, these data do raise the question of
8 whether or not we're getting the value that we expect from
9 the additional spending that we're making.
10 The main reasons that researchers cite for higher
11 U.S. spending are shown on this slide. The first refers to
12 the notion that as national income increases, so does health
13 care spending. However, in the case of the United States
14 national income alone does not explain the magnitude of our
15 spending, the fact that it is so much higher than other
16 countries. So for that, researchers tend to turn to a
17 closer look at the organizational structure of payers and
18 providers in the United States.
19 The one key difference about the United States is
20 that public financing is a smaller role and private
21 insurance and private payers a larger role. For example, in
22 the United States, public financing makes up about 46

1 percent of National Health Expenditures compared with a
2 median among OECD countries of about 75 percent.
3 Researchers have argued that because we have a
4 more fragmented financing system with lots more payers, that
5 gives providers greater market power. Other countries, I
6 should mention, also use a more regulatory approach than we
7 tend to in the U.S.
8 Again, the analysts who have looked at these data
9 contend that this leads to higher prices for similar sorts
10 of services. The particular example they tend to point to
11 is physician incomes in the United States where some data
12 something suggests that they are quite a bit higher than
13 those of other countries.
14 Another argument is that there's a greater
15 orientation in the United States toward specialized care.
16 I'll discuss this in a little more detail in just a minute,
17 but closely related to this is the adoption and diffusion of
18 new technologies. Many economists have argued that this
19 notion of new technologies is really the biggest long-term
20 driver of growth in health care spending.
21 Another reason cited for our higher spending is
22 our society's strong preference for broad access to

1 providers and to advanced technologies. The evidence for
2 this taste, if you will, there are a couple of things.
3 First is the managed care backlash. After the managed care
4 organizations tried to institute certain techniques such as
5 restrictive networks and broader use of gatekeepers, the
6 backlash after that experience in the 1990s is thought of as
7 evidence of this broad taste for access. And also, the fact
8 that so many Medicare beneficiaries remain in fee-for-
9 service program rather than Medicare advantage.
10 Another argument put forth is that because we have
11 a more complex system with more payers that translates into
12 greater administrative complexity and higher administrative
13 costs. But I don't think that there's a real consensus in
14 the literature out there yet on what the exact magnitude of
15 these costs are. There are some very high estimates and
16 other people have taken issue with the methodologies.
17 Nevertheless this is a concern.
18 To go back to the point briefly about our
19 orientation toward specialized care, this chart is showing
20 you an example of some of the evidence that's cited in
21 literature. What I'm showing you here is the numbers of
22 inpatient procedures per 100,000 population for some

1 selected procedures. You can see that the left-hand bars in
2 red are data for the United States. The yellow bars next to
3 it are the median of OECD countries. And then I've shown
4 three other countries just for example, Canada, Germany, the
5 United Kingdom.
6 There are a number of caveats one should always
7 use, particularly doing cross-national comparisons. Data
8 are usually collected for different purposes in different
9 countries so it's hard to be assured that they're completely
10 comparable. Nevertheless, the OECD has given a stab and
11 these are data that they prepared.
12 The rates shown here are not adjusted for
13 countries' differences in demographic makeup or health
14 status so that's a clear caveat.
15 There may be issues related to border crossing in
16 these data. For example, Canadians coming to the United
17 States for certain high-tech procedures would show up in the
18 U.S. statistics and not necessarily those in Canada.
19 Again, these are for inpatient procedures and it
20 may be the case that some countries like the U.S. perform a
21 greater share of certain types of procedures in an
22 outpatient setting.

1 I should also point out, in particular for hip and
2 knee replacement data, it's not that Germany's values are
3 zero, they're simply missing on this chart. So again, the
4 U.S. values are on the left-hand side. As you can see, for
5 all of the procedures I'm showing, with the exception of hip
6 replacement, U.S. rates are higher than those for the OECD
7 median.
8 It's not always true that they are the highest.
9 You can see the example of Germany with cardiac caths,
10 however they're higher than the median of other
11 industrialized countries.
12 So to summarize, we talked about how the
13 combination of upward pressure on spending plus the MMA's
14 warning system could lead policymakers to consider some
15 fairly substantial changes to the Medicare program very
16 soon. The effectiveness of these changes could vary across
17 sectors, depending on things like the prevailing way of
18 doing business in the U.S. health care system, the degree to
19 which Medicare has market power or clout, and Medicare's
20 ability to coordinate with other payers.
21 We took a look at some cross-national data to see
22 how the U.S. system compares and we saw that there's much

1 higher spending in the United States per person.
2 Researchers tend to attribute that to a more fragmented
3 system of financing, a larger number of payers and a larger
4 role of private versus public financing. This has led some
5 analysts to believe that the supply side has greater market
6 power in the United States and providers are able to charge
7 higher prices for similar services.
8 Also, it appears that the United States' greater
9 orientation towards specialized care, and this is related to
10 the rate at which providers adopt and expand the use of new
11 technologies.
12 These factors work hand in glove with what appears
13 to be strong social preference in the U.S. for broad access
14 to providers and to advanced technologies.
15 As a next step, we hope to begin to look at where
16 Medicare might be most fruitful at taking a leadership role
17 for change versus other policy areas where broader change in
18 the U.S. health care system needs to occur.
19 At this point I'm happy to take your questions and
20 I particularly look forward to your input on next steps.
21 MS. BURKE: Rachel, a terrific job of sort of
22 laying all of this out. These are really just in the nature

1 of some suggestions in terms of how we might present this
2 information going forward in terms of materials we
3 distribute. And also just a couple of clarifying questions.
4 First of all, I had mentioned to Rachel earlier, I
5 suggested that on page 4, as she talks about and as we talk
6 about and describe sort of the distribution of Medicare
7 challenges and issues, that we particularly note the share
8 in the premium structure which isn't included. We talk
9 about FICA tax but we don't talk about the premium
10 structure. I suggested she add that.
11 On the charts that you laid out, let me ask just a
12 couple of questions. One on the fourth chart, where we talk
13 about public financing, remind me whether or not all public
14 spending includes tax expenditures?
15 DR. SCHMIDT: No, it does not.
16 MS. BURKE: Query whether or not that ought to be
17 identified. There is a huge amount of money that is in
18 essentially revenues foregone as a result of the way we've
19 structured the tax code. So I think it is, in fact, an
20 explicit expenditure on health care that ought to be
21 identified, or at least we ought to talk about it. There's
22 a clear preference that we've established through the code.

1 MR. MULLER: [Inaudible.]
2 MS. BURKE: Well sure, it's revenue foregone.
3 It's a tax expenditure policy in terms of the way we treat
4 health benefits.
5 DR. SCHMIDT: I don't know that we would ever be
6 able to get it data on a time series, but I can --
7 DR. REISCHAUER: [off microphone] Resources that
8 we have devoted to health.
9 MS. BURKE: No, but it is revenue foregone, in a
10 sense.
11 DR. REISCHAUER: [off microphone] Yeah, but I
12 mean so is the personal exemption but you don't say we're
13 spending umpteen billion on children because we have a
14 personal exemption for children.
15 MS. BURKE: But in fact, Bob, when we look at -- I
16 mean, one of the great issues over the years in the Finance
17 Committee was, in fact --
18 DR. REISCHAUER: [off microphone] You don't have
19 to argue with me about its importance and all of that, but
20 it's in a different food group.
21 MS. BURKE: Well, then maybe we describe the food
22 group differently. But I think as a statement of

1 essentially how much we have committed in one way or
2 another, I think that that issue, which is the tax
3 expenditure and tax policy, is something that we ought to
4 capture in some fashion.
5 DR. REISCHAUER: [off microphone] One place to
6 put it is in why did you spend so much? And the answer is
7 it's tax-free.
8 MS. BURKE: It's subsidized; right.
9 MR. SMITH: [off microphone] But it shows up on
10 this chart as all private.
11 MS. BURKE: No, it doesn't.
12 MR. SMITH: [off microphone] It doesn't add to
13 the level. It changes the distribution of where it comes
14 from, depending on how you think about what would happen in
15 private spending.
16 MS. BURKE: Right, but it is a policy issue. It's
17 an affirmative action that we've taken in terms of
18 encouraging certain kinds of behavior. So Bob is exactly
19 right. It's a different food group, and perhaps we have
20 another food group distribution or discussion.
21 On chart five, as we think about how we partner
22 and how we influence behaviors, I think it would be a

1 mistake not to separate out the generic all public programs
2 -- Medicaid. I think there is a unique aspect to Medicaid
3 and the potential for Medicare and Medicaid. I think we
4 ought to have essentially -- and particularly in terms of
5 the distribution among certain kinds of services.
6 The disproportionate piece of the nursing home
7 benefit, for example, that falls within Medicaid as compared
8 to care. I think we might benefit from separating those out
9 separately from all public programs because it is sort of a
10 unique relationship and I think we ought to understand how
11 it differs in terms of its purchasing power and how we might
12 partner there.
13 And then finally, on chart number seven, I think
14 one of the other questions that would naturally occur is the
15 order of magnitude issue. Because there really are
16 differences in terms of their perception of which of these
17 might contribute more. We may or may not know that but
18 there may be some value in understanding, in terms of
19 influence, which of least do we believe to be the greater
20 influence. And we may or may not be able to note that but
21 it might be helpful to understand that.
22 The administrative cost is always highlighted as

1 particularly unique to the American system, particularly as
2 you compare it to the OECD and others. But again, if we
3 have any sense or any ability to sort of know which of these
4 seems to be a greater contributor without absolute
5 specificity of 15 percent or 10 percent, that might be
6 helpful, as well, in understanding.
7 DR. NELSON: Rachel do you have that information
8 about the impact of direct-to-consumer advertising,
9 particularly whether other industrialized countries do
10 direct-to-consumer marketing for things like virtual
11 physical exams? Something other than pharmaceuticals, which
12 is obvious. But what about imaging procedures, hips, some
13 of the big examples that we hear marketing a lot around.
14 And I always wonder how much it drives consumption.
15 DR. SCHMIDT: I don't have great information on
16 the extent to which other countries use DTC, but I do know
17 from reading some of the literature put out by OECD that
18 other countries have a much more regulatory approach when it
19 comes to new technologies. So I suspect that there is
20 considerably less of it. For example, some countries have
21 specific facility constraints or something similar to a
22 certificate of need sort of approach before a hospital say

1 can incorporate a new sort of suite.

2 In keeping with that, I would suspect that it's
3 far less used.

4 DR. MILSTEIN: This is referable to chart three.

5 One thing that would be very helpful to me and
6 perhaps some of the other commissioners would be to have a
7 sense as to if our goal was to, for example, stabilize
8 Medicare spending as a percentage of GDP or any other goal
9 we wanted to set, it would be helpful for me to understand
10 what that implies in terms of annual efficiency gain we
11 would then need to expect of our health industry, serving
12 Medicare beneficiaries.

13 In other words, if every year the American health
14 industry gained two or three points in the efficiency with
15 which it generated health, would that flatten the line? Is
16 it four points? What's our mark around which we can then go
17 back and examine the prior slide in terms of efficiency as a
18 solution? And then we can ask broad questions like in a
19 consumer facing industry, we're not manufacturing widgets
20 here, we're taking care of people, are there any precedents
21 in any other consumer facing industries for achieving that
22 annual degree of efficiency gain?

1 My question really, to refocus this, is if we
2 don't know it, it would be helpful maybe at some future
3 session to get some feedback on what percentage point annual
4 gain in efficiency would flatten this curve.
5 DR. SCHMIDT: Maybe I can tell you one thing that
6 put a little perspective on this, and this is based on the
7 Trustees' intermediate set of assumptions, which is one
8 percentage point above real GDP growth. The long-term
9 historical average growth in health care spending is about
10 2.5 percentage points above.
11 DR. MILSTEIN: Thank you. That becomes our mark.
12 If we, through policy or any other changes, could induce a
13 2.5 percent annual efficiency capture by America's health
14 industry that's not currently happening, above and beyond
15 what's currently happening, that's an order of magnitude
16 notion as to how much -- of the gain we would have to induce
17 in order to solve this problem by, as you described it, the
18 most desirable of the four alternatives.
19 MR. MULLER: Rachel, as I said before a superb
20 chapter.
21 One of the things you really brought out very well
22 in the text that we received is how these spending forces

1 are very much driven by value choices. I'd like to
2 highlight that, and whether it's the administrative costs
3 being a function of the multiple ways in which we finance
4 the system, the lack of global budgeting in any kind of way,
5 the less reliance on the public sector than the private
6 sector, the concern for choice versus equity in terms of
7 beneficiary access to services, the belief in technology,
8 and the fact that we have much more -- and I think these
9 value choices are very positive part of what we have inside
10 the system.
11 But it's so important as we look at those kind of
12 curves there, to say unless one is willing to take on those
13 value choices in some kind of political process, this curve
14 is not going away. I think Arnie and others can speak about
15 what does it take to get the 4 percent savings, but those
16 are not going to be done by technical means until there's a
17 broader debate about the policy choices we're willing to
18 make.
19 In the session we had earlier, were there was
20 concern about whether we should have any kind of
21 effectiveness measures inside the program, but it limits
22 beneficiary choice too much, is an indication that they

1 value choices are so interlaced into the design of this
2 program as well as the whole health care system.
3 So I think we need to, while we're basically a
4 payment commission, these curves are very much a result of
5 the values that are built into our system, values people
6 very deeply and therefore ones they're not going to shed
7 that easily.
8 MR. HACKBARTH: I agree with that completely,
9 Ralph. The values embodied right at the beginning of the
10 Medicare Act are patient choice and clinician autonomy and
11 they trump everything else. And pretty consistently over
12 the decades, when push comes to shove, that's what prevails.
13 I agree with your premise that if we really want to change
14 those lines there have to be other values included in what
15 we want.
16 Let me use that as the springboard to ask a more
17 narrow question. What people want is a function, in part,
18 of how much they have to pay for it. It's commonplace to
19 say, as you say, that Americans value choice and no waiting
20 times and the latest technology. But one of the issues in
21 the system is that often the choices are structured so that
22 somebody else is paying the bill. If it's free, sure I want

1 more choice and I want more technology and I want zero
2 waiting times.
3 I wonder whether we can get a little bit of a
4 handle, a more discriminating handle, on what it is that
5 Americans want. For example, can we look at time series
6 data about the choices people make on health insurance? Now
7 as employers are increasing the share borne by employees,
8 what's happening to the take-up rate? Are the American
9 people starting to say I'm not willing to pay for this, I
10 don't value it that much? I don't know what sort of
11 evidence we might start to marshal there.
12 DR. REISCHAUER: [off microphone] The healthy
13 ones are.
14 MR. HACKBARTH: I think that that's a topic that
15 might be usefully addressed in this chapter, not in an
16 exhaustive way. But if we can bring some of that evidence
17 into it, I think that would be good.
18 DR. MILLER: Just on that point. I remember, I
19 think when we were CBO, there was some literature we were
20 looking at at responses to changes in premiums and how
21 people were making choices. I don't know if any of that
22 actually might also bear on this question.

1 DR. SCHMIDT: You mean some of the older
2 literature on price sensitivity and that sort of thing?
3 There is some academic literature out there trying to look
4 at elasticity of demand for health insurance based on sorts
5 of premiums out there. There RAND health insurance
6 experience is, of course, considered the gold standard for
7 that. That's pretty dated at this point and it wasn't
8 really applicable to the Medicare population. But we can
9 take a look at some of the other literature out there and
10 see if there's anything that gets at your question.
11 DR. MILLER: I thought there was something that
12 was done in California were recently, within the last few
13 years.
14 DR. SCHMIDT: Tom Muller's piece maybe?
15 DR. MILLER: That's more the piece I'm thinking
16 of.
17 DR. CROSSON: Thank you, Rachel. I enjoyed the
18 paper, too. I also enjoy anything like this that seems to
19 be able to help me understand what is sometimes inherently
20 not understandable.
21 I had one thought, and you bring up the issue of
22 technology, new technology as a cost driver. And also the

1 issue of the market power of providers.

2 It struck me, as I was reading it a little bit,

3 that in fact the interface or the interaction between those

4 two things, the growth of expensive technology and the

5 impact that that has had through various payment systems

6 both on the physician side, for example, and on the hospital

7 side, is a significant piece of this. We've talked about a

8 number of aspects of this over the last year here at the

9 Commission, the rise of the specialty hospital industry, for

10 example. Issues at the last meeting around the impact of

11 physician payment changes over time on the changes that are

12 taking place in the profession and who chooses to go into

13 what specialty and the like.

14 I just wondered whether you might cogitate a

15 little bit on the interaction among elements, particularly

16 those two elements. Because it has seemed to me over time

17 that we have these two unique or somewhat unique

18 characteristics in the United States. But actually the

19 interaction of them and the interaction over time may, in

20 fact, be the single most unique issue that we have in the

21 country.

22 Second was a more narrow issue and it relates to

1 just one statement on page 19 at the top of the page there.
2 It talks about the overwhelming number of beneficiaries who
3 remain enrolled in traditional Medicare rather than in
4 Medicare Advantage plans are another piece of evidence of
5 our collective taste for broad choice.
6 I guess I have two thoughts about that. I think
7 the fact that Medicare fee-for-service, rather than Medicare
8 Advantage, is the dominant system or choice at the moment is
9 complex and it raised a lot of historical factors and issues
10 of availability, issues relating to the industry itself and
11 other things. I probably think that it's more complex than
12 that says.
13 Secondly, and perhaps even narrower still, the
14 issue of broad choice. I'm actually not sure it's broad
15 choice as much as narrow choice. Obviously, because of our
16 organization and the way we have structured ourselves, we
17 think a lot about the choice issue. It often comes down,
18 when people choose an organization other than ours, it's not
19 an issue of broad choice because in many parts of our
20 program we have thousands of physicians in our medical
21 groups, as much as narrow choice. And that is, gee, I
22 really like your organization except I have this one

1 wonderful dermatologist that I'd like to stay with.

2 So just the issue of broad choice as opposed to

3 selectivity or some other term, I think is more accurate.

4 Thanks.

5 MR. DURENBERGER: [off microphone] I have a lot I

6 would like to say but I would also like to say it and put it

7 in writing and follow up if you don't mind, rather than take

8 a lot of time.

9 MR. HACKBARTH: Absolutely.

10 MR. SMITH: Jay and Ralph said most of what I

11 wanted to say. So Rachel, let me only say, I also learned a

12 lot from this. I appreciated it. Great work.

13 But the points have been made.

14 MS. HANSEN: Again, I thank you for that. Two

15 points here.

16 One is the whole issue of the fact that we do

17 spend more, do we have a sense of comparative across the

18 countries for our people's well-being relative to these

19 chronic diseases and so forth, any different or better off

20 because we spend money more? That's one thing.

21 And then the other one on the administrative

22 costs, I guess it would be a more go forward aspect of

1 whether or not what's going to be the additive factor of the
2 electronic medical records and the technology that we're
3 going to build in.
4 And one subtext on this is the value choices that
5 we have, which include a free-market society as we have, is
6 that direct-to-consumer aspect and whether or not that would
7 be built in. Because one of the things we start to see now,
8 in terms of future use, and maybe a little more cutback in
9 the pharmaceuticals on the DTC, but there's more in other
10 devices that we now see on the DTC level.
11 MS. MILGATE: To start with your first points on
12 health outcomes and overall health status, that's often a
13 key criticism, that we spend much more money in the United
14 States and yet don't have better health outcomes.
15 I'm particularly familiar with a study the OECD
16 has done on heart disease and looks at the fact that it
17 appears we have quite a bit more spending, quite a few
18 larger number of procedures done in the United States
19 relative our population. And even when they tried to look
20 at differences in health risk, underlying health risk of the
21 population, this was true.
22 That's a common complaint that we are not

1 necessarily spending it because of the health status of our
2 population or getting better outcomes for the money.
3 On the issue of IT, there are some studies that
4 have come out fairly recently arguing that it will lower
5 administrative costs. Far be it from me to say that those
6 are definitive. I think that there is so much uncertainty
7 out there it would be hard to place a number on exactly how
8 much that could lower the magnitude of our administrative
9 expenses, especially when there's no consensus on what it is
10 now to begin with. But that's certainly something that I
11 can add to the discussion.
12 And on the DTC, I'm not sure, was there a question
13 there exactly?
14 MS. HANSEN: I think it was in the things that
15 shape our extra spending, and one of them was the fact that
16 we do have a free-market aspect. As you pointed out, some
17 of the other countries deal with access to this differently
18 by stronger regulations, whereas ours is really a free-
19 market kind of approach to the consumer. And just that that
20 also seems like that would be a factor for our country.
21 DR. SCHMIDT: That's certainly true, and I can
22 certainly add that to the discussion.

1 DR. KANE: Thanks. I appreciated your work and
2 enjoyed reading it. And I guess I came away with the same
3 basic conclusion that Ralph did, which is that these aren't
4 technical so much as they are value and political value
5 issues. And wondered what tools do we have really to
6 influence those values.
7 I guess what came to mind was that we should do a
8 movie with Jack Nicholson in it, of course, talking about
9 what health care will be like in the year 2020 if we
10 continue on with the set of values that we have today. It's
11 not clear to me, but there is a need to have people
12 understand these trade-offs and appreciative them better
13 than I think we've had today. Perhaps we should collude
14 with Hollywood and make a strong message.
15 A couple of details. On page five, I'm
16 uncomfortable leaving Medicare's relative market power as 2
17 percent of retail drug. I think obviously we've changed
18 that with the Part D to be begin with. But we've also given
19 up and fragmented enormous purchasing power by the virtue of
20 the way we've chosen to implement Part D. And I think that
21 should not be left out of the discussion of what some of the
22 options might be in the future for improving market power.

1 I know it's highly political, as everything else
2 is, but really fragmenting our Medicare purchasing power
3 into 6,000 Part D plans just doesn't do much for the
4 potential power Medicare could have in that marketplace.
5 DR. SCHMIDT: I was just going to say that that 2
6 percent was based on data obviously before Part D --
7 DR. KANE: Obviously before Part D.
8 DR. SCHMIDT: Our projections and those from OACT
9 are that Medicare would be paying for, I think it it's on
10 the order of 28 percent of retail drug spending.
11 MR. HACKBARTH: Although, to follow Nancy's point,
12 I assume the hospital figure does not include the amount
13 that Jay's organization spends on hospital care for Medicare
14 enrollees. That's not Medicare spending. That's Kaiser
15 Permanente. That's private spending.
16 So in this case, although Medicare beneficiaries
17 will have access to drugs through a Medicare sponsored
18 program, it will still, in this sort of accounting, be
19 private spending, wouldn't it because they're private plans?
20 DR. KANE: I think it is.
21 DR. SCHMIDT: I'm trying to recall exactly how
22 OACT does it in the National Health Expenditures. They do

1 have a protection of 28 percent retail drug spending, so I
2 think it's going to be reflecting their payments to Part D
3 plans.
4 MR. HACKBARTH: So that Medicare share of the
5 premium would --
6 DR. SCHMIDT: Exactly.
7 MR. HACKBARTH: Although if you're looking at it
8 for evidence of leverage over providers...
9 DR. SCHMIDT: You need to be mindful of how the
10 plan works.
11 MR. HACKBARTH: It's really the private plans that
12 are doing the negotiating, and not the government, even
13 though the government is financing 28 percent of it.
14 DR. SCHMIDT: Exactly.
15 DR. KANE: That's my point, that we have market
16 power we're giving up. And perhaps that should be
17 highlighted as one of the topics.
18 I guess the only other thing I wanted to mention
19 is on your inpatient procedure. In the cases I've done on
20 international procedure rates, we do much more outpatient.
21 It could have changed in the last five years but the U.S. is
22 far more outpatient procedure oriented than any of the OECD

1 countries. And so this is all the more powerful.

2 And perhaps we should try to put it something

3 about the proportion of our procedures that are done

4 outpatient compared to these other places, because our

5 inpatient rates are high and we do far more on the

6 outpatient side. So I think that maybe -- I can help you

7 try to find something there, if you can't find it yourself.

8 DR. REISCHAUER: Just to comment on Nancy's

9 comment. She was very careful and she used that in the MMA

10 we gave up potential market power. There's not a huge

11 history of the federal government or CMS ruthlessly

12 unleashing market forces on the provider community. So I

13 would bet with the fragmented folks on that.

14 We can have a debate about this.

15 A couple of presentational things. On the second

16 chart, I would certainly explain what tax on benefits means.

17 I mean, it's Social Security benefits, which is what we're

18 talking about here, and probably a lot of people didn't

19 realize that.

20 But also, I wonder why we exclude the interest

21 income from the trust fund? I know CMS and the

22 Administration would like to do that. But imagine a world

1 in which we had had perfect foresight and built up a $3
2 trillion trust fund balance at this point purposefully
3 because of the aging population and all of that, and we're
4 running it down on the interest income and the other. Would
5 that be an HI deficit? I don't think it would be.
6 Now, if you include interest income, and I can see
7 why you can leave out drawing down the balance of the trust
8 fund, it's going to change that line infinitesimally. So
9 people aren't going to see it. But I think we're making a
10 political statement actually, when we exclude the interest
11 income.
12 On the fourth table, you might point out why these
13 things don't add to 100, all of them. And there is
14 charitable contributions from reserves, et cetera, et
15 cetera, which accounts for some of this. And then the next
16 chart, which is the diagram, I'm not sure why I should be
17 interested in this chart to tell you the truth. Because
18 what I expected to see, based on the description in the
19 text, was per capital GDP related to per capita health care
20 spending because the United States is way over there, in
21 part because it's richer than Mexico, and in part because a
22 lot of other things are going on. And the percent of GDP

1 devoted isn't really telling us anything. I think it's
2 confounding the story, confusing us, as opposed to what the
3 text says.
4 MS. SCHMIDT: That's data that's readily
5 available. I'll be happy to change it.
6 MR. DURENBERGER: I looked at the context chapter
7 the way I would have when I was in the Senate, because
8 mainly I'm the messagee that a lot of this is supposed to
9 get to. And I also look at it in the context of the people
10 who should have the most influence on people like me. And
11 right now, the growing influence is with employers and other
12 third-party payers.
13 The way in which they would look at the Medicare
14 program if they knew the facts is they would distinguish it
15 by its inefficiencies. I'm just picking a word, I don't
16 know whether it's exactly appropriate. And they would look
17 at not just Medicare but they would look at payment programs
18 generally as being inefficient.
19 The best line you have in here is on page seven
20 where you talk about the research on why geographic
21 variation suggests we do not use our resources very
22 efficiently. Many of our systems financing mechanisms

1 contribute to the problem of wasteful spending, et cetera.

2 That sets the context for me. It says the whole

3 system will be known by its inefficiency. The practice is

4 very inefficient and you got lots of stuff in here on

5 inefficiency of the practice, some of which is our fault,

6 some of which is doctors and hospitals and things like that.

7 And then the policy is inefficient because the

8 policies that we use, whether they're public and even some

9 private, foster the inefficiencies in the system.

10 So if you're speaking to a business person in

11 America who's living on TPS and Lean something and six Sigma

12 and all the rest of that sort of thing, bleeding the costs

13 out of the system, while over here the competitive advantage

14 is being driven both by inefficient policies and the

15 inefficient practices that flow from that. That, if you can

16 get it all on one page.

17 It's sort of like you start with on 2007 we're

18 going to start spending money we don't have or that we don't

19 have authorized. That's the big signal. Then the second

20 one is the inefficiency message. And then the third one is

21 everything else you have in there which is really, I agree

22 with everybody, that the way in which these various drivers

1 in the system are laid out are really important.

2 Last observation, I'm not sure -- and one of the

3 charts I'd love to see is beneficiary cost sharing if we

4 have the data, show how the beneficiaries are going to be

5 paying for a lot of this in future years.

6 But the other side of this is I'm not sure of the

7 value of the OECD comparisons. You have a lot of it in

8 here. We've seen it a lot of it in the past. I don't know a

9 lot of pols up there that relate to it. I mean, they may

10 read it. when Uwe Reinhardt makes a speech they will laugh

11 at it, you know ha, ha, ha, why do we spend so much money.

12 But the reality is, I don't think it means a lot

13 to the individual member of Congress or the Senate.

14 So I'm not saying it's wrong to do it. I think

15 it's just fine. But I wouldn't put quite as much emphasis

16 on it.

17 And I would conclude on purchasing power that it

18 isn't the numbers, 2 percent, 60 percent, 50 percent because

19 the marginal dollar is the one that always makes the

20 difference in any kind of a system. And because this

21 marginal dollar is controlled by one place, it's a single-

22 payer system, it's a stronger marginal dollar unless we give

1 it away, as you just said. It's a stronger marginal dollar
2 then John Bertko's marginal dollar or Jack Rowe's marginal
3 dollar or my little company's marginal dollar. Do you
4 follow me?
5 You can probably say that better than I can,
6 drawing on research and analysis. But I think the power of
7 the marginal dollar, particularly when it comes from a --
8 now that's going to get diluted by politics, obviously,
9 because we also as a single-payer, our weakness is we don't
10 make good decisions because of politics.
11 But I do think that the argument for the marginal
12 dollar rather than 50 percent or better is important.
13 But again, thank you for taking this project on
14 because I think it's a critical part on which you put
15 everything else we do in context.
16 DR. REISCHAUER: Let me just make a comment on
17 Dave's suggestion that we play down the OECD data in large
18 measure because nobody up on Capitol Hill ever paid any
19 attention to it. I think that was really true but I would
20 expect that that's going to change very much because it used
21 to be that we'd look at the stuff and we'd say ha, ha, but
22 they wait years to get their hip replaced and their

1 satisfaction level is below zero and all of this.
2 But Commonwealth and other people have been
3 collecting some data quite recently and that data seems to
4 show that on a number of qualitative and satisfaction
5 measures, in fact, we look pretty second rate. That a
6 number of Western European countries are quite superior to
7 us.
8 So I think people are going to say well, maybe we
9 shouldn't be laughing as much.
10 MS. BURKE: Can I just add one qualifier to that?
11 I don't disagree with either of you.
12 DR. REISCHAUER: [off microphone] Even though we
13 disagree with each other.
14 MS. BURKE: Both of you are correct. But I think
15 there's sort of a middle ground, which is fundamentally, at
16 least my experience, as ancient as it is, is that
17 notwithstanding the fact that the data now and in fact
18 increasingly suggest that we are not as -- we don't have
19 bragging rights as we should. They fundamentally still, I
20 think, don't want to look to some other country for
21 direction on what to do.
22 So I think dialing down a little bit about the

1 comparative information, I think it is important. I do
2 think, in fact, increasingly we are appearing to be very
3 much second rate in the number of cases.
4 But in fact, that's been true for a long time. In
5 mortality rates and infant -- I mean, there are a whole
6 variety of indicators that we've not been so hot about for
7 some period of time.
8 But fundamentally, particularly in the House
9 historically but I think in both the House and Senate, they
10 don't want to look to our European colleagues for how best
11 to do these kinds of things. So I think perhaps just a
12 little dialing down might be helpful.
13 DR. NELSON: It may provoke them to asking some
14 questions that they should be asking.
15 MS. BURKE: Maybe.
16 DR. KANE: Is there any data that shows how our
17 health care costs affect our relative industrial
18 competitiveness on a global environment? Because that would
19 be the way to tie this to interest that maybe Congress would
20 be more --
21 DR. REISCHAUER: [off microphone] Don't start a
22 fight between the economists and everybody else on this one.

1 DR. KANE: There's got to be -- even people who do
2 global manufacturing must have some data.
3 MR. HACKBARTH: I think what Bob is alluding to is
4 that business people often make that argument. Economists
5 will say well, the incidence of this really falls on the
6 employee in the form of lower wages. It's not borne by the
7 employer. And so it doesn't therefore affect global
8 competitiveness. I think that's a years-long debate.
9 Thank you. Good job, Rachel, as always.
10 We will have a brief public comment period before
11 lunch.
12 Seeing none, we will go to lunch and we will
13 reconvene at 1:15.
14 [Whereupon, at 12:18 p.m., the meeting was
15 recessed, to reconvene at 1:15 p.m. this same day.]
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1 AFTERNOON SESSION [1:21 p.m.]
2 MR. HACKBARTH: First up this afternoon is quality
3 differences in the Medicare Advantage plans. Niall.
4 MR. BRENNAN: Thanks, Glenn.
5 I'm going to talk to you about quality variation
6 in Medicare Advantage plans today. Obviously, this is an
7 issue that you all are familiar with.
8 In recent years the Commission is made
9 recommendations on pay for performance in both the Medicare
10 Advantage and the fee-for-service programs. As part of our
11 ongoing work in the area we convened an expert panel a month
12 ago and they talked to you all on P4P in the private sector.
13 The results of our analysis today, I think, are
14 quite interesting and highlight the need for P4P program in
15 MA and the feasibility of using HEDIS data for
16 differentiating among MA plans. Plan composite scores range
17 from a low of 1.2 to a high of 9.8 on the 10 .scale that we
18 utilized.
19 We used HEDIS data for our analysis. HEDIS is the
20 Health Plan Employer Data and Information Set. It's a set
21 of standardized performance measures and is quite widely
22 used and accepted, particularly in the private sector. It

1 helps both purchasers and patients compare plans in terms of
2 quality.
3 For the purposes of this analysis, we excluded any
4 PPO or private fee-for-service plans because they are not
5 required to report on all HEDIS measures. And so their
6 scores would be significantly lower than other plans.
7 I have a table at the bottom of the slide that
8 just outlines to you the measures that we're looking at.
9 The one note I'd like to make is that some of the measures
10 such as diabetes care is actually an amalgamation of six
11 different diabetes measures from the HEDIS survey, whereas
12 breast cancer screening is just a single measure on its own.
13 I'd like to spend just a little bit of time on
14 this slide because it's the scoring method that we used to
15 assign these composite scores to plans. What we did was we
16 took the HEDIS data and we created composite scores using a
17 method which is based on the NCQA accreditation standards.
18 What we did for each measure was we calculated percentile
19 thresholds and then scored each MA plan first based on their
20 performance relative to the performance of other plans in
21 that measure.
22 So if you scored above the 90th percentile on a

1 given measure, let's say breast cancer screening, you'd
2 receive a point for that measure. If you scored between the
3 75th and 90th percentiles, you'd receive 0.88 point.
4 Between the 50th and 75th percentiles, you'd received 0.68
5 point and so on and so forth.
6 The maximum score is 10 points. If you remember
7 from the previous slide, we only had nine measures. The
8 extra point is because NCQA assigns a double weight to the
9 diabetes care measures because it considers them to be
10 particularly important.
11 One other note on the scoring methodology, plans
12 can have either NAs or NRs on any measure. An NA occurs
13 when a plan does not have sufficient sample size in their
14 beneficiary population to generate a meaningful score on
15 that measure. Part of the methodology is that plans can
16 have up to four NAs without affecting their overall score.
17 So if you had a plan that had a perfect score,
18 let's say a plan scored above the 90th percentile on all
19 nine measures, it would receive a composite score of 10
20 points. If you had another plan that scored above the 90th
21 percentile on six measures and had NAs on another three
22 measures, that plan would also receive a perfect score of 10

1 points.

2 MR. HACKBARTH: Niall, can I just make sure of one
3 thing. This week NCQA released their annual ranking of
4 plans. And my understanding is that that included the
5 patient satisfaction data as well as the clinical measures.
6 But what we're doing here is just the clinical measures; is
7 that correct?

8 MR. BRENNAN: That's right. The data that NCQA
9 released earlier this week combines information both from
10 the HEDIS and the CAHPS. Going forward, we hope to also
11 merge on CAHPS information so we can look at things like the
12 correlation between clinical performance and patient
13 satisfaction and things like that.

14 But this is a slightly different methodology,
15 focusing just on HEDIS for now. What this table does is it
16 presents the average score for all MA plans in our analysis.
17 And then also presents the average score according to
18 certain plan characteristics. So across all MA plans, the
19 average composite score was 6.6. You can see that as plan
20 size increases, plans with greater amounts of enrollees tend
21 to have higher average HEDIS scores. And there's also a
22 small difference according to tax status. Not-for-profit

1 plans tend to have slightly higher average HEDIS scores than
2 for-profit plans.
3 In the reading materials that you were sent, there
4 were also a few other cuts on the data, including one that
5 looked at geographic variation. In general, there was not a
6 lot of geographic variation. But what is worth noting is
7 that the Boston area was significantly higher in terms of
8 quality based on this composite measure
9 The next slide just shows the variation in total
10 plan HEDIS scores. Plan scores range from a low of 1.2 to a
11 high of almost 9.8. The mean, as I said earlier, was 6.6
12 and the median was 7.1.
13 This is probably a good time to mention a
14 limitation associated with the methodology. That is
15 essentially we're grading all plans on a curve. Whenever
16 you create these composite scores or assign scores based on
17 percentiles, you are automatically placing any plans who are
18 in the lower percentile, you're assigning them lower points
19 regardless of the underlying scores on those measures.
20 Speaking of individual HEDIS measures, what this
21 slide does is shows you the variation on some individual
22 HEDIS measures, beta blocker after heart attack, lipid

1 screening, controlling high blood pressure, colorectal
2 cancer screening and osteoporosis management in women.
3 I think this slide is interesting because it shows
4 you that across different measures you can have very
5 different results. If you look at the use of beta blockers
6 after discharge from hospital for a heart attack, it's a
7 fairly well-established quality measure. I think it's been
8 identified as adding value for a considerable period of
9 time. As you can see, in general, plans tend to score very
10 highly on this measure. The 25th percentile threshold for
11 this measure is almost 90 percent and the 90th percentile
12 threshold is over 99 percent. Basically what that means is
13 75 percent of MA plans are roughly at 90 percent or above on
14 beta blocker prescription after discharge.
15 Other measures are a little lower and a little
16 more widely dispersed. If you look at osteoporosis
17 management you can see that the 25th percentile is only 13
18 percent whereas the 90th percentile is 30 percent. This
19 also is a new measure in the HEDIS instrument, so one would
20 hope that that would grow over the years
21 We also thought it would be interesting to look at
22 the stability of plan scores over time so we combined 2004

1 data and 2003 data for plans that were in both samples and
2 divided the plans into quartiles. For simplicity, we
3 combined the middle two quartiles.
4 I think the interesting thing from this table
5 suggests that there's quite a lot of stability year-to-year
6 in scores. If a plan wasn't in the lowest quartile in 2003,
7 74 percent of plans were also in the lowest quartile in
8 2004. Similarly, if you look at high performing plans, 62
9 percent of plans who were in the highest quartile in 2003
10 were also in the highest quartile in 2004. But it also does
11 illustrate that there is an ability to move between
12 quartiles.
13 Our conclusions are that relatively simple
14 composite methodologies can be used to compare MA plan
15 performance. Many MA plans are achieving high levels of
16 quality but there's definitely room for improvement. And
17 that the HEDIS instrument appears to be adequate to
18 differentiate among plans based on quality. That's
19 important because plans are already reporting HEDIS
20 information to CMS on a yearly basis.
21 I would be happy to answer any questions that you
22 all might have.

1 DR. REISCHAUER: I'm not sure what we're doing
2 here, so these remarks may be off course. But if we're on
3 the road to saying this looks like a good measure to
4 actually implement a P4P program with I'd like to step back
5 and suggest it isn't.
6 First is sort of a question. It's my
7 understanding that this is actually a subset of the measures
8 that are used for commercial plans. So there's a more
9 robust HEDIS measure for somebody who is selling a plan to
10 employers. But because that's proprietary information and
11 this is public information, there's a problem. Am I right?
12 MR. BRENNAN: Two responses to your broader
13 question. The intent is certainly not to say that let's use
14 HEDIS for P4P right now. I think it should be viewed more
15 along the lines of we've made recommendations to have pay
16 for performance programs in various sectors of the MA
17 program. This is an illustrative approach of how you might
18 use an existing dataset to do it. It won't necessarily
19 result in a recommendations saying we have to do it this
20 way. But I think it's worth thinking about, given that the
21 data already exists.
22 Now regarding whether or not it's a subset of data

1 that plans use in the private sector, certainly the measures
2 that I selected are a subset of a broader set of measures
3 that are available for MA plans. And some of the measures
4 in the private sector don't necessarily apply to the elderly
5 population.
6 DR. REISCHAUER: But Medicare collects more than
7 these?
8 MR. BRENNAN: The HEDIS data contains yes,
9 significantly more information that these nine measures that
10 I selected. I selected them because the NCQA uses it as
11 part of its accreditation standard program.
12 DR. REISCHAUER: It strikes me that if we were
13 moving forward, I'd want to know why do we have a step
14 function here as opposed to a continuous measure where when
15 you go from the 25th percentile to the 26th you get a jump,
16 but when you go from 26th to 48th you get no reward at all.
17 And so that strikes me as not particularly useful.
18 I also sort of question whether we should endorse
19 systems in which when you're missing four of the 10
20 elements, we presume that the scores on them are sort of the
21 average. Then I would wonder why, when we're aggregating
22 these things, they're all equally weighted. And then I'd

1 ask myself do percentile's really -- is that where we want
2 to go when for some of these things the data are bunched all
3 together. I would say getting your beta blocker right from
4 89 percent, the 25th percentile, to 95 -- which is probably
5 the 85th percentile -- maybe doesn't make a whole heck of a
6 lot of difference compared to moving on one of these other
7 scales which we're way down in the mud on. And so you'd
8 want some notion of clinical relevance to the change.
9 And then if you were doing this in a way that
10 would be perceived as fair by plans or providers, you
11 wouldn't want a moving target. You'd want to take the
12 distribution as it existed in year –minus-one. And so that
13 if people improved they would have some guarantee that they
14 would be rewarded.
15 MR. BRENNAN: I think they're all excellent
16 points. A large part of this was intended to stimulate --
17 DR. REISCHAUER: I'm not jumping all over you.
18 MR. HACKBARTH: But to go back to your initial
19 question, which I think I understand better now, what we did
20 say two years ago I guess is that we think that the HEDIS
21 measures, given the quality of them, their acceptance, the
22 existing methods for collecting the data and verifying it,

1 we think are appropriate for use in a pay for performance
2 program and we urge Medicare to go ahead and do that.
3 What we have avoided is saying here's how they
4 ought to be aggregated, here's how the formulas ought to be
5 written, here's how you ought to reward absolute performance
6 versus improvement. And we've stayed away from those
7 specific questions, very important questions, for all the
8 reason that you enumerated and some others. But I think
9 they require a time and devotion to thinking through the
10 issues that we haven't been able to give it and I don't
11 think is really the best use of our time.
12 DR. REISCHAUER: But then what are we doing here?
13 If you're saying we're showing you that you can measure
14 variation in health plan performance, I didn't need this.
15 All I'd have to do is go look and see that HEDIS scores
16 differed.
17 MR. HACKBARTH: This is in direct response to a
18 request from me, as well as some other commissioners, to try
19 to get a handle on what the variation is in performance.
20 And so Niall understandably took what is an existing
21 methodology used by NCQA and applied that to illustrate the
22 variation.

1 Now I think you're raising a lot of good points.
2 We're not endorsing that methodology. I just want to be
3 clear about that.
4 DR. REISCHAUER: But I think people might read, if
5 we write something like this, that we are.
6 MR. HACKBARTH: I think when we write it, we can
7 include the sort of points that you're raising. I don't
8 want to get into the business of trying to write the
9 formulas though.
10 DR. CROSSON: I had two issues, and the first one
11 is the same one that Bob just brought up. It's the
12 combination of using percentiles with the compression issue.
13 You're using the percentiles and then the problem of
14 compression creates the same issue. Even with some HEDIS
15 measures, the compression is greater than the example that
16 was shown. It can be just a few percentage points moving
17 from the 25th to the 90th percentile.
18 And if the weighting then, according to that
19 formula, weights that difference as much as it weights the
20 other differences it does a couple of things potentially.
21 It impacts on the stability of results over time because
22 you're going to get -- small variations will move the

1 results.

2 It also feeds back into resource allocation. As
3 Bob was saying, as you're sitting planning where you're
4 going to put your investment, you may very well should be
5 putting your investment in areas where the difference is
6 very great. But if they're all scored the same, the system
7 may not drive the right incentives. So that's a problem.

8 The second point I just wanted to make with
9 respect to some of the other information that can be gleaned
10 from this kind of analysis, and I noticed on the slide the
11 for-profit/not-for-profit, in the text actually there's
12 other information that looks at the delivery system design.

13 I'm just suggesting maybe some more work in this
14 area, not looking so much at for-profit/not-for-profit but
15 the exact kind of delivery systems and payment structure if
16 they can be segmented better. Because I think we might get
17 useful information out of that, as opposed to just
18 separating and categorizing them in that way.

19 MR. BERTKO: I want to follow up both comments
20 here and first start by recognizing what Niall has shown us
21 is probably as good as it gets today. And secondly, there
22 are real differences in quality that could be measured.

1 Having said that, I'm going to get a little more
2 technical and just say some of this is an appearance or data
3 collection problem. Jay's organization, Kaiser, should get
4 credit for being way ahead of most of us on electronic
5 medical records and the ability to easily get this. Whereas
6 we, in some of our markets, need to literally go and knock
7 on doctor's offices to collect this data.
8 So HEDIS is good but it's data intensive, it's
9 expensive, and it only does a few things. I would hope that
10 the Commission and staff might think about some of the other
11 things. We talked a little bit about are there things that
12 are claim-based this morning. We've been working with RAND
13 who have roughly 145 quality measures that actually appear
14 to work in terms of things like this.
15 And to the extent, particularly if we're going to
16 talk about PPOs in Medicare and private fee-for-service, it
17 would be really important to have what I'll call an easier,
18 lower cost way to visit thousands of doctors who might not
19 be very coordinated systems. And I would think we want to
20 know that.
21 I would hope that you maybe end where Niall is
22 today, but then have another few pages that say what

1 directions might we want to look towards for some ultimate
2 system.
3 MR. DURENBERGER: I think I'm going to make a
4 point very similar to the one that John Bertko just made it.
5 I serve as a director at NCQA so I love seeing NCQA and
6 HEDIS and the rest that that sort of thing. But that isn't
7 the real purpose of doing this work. The purpose of doing
8 the work is to start moving in the direction of performance
9 and recognizing that is and how we're going to pay for it.
10 And also what you said, Mr. Chairman, the current
11 system, in terms of practice, has so much variation that we
12 have a relatively long way ago regardless of what measure or
13 measures that we use.
14 So in light of what Bob said and what we've heard
15 so far, my instinct is to say right up front we ought to say
16 what it is, why path we are on. When you use words like
17 quality or performance, it's all in the eye of the beholder
18 and so forth.
19 You know, I go to the newsstand and I pick this up
20 and I'm reminded that Jack Wennberg can take the top 50
21 academic medical centers in America, the best American
22 medical centers in America, and applying an overuse as a

1 quality failure to that, he can find in disparity of three
2 to one across this country.
3 So we call it best but we know it isn't. It just
4 seems to be the best we can do with existing measures. And
5 making that point very up front in all of this becomes very
6 important.
7 The second point is if we're going to use words
8 like quality and performance, what this seems to do and
9 HEDIS seems to do, as least as presented here, is the
10 underuse side of quality. What Jack and his colleagues do
11 is the overuse side of quality, which we don't get to here,
12 but we could because there are some references.
13 So just explaining in that context want is quality
14 and what path are we on, not to discredit an organization on
15 which I also sit, nor to discredit a magazine like this, but
16 to demonstrate how far we have to go in terms of financing
17 policy and how important our future recommendations will be
18 also, I think should be part of this chapter.
19 MR. HACKBARTH: In that same vein, to me there are
20 a couple of other things that people need to be cognizant
21 of. One is this focuses on variation across plans. The
22 reality is that there is substantial variation within these

1 plans. So you take a high ranked plan and a market -- take
2 Boston College, one that I'm familiar with. The average
3 scores for the Boston plans are high. But within those
4 plans there is a lot of variation. There's more variation
5 within plan in Boston than there is across plans in Boston.
6 So if you're a Medicare beneficiary trying to get
7 good health care, knowing that Harvard Pilgrim Health Care,
8 as much as I love them, is ranked number one doesn't tell
9 you at all anything, where to go within the Harvard Pilgrim
10 network to get really outstanding care.
11 I think that is something that needs to be
12 understood about plan rankings.
13 The other point is one that we've made before and
14 made recommendations on. A beneficiary really ought to be
15 able to compare their plan offerings choices to the ambient
16 level of quality in fee-for-service Medicare in that same
17 community. Again, that's what the beneficiary wants to
18 know.
19 So I think we're moving in the right direction but
20 there are a host of questions about how you best view these
21 things in the context that they need to be put into.
22 DR. WOLTER: I was just thinking, as Bob went

1 through all of his questions or suggestions, we will have
2 the same list for hospital measures, for physician measures,
3 et cetera. As there's so much enthusiasm developing around
4 pay for performance, the question I've wondered about a
5 little bit is going forward where does sort of the design of
6 the details and then the oversight, and then of course
7 evidence-based medicine changes and so things need to be
8 changed over time.

9 Where does that all sit? And at this phase we're
10 in now, how much of this design is something we should be
11 tackling? Do we have the expertise to tackle it? And if it
12 isn't us, where would it be? Because there's a lot of
13 places now where this is all happening and it actually is
14 fairly confusing. I know the provider community is kind of
15 confused about it and are really wondering who's going to
16 come out with the next set of measures. And things like is
17 somebody looking at how to coordinate the physician measures
18 with the hospital measures, et cetera.

19 I'm not sure what question I'm asking, but I think
20 it's along the lines of should we be suggesting that there
21 be a place where people with the right expertise ask those
22 kinds of questions that Bob just did and try to really get

1 into the details in a way that we may either not have the
2 expertise or the time for? And is that in CMS or is an
3 advisory task force or what is it?
4 MR. HACKBARTH: I agree that that's a critical
5 question. We've talked about a piece of that back in -- I
6 can't remember which chapter or which of our reports. But
7 we did talk about how it would be potentially more efficient
8 and more effective for there to be a place where the work
9 was done of saying these measures of quality are ready for
10 prime time. And that's done by experts as opposed to by
11 interest groups and hopefully in a thoughtful away.
12 But that's just really one layer of the questions.
13 You could have the right measures. Then there are the host
14 of issues of the sort that Bob is raising about you do you
15 compile these in an index and scores? And then how do you
16 right the P4P formulas that reward both attainment and
17 improvement? They're big, big questions.
18 DR. REISCHAUER: And I won't give you the answer
19 just yet.
20 If our purpose here is to illustrate the variation
21 in plan quality and then relate that to size of plan, nature
22 of delivery service, for-profit, not-for-profit, that kind

1 of thing, then what I think we want is the most sort of
2 robust measure of variation possible rather that this step
3 function, sort of I'll give you credit when we're ignorant
4 kind of thing.

5 I would suggest that what we would do would be to
6 look at the range between the top plan and the worst plan
7 and give you points along that scale. Sort of what is
8 possible here, not sort of what's the 90th percentile. And
9 then weight them by the percentage point range between let's
10 say the 10th and the 90th divided by 100.

11 What I'm saying is you look at the beta blocker
12 thing and it went from say 85 to 99. So you have 14 points
13 over 100 points, which would give you a pretty low weight.
14 It's because everybody's doing well and there isn't much
15 variation. And create some kind of measures like that which
16 then I think would be more enlightening to our analysis of
17 what the variations really are.

18 MR. HACKBARTH: Let me ask, one way that we could
19 shape this chapter, we could do some reporting of the
20 analysis and then have a concluding part that is more policy
21 oriented in which we could delve into questions about where
22 this work is done and be more pointed and maybe more

1 expansive than we've been to this point about the need for
2 appropriate people to be doing this work.
3 I'm open to --
4 DR. MILLER: I can understand the question and why
5 you're asking it. I think it's important not to dismiss --
6 there was an interest on the part of the commissioners and
7 it took us down this road. And so obviously we did it for
8 that reason.
9 But I also think we did it for the reasons that
10 Niall did touch on. You know, we put this proposal out, pay
11 for performance. There has been a lot of enthusiastic
12 response to it, and some resistance to it. And I think some
13 of the questions are how would it work? Do you really need
14 it? is there really all that much variation?
15 And I think some of what this was about was to
16 illustrate the degree of variation, how someone could look
17 at it both on an aggregated and a disaggregated level, and
18 to implicate some of the very issues that we're talking
19 about here. You can only say so much in 10 or 15 minutes.
20 We specifically wanted to implicate the issue of
21 grading on a curve and how actually that can be kind of a
22 problem. And then some of the issues that you're talking

1 about are precisely the kinds of things that we expected to
2 come out of this, not to resolve not to say -- and I can see
3 how we can link it to Nick's comment -- but to say as you're
4 thinking through these kinds of systems and thinking about
5 how these issues will have to be addressed. And it might be
6 that some of them we actually feel pretty strongly on. You
7 shouldn't do it on the basis of a curve. We can make that
8 statement. But for other things it's a little bit more
9 agnostic. You could do this or you could do that.
10 But at least to lay it out in a systematic way,
11 some of the issues that they're likely to collide on or have
12 to be thought through.
13 I could see us linking it to Nick's comment and
14 the fact that we made a recommendation before about the need
15 for an entity and say that this is one of the missions for
16 the entity and these are the kinds of issues. I sort of saw
17 it surfacing a lot of these kinds of comments.
18 So I think I'm agreeing with you that I did see
19 this chapter after we got your comments as sort of saying
20 now, these are the kinds of issues that fall out of these.
21 MR. HACKBARTH: I think the institutional piece
22 that Nick's talking about, who is going to do this work is

1 increasing important right now. We're at the threshold of
2 this. There's obviously a lot of jockeying for position,
3 and different organizations trying to hold themselves out as
4 the arbiters of this and that.
5 And how those decisions are made, who is bestowed
6 with the mantle of arbiter, could have important
7 ramifications for how successful this effort is. It's
8 something that I've been worried about.
9 So I would be happy for us to at least try to
10 frame those issues. I don't think we're in a position to
11 say well, it ought to be these people, XYZ. By I think to
12 sort of put a point on those issues would be a helpful thing
13 to do right now
14 DR. MILSTEIN: I'd like to speak in support of
15 this idea of this report aiming for mid-ground between
16 getting into a lot of proscriptive detail which is obviously
17 what we want to do, but going beyond the idea of simply
18 saying you ought to do this and here are the issues. I
19 think there's a mid-ground.
20 What we may aim for, and what I would advocate
21 aiming for, is we might see if we can agree on principles
22 for some of these, I'll call it pivotal planning variables

1 that Bob has addressed and Alan and others have addressed.
2 Just a brief list of some of these pivotal planning
3 variables, on which we could perhaps at least agree on what
4 the principles should be, would be the sort of scope of
5 quality measure. Should they be a narrow pristine set such
6 as these nine? Or should it include a much wider range?
7 And move beyond pure process measures to things like the so-
8 called Health of Senior Survey or Health Outcome Survey that
9 begins to get at why the customers are paying money to begin
10 with, which is to have the least interference in their
11 ability to function in every day life from health problems.
12 The second variable might be the size of the pool
13 as a percentage of total spend. Again, we don't have to get
14 down to the micro detail.
15 DR. MILSTEIN: Third would be the steepness of the
16 performance reward slope. Is this going to be everybody
17 gets a bonus except the bottom 10 percent? Or is this going
18 to be something that's geared to driving excellence?
19 The fourth might be the grading system where we
20 talk about absolute versus relative.
21 The fifth, which I want us to at least consider,
22 would be the width of the comparison pool. For example, if

1 the plans begin to open up bigger distance between them and
2 Medicare fee-for-service should there be a way of
3 potentially -- or vice versa. Should there be a way of
4 potentially moving money between these two bigger pools?
5 And last, the issue that's been addressed of who.
6 If we're not going to issue a report every year that gets
7 more specific and we don't think this should be arbitrated
8 by Congressional staff who perhaps are not that familiar
9 with some of the detail and relevant social science
10 research, who might do it?
11 MS. HANSEN: My comment is more on the broader
12 scale of perhaps thinking of the disparities, health
13 disparities, and whether or not whenever we look at these
14 scores we take a look at especially with the IOM report out
15 about health disparities, whether some of those measures can
16 take -- when we eventually do it, whoever does it -- takes a
17 look at the subset of that.
18 Also, there are issues that are even that two out
19 of the nine measures are unique to women, and there are
20 issues that are unique to men, whether not that too be
21 elements here of consideration whenever this gets done.
22 MR. SMITH: Arnie anticipated much of what I

1 wanted to say. We need to be careful here not to conflate
2 three different discussions that are going on.
3 Glenn, you raised the issue of how can a
4 beneficiary usefully use this data with respect to the
5 ambient pool, the fee-for-service pool? That's a different
6 question than the sort of design issues that Bob raised.
7 But it strikes me that the third set of concerns
8 is the one where we can add real value here. Those are the
9 questions that Arnie raised about the design of pay for
10 performance. How robust, how do we deal -- how robust is
11 the information base? How deep is the pool that we're
12 prepared to move around? And how do we sort out the
13 question of paying for high performance, paying for improved
14 performance?
15 It seems to be we can add some value there. The
16 design questions that Bob raised need to be addressed but we
17 probably don't add a lot of value there. And clearly having
18 a step function instead of a smooth function is a bad idea,
19 particularly when you've got the individual plans clustered
20 in very, very narrow bands in some cases.
21 But I'd concentrate, it seems to me, on the third,
22 on the design or the principles that ought to inform the

1 design of a pay for performance system. If we can head in
2 that direction.
3 On the first one Glenn, the useful information for
4 beneficiaries, the most useful thing we can do for
5 beneficiaries, I suppose, is seek to improve performance
6 broadly by the use of a well designed pay for performance
7 system and whether or not we have to simultaneously figure
8 how best to communicate that strikes me as less important
9 than sticking with the design of a powerful P4P instrument.
10 MR. HACKBARTH: My point on that beneficiary
11 question was actually quite a narrow one, and this is maybe
12 just a pet peeve of mine. But we talk about plan
13 performance. Well, it may be in some cases it's not plan
14 performance but it's the community, the underlying health
15 care community in a given market is performing high and the
16 plan is not actually doing anything at all. It's just
17 located in a high performing health care community.
18 MR. SMITH: But we would want to reward that
19 community regardless of the value added by the community or
20 the plan that employed the community.
21 MR. HACKBARTH: But we'd also want the Medicare
22 beneficiary to know that you don't have to go into the

1 health plan to get it, you can get it in fee-for-service
2 Medicare.
3 MR. SMITH: Right, but two different questions.
4 MR. HACKBARTH: That was the only point I was
5 trying to make.
6 MS. DePARLE: I agree with Dave Smith that our
7 largest contribution would be in the area of principles. I
8 think that's what you've said before, as well, Glenn. And I
9 just want to underscore my agreement with the point that
10 Dave Durenberger made earlier, which is that maybe we've
11 said this before but, like you, I'm losing track.
12 On this issue, we've certainly surveyed what's out
13 there and talked about the various measures. And here we're
14 talking specifically about HEDIS. But I would want us to
15 come down strongly on endorsing that there need to be some
16 measures of efficiency, as well. That seems to me very
17 consistent with our long-standing principle and the way
18 we've looked at our mission.
19 And right now I think Dave is correct that there
20 really isn't -- these are mostly measures of adequacy or
21 where there's been stinting on care, I suppose you could
22 see. But you can't really see a measure of efficiency, per

1 se.

2 MR. HACKBARTH: Isn't this less of an issue in the

3 health plan context than it is in the fee-for-service

4 context? Because the plans are taking responsibility for

5 all of the costs, virtually all of the costs associated with

6 a beneficiary. They're in a competitive market where

7 they're --

8 DR. REISCHAUER: They're capitated.

9 MS. DePARLE: They are, but price is an issue.

10 How much are they being paid to do it, versus fee-for-

11 service?

12 MR. HACKBARTH: You know where I stand on the

13 contribution levels. But from a beneficiary perspective,

14 they're getting pretty clear signals about relative

15 efficiency in terms of the added premium and benefits they

16 get through different options. We've got tools in place

17 there that look at aggregated efficiency much better than we

18 do in the traditional fee-for-service program where it's a

19 huge problem.

20 MS. DePARLE: I would agree they're better. I'm

21 not sure I'm articulating this very well, but let me think

22 about that.

1 MR. HACKBARTH: Any others on this topic?

2 Okay, thanks Niall.

3 DR. NELSON: Can I come in late on this?

4 Simply to point out that three of us spent all
5 last week, the latter part of last week, talking about these
6 things in Woods Hole. Bob and Nancy-Ann and I are on the
7 IOM committee that is looking at performance measures and
8 pay for performance. We spent a fair amount of time talking
9 about the kind of principles that we've been discussing
10 here.

11 I wanted to ask Mark if there was any
12 communication between the staffs of these two efforts,
13 understanding that legislative mandate wanted some overlap,
14 at least in terms of membership on the various committees.
15 I didn't know whether you were having any kind of
16 discussions with your counterparts with the IOM or not, or
17 whether that was possible.

18 MR. HACKBARTH: Just to make sure everybody
19 understands that we're talking about here, Alan is referring
20 to the Institute of Medicine committees that have been set
21 up to answer the Congressional questions they were asked in
22 MMA about our readiness for pay for performance and what

1 measures were appropriate. I can't member all the

2 DR. NELSON: That's pretty close.

3 MR. HACKBARTH: There actually are two committees;

4 is that right?

5 DR. NELSON: Actually, there will be four.

6 There's one big committee and then subcommittees.

7 MR. HACKBARTH: The statutory mandate to the IOM

8 said do this in consultation with MedPAC.

9 DR. MILLER: There's a couple of things. There's

10 maybe four committees or whatever. But the way we've been

11 thinking about it is there's people thinking about measures

12 and then people thinking about how you link measures to

13 payment.

14 For everybody to know, there are several

15 commissioners that are actually on the committees and

16 working with IOM. There's been a series of things that have

17 happened at the staff-to-staff and staff-to-the-committee

18 levels. Karen and I have gone over at least once or twice,

19 I can't remember now, and briefed them on what did you guys

20 do? And what were you thinking? And what were your

21 principles? And how did you deal with these problems? And

22 in those kinds of things. I think we've done it twice now

1 for two different committees or subsets of a committee.
2 So we did that and explained, as clearly as we
3 could, what MedPAC had done and what all of our thinking
4 was. And of course, all of our information is pretty public
5 and so that's been made available to them.
6 Additionally, there have been more precise kinds
7 of consultations. Could you help us with some data on this
8 and that type of question, that we're working with really
9 more staff-to-staff. I'm sure it shows up in front of the
10 committees where we're just helping them more at that level,
11 as well.
12 Is that getting to your question?
13 DR. NELSON: Exactly, and it's very reassuring.
14 Thank you very much.
15 DR. MILLER: There's been a lot.
16 MR. HACKBARTH: The next topic is care
17 coordination in fee-for-service Medicare.
18 MS. MILGATE: I wanted to start off by just
19 acknowledging that Cristina Boccuti and Ariel Winter are
20 also working on this project and will be giving
21 presentations in the future. And also Sarah Friedman and
22 Sarah Kwon have been very helpful in setting up and also

1 recording the interviews we've been doing. Having said
2 that, I'm going to just begin.
3 When Janice Smith, a 75-year-old Medicare
4 beneficiary, leaves the hospital she needs to understand how
5 her new four medications should be taken alongside the five
6 she's already on. She also needs to know what symptoms to
7 look for to indicate her condition may not be healing
8 properly. And she needs to make and go to the follow-up
9 visit the physician in the hospital recommended. Further,
10 the clinician she sees needs to know what happened in the
11 hospital and the details of her previous care.
12 If Janice Smith is living at home and has
13 uncontrolled glucose levels, CHF and is in the early stages
14 of Alzheimer's, she needs to follow her medication regime,
15 have her glucose levels checked regularly and maybe a
16 psychiatric assessment.
17 Yet the fee-for-service payment system provides
18 little incentive for providers or others to support Mrs.
19 Smith in her care. While we do not know the direct
20 relationship between the level of support for Mrs. Smith and
21 whether her health worsens, we do know that 9 to 40 percent
22 of all readmissions are considered preventable and that 12

1 to 75 percent of them could have been prevented through
2 better education, pre-discharge assessment and more support
3 at home after the discharge.
4 For these reasons, over the past two years the
5 Commission has repeatedly stated its interest in finding
6 strategies Medicare could use to encourage care
7 coordination. In this session we're going to talk about how
8 we're planning on evaluating that question and some
9 preliminary findings on one possible strategy. That is the
10 strategy of using measures to encourage care coordination.
11 What we've been doing over the past few months is
12 trying to identify best practices in care coordination and
13 also to talk to some of the folks we've been interviewing on
14 policies that they think could support care coordination and
15 that they find support the best practices that they are
16 performing already. So what we've been doing in the last
17 few months, and we are really in the middle stages of this,
18 is interviewing group practices, integrated systems, we're
19 talking to CMS demonstration sites as well as CMS staff,
20 representatives of providers, plans, accreditors and disease
21 management organizations.
22 We're also planning on using the data in the

1 physician resource use analysis to consider groupings of
2 services or beneficiaries that might actually have a high
3 need for care coordination. As I said, we're partly through
4 our interviews and in this session will present some
5 additional findings.
6 First it's important to try to define what we're
7 talking about by care coordination. Through our interviews,
8 as well as discussions at the Commission, we've identified
9 two sort of broad categories of care coordination. One has
10 to do with patient transitions among providers. That is
11 when patients go from physician to physician is the right
12 information passed along between those physicians? And one
13 major area where we hear over and over again in our
14 interviews is at the hospital discharge. Does the next
15 provider have the information they need? Does the patient
16 really know what to expect when they go to the next setting,
17 whether it be home or to a nursing facility?
18 The other type of care coordination we also hear a
19 lot about are for patients who may have more complex needs
20 and may have a longer-term need for support. That includes
21 patients with chronic conditions either single or multiple
22 chronic conditions, as well as patients who may have

1 multiple needs having to do with their frailty or
2 Alzheimer's, for example.
3 Through our interviews it's also become somewhat
4 apparent that there are a wide variety of strategies to
5 coordinate care. But here we've summed up I guess what we
6 have found are three primary characteristics of the programs
7 that we've talked to. First, there's usually a person,
8 who's either called a case manager or a care manager, who is
9 usually, we have heard nurses but sometimes physicians do
10 this or other specially trained clinicians who communicate
11 both with the patient as well as other providers and provide
12 what one interviewer said is sort of the glue for the
13 integration of the care through phone calls, home visits.
14 We've also heard some examples of home monitoring devices
15 where patients will key in certain final statistic
16 information that will go to a center and then that
17 information will go to the case manager.
18 The second characteristic I wanted to highlight is
19 over and over again the comments were about the necessity
20 for information transfer and analysis. There were really
21 two ways that seemed to be necessary. First of all, the
22 information needs to be transferred between providers to

1 make sure they have the right information and also to make
2 sure that the patient has the right information. So there's
3 sort of an information that's used in the pathway of care.
4 But the other information analysis and the
5 information systems need was to in the beginning of the
6 process identify beneficiaries that might need this type of
7 care. So for example, we heard from various programs they
8 either use claims analysis, patient registries or in the
9 best cases electronic health records to identify patients
10 who really needed this higher level of management and then
11 to use those systems to track those patients' care over
12 time. So they could look and see who had, in fact, higher
13 utilization of certain services or, in fact, they could look
14 at their glucose levels depending on the type of information
15 they were getting.
16 The third characteristic is that in pretty much
17 all cases we heard a lot about them measuring the results of
18 what they were doing. It's kind of a common sense thing in
19 a sense because most of the programs, what they were doing
20 was the goal was to improve quality. So they tracked, in
21 fact, did they improve the quality of care for those
22 patients? But they oftentimes paid for these programs

1 through savings. So they would, first of all, figure out
2 how much savings they think they could get. And that would
3 help them decide, for example, how many care managers they
4 could hire or did they have enough to actually put some
5 investment into information system technology? So they
6 tracked the savings as well as the quality on an ongoing
7 basis.
8 I've just listed here probably the two broadest
9 measures we heard about were hospitalizations, either
10 initial admissions, readmissions or ED visits.
11 Having described a little bit what we mean by care
12 coordination, these are the five potential strategies that
13 we've identified both through the previous Commission
14 discussions, but also they were pretty much corroborated
15 when we spoke with the folks that are doing care
16 coordination.
17 First of all, the one that we'll talk about in
18 some detail in just a moment is the possibility of using
19 measures. This could be through confidential feedback,
20 public reporting or pay for performance programs, to
21 encourage care coordination.
22 The second is the care management fee. Most of

1 the time this is talked about as a fee that would go to a
2 physician's office for a defined set of beneficiaries, a
3 defined set of services that would actually reward the
4 physician's office for either participating as part of the
5 care coordination program or else doing it him or herself
6 through their office.

7 The third is bundling, and this concept is
8 grouping services together to create incentives both for
9 efficiency as well as care coordination.

10 The fourth is shared savings. Shared savings is a
11 mechanism that CMS is currently doing quite a bit of testing
12 on where the Medicare program would make it possible to
13 share savings that were the result of care coordination with
14 providers to help give them some of the funding and
15 incentive to actually put in place some of these programs.

16 The fifth we've heard about both through the
17 Commission discussions, but it's also come up quite a bit in
18 the interviews. That would be encouraging the formation of
19 integrated groups of providers. Through our interviews,
20 we've heard quite a bit about groups of providers,
21 particularly integrated groups, having the infrastructure
22 and relationships necessary to coordinate care. So one

1 thought would be just to try to think of incentives for
2 providers to form into larger groups or into groups at all.
3 Today we're going to focus on the first strategy
4 and we'll will discuss the other strategies in some detail
5 in further meetings.
6 The primary focus in our analysis of whether
7 measures of care coordination could encourage better
8 coordination has really been to consider whether, in fact,
9 we have measures and if they are currently used. We have
10 not done as much thinking about how those would actually be
11 used. For example, would it be confidential feedback or pay
12 for performance? Or exactly who the entity would be that
13 would be accountable for the measures.
14 But what we did was look, thinking about the
15 quality framework of process structure and outcomes
16 measures, if we could find measures that were used and for
17 both types of care coordination, both transition as well as
18 long-term management.
19 So in terms of transitions among providers, the
20 measures we heard the most about were patient reported
21 measures of things like whether the patients had a high
22 knowledge of what to look for for symptom change, whether

1 they felt like they had the ability to manage their
2 medications are just some examples. The primary examples we
3 heard, the one set that we heard the most about were called
4 the care transition measures. These set of measures were
5 developed by some researchers at the University of Colorado.
6 They've been tested fairly extensively and are not in
7 widespread use at this time. But several of the programs we
8 talked to are piloting their use at this point in time.
9 The Joint Commission on Accreditation of Health
10 Care Organizations is also trying to use three of their
11 measures and pilot them in some of their new survey
12 methodology.
13 The National Quality Forum has also looked at the
14 care transition measures and is considering whether to
15 recommend them as part of their revised set of hospital
16 measures.
17 The other one of the slide is just to say there
18 are others out there, PeP-C stands for the Patient's
19 Evaluation and Performance in California. Again, it's a
20 patient perception survey that is done on hospitals that has
21 some similar measures.
22 To look at long-term management for patients with

1 chronic conditions, it was interesting to us to hear really
2 interviewee after interviewee and program after program
3 basically saying well, what we look at are the condition
4 specific measures that we would associate with ambulatory
5 care. The diabetics, did they get the necessary services
6 they're supposed to? Are glucose levels at healthy levels?
7 Were cholesterol levels checked? The kinds of things that
8 we've talked about before for a physician pay for
9 performance program.
10 So that raises a question about whether care
11 coordination is really a separate process in some ways for
12 long-term management or just simply good primary care, which
13 might be a discussion the Commission might want to have.
14 In terms of structural measures, we find a couple
15 of sets of measures have been used. And I guess the other
16 finding I would present broadly is that we also find, in
17 terms of structures, pretty well defined types of structures
18 that could be measured. So we may not have measures for
19 them yet but there are some key functions that we perhaps
20 could measure.
21 So in terms of structural measures, the primary
22 ones we find were around information transfer. The NCQA

1 recognition program that's called the Physician Practice
2 Connection, which again we talked about in terms of how it
3 could be useful for looking at physicians ability to
4 identify and track patients, are one set of measures that
5 some have used. I guess it was at least a couple of the
6 group practices we talked to had gone through this program
7 and had got recognition for the systems they used to better
8 coordinate care.
9 The other type of information transfer practice
10 that we heard about and something that could be measured is
11 the need to standardize the core patient health information
12 that moves between and among providers.
13 So for example, there's an effort that's been led
14 by the American Academy of Family Physicians to create a
15 continuity of care record where they would identify key
16 feels that every provider could expect would be filled out
17 when the patient came to them. That could either be carried
18 by the patient or it's designed to be web-based so also
19 physicians could also just go into the Web and when they
20 have a patient know that they could get the information they
21 need to treat that patient.
22 Another take on that concept is there have been

1 folks that have developed personal health records. Personal
2 health records would be a little bit different concept in
3 that it would provide the patient with some prompters for
4 the kinds of questions they might ask but would still have
5 some very core information like the results of your recent
6 labs and these are the medications you're on, and that could
7 be carried to the provider.
8 One of the tools for measuring structure are
9 accreditation and the conditions of participation. We found
10 that the Joint Commission, as well as NCQA, do have
11 standards for coordination of care across settings. NCQA's
12 are fairly specific sort of goals and they require some
13 quality improvement in identified areas. JCAHO is currently
14 looking at applying their broader strategy of actually
15 surveying by tracing the patient and following the patient
16 through their system. And they're looking at applying some
17 of these care transition measures in that process to get a
18 better idea from the patient's perspective, how do they feel
19 like they came out at the end of the process? Did they
20 really understand what needed to happen after that
21 discharge?
22 So while standards are in existence, and far be it

1 for me to say they're good or bad, the question may be
2 whether they're effectively monitored and if there may be
3 more creative ways to monitor and to survey on those
4 standards.
5 In terms of outcomes measures what we heard, as
6 I've said before, is that the programs continually use the
7 rate of hospitalizations for certain preventable conditions,
8 readmissions, ED visits. And there's also wide use of
9 intermediate outcomes such as glucose control, blood
10 pressure levels, body weight, those kinds of measures that
11 you would look at to see if the patient's health has
12 improved.
13 So having outlined what we found so far about the
14 availability of measures, it's important to say that this is
15 certainly not an exhaustive list. Others we could just
16 think of sitting in this room could include the number of
17 physicians that beneficiaries see, is there multiple and
18 duplicative testing going on?
19 I've talked mostly about quality measures, but of
20 course we could also, I'm sure, identify a fairly robust set
21 of cost measures if we wanted to talk about that as a goal
22 of care coordination as well. Certainly some of the

1 programs do do that and they use hospitals kind of as a two-
2 for, lower hospitalizations could mean lower cost as well as
3 higher quality.
4 We also heard a few comments, and I don't say this
5 was widespread, about whether we might want to more clearly
6 define the actual processes for care coordination. So
7 rather than using some of the more outcome measures, could
8 we define specifically what happens and then create measures
9 around those? However, on the other side of that discussion
10 were people that said we don't really need to do that.
11 Let's just look at the outcomes of our processes and let the
12 processes vary amongst different programs.
13 As I said before, we have not talked extensively
14 here and we can do that some in the coming months about
15 these measures should be used. Some of them may be more
16 appropriate for pay for performance context rather than --
17 and others may be more appropriate for feedback to
18 providers.
19 Also, there’s a question about identifying who
20 would be accountable for these measures. Many of the
21 organizations with whom we spoke looked at a broad
22 population level. So they didn't really look at individual

1 physicians. They were some certainly that looked at
2 individual hospitals, but a lot of them were group
3 practices.
4 And some measures may be more difficult than
5 others to attach to individual providers. For example,
6 whether a physician did the HbA1c test is sort of a yes or
7 no question. But whether a diabetic actually ended up in a
8 hospital, there may be more factors that would affect
9 whether that occurred.
10 So in conclusion, this is really a summary of what
11 I just said. We did find process measures were available
12 for both care transitions and long-term management of
13 conditions. We found that there were some fairly well-
14 defined structures that could be measured, and some measures
15 of structures already. We found that some outcomes measures
16 are already in use and I've identified some outstanding
17 questions regarding whether there are additional measures
18 and how to apply the measures that we found.
19 So we'd appreciate your feedback on the overall
20 work plan, but also a discussion on whether you think using
21 these kinds of measures could help encourage care
22 coordination.

1 MR. BERTKO: Karen, a great report, as usual.
2 I guess I'd like to focus, if you can flip back
3 one slide to the last bullet point there. As I read this, I
4 was struck here, given that this is fee-for-service
5 Medicare, maybe thinking about doing some more work about
6 this accountable entity. From the other work that's going
7 on with episode-based groupers, we know we can infer doctors
8 who "own" a patient for that episode. The RAND people that
9 I've worked with can infer one or more doctors that own an
10 event, their slightly different categorizing of those.
11 I'm wondering on a policy basis for the
12 Commission, should we go down this path a bit because so
13 what if you collect all of the feedback in the world and it
14 doesn't go anywhere?
15 So I would raise this by itself as important as
16 the whole process of looking at it because otherwise it's
17 not actionable.
18 DR. MILSTEIN: A couple of areas for suggested
19 exploration as we home in here.
20 First, I think that in the measures department one
21 of the things I'd like to advocate for is use of the
22 measures that are being developed now at places like

1 University of Oregon, to begin to measure the degree of
2 which -- whoever the accountable entity is, whatever it is -
3 - the degree to which they are enabling the patients
4 themselves and their caregivers to be successful at care
5 management. Because that's the level of care where if you
6 can optimize that then everything else -- then paying
7 incremental dollars for care management can be judiciously
8 used.
9 I think, for example, the so-called PAM survey
10 that Judy Hibbard is developing is a great example of a
11 relatively well validated way of assessing the degree to
12 which patients have been enabled to be more successful self
13 managers.
14 Another area I think it would be nice to develop
15 would be this whole area of what do we know about the cost-
16 effectiveness of different approaches to care management?
17 Pioneers like Hal Holman, for example, at Stanford have
18 shown that successful patients can be among the most
19 persuasive and influence care managers and educators. There
20 are certainly examples around the country of care management
21 programs where successful patients or non-health care
22 professionals have been quite effective in helping with care

1 management.

2 And so it makes a great deal of difference to the
3 Medicare program as to whether or not we're inducing a
4 program that is more rather than less cost-effective as we
5 begin to incentivize this new area of activity in a
6 systematic way.

7 Last but not least, this is the same theme I
8 bought up before, but I would love to see among the measures
9 used -- not the only measure because it has its
10 imperfections -- is this Health of Seniors measure, which
11 again focuses on why the customers are paying their money to
12 begin with, which over a longitudinal period is their degree
13 of impairment and their health status from health problems
14 greater or less than what would be expected based on their
15 age and their baseline health care state?

16 DR. WOLTER: In my experience, a lot of what we do
17 in care coordination, focusing particularly on chronic
18 disease, involves non-physician providers. That tends to be
19 where we've had the most success. And you did mention,
20 Karen, that in fee-for-service there's not a lot of
21 incentive to tackle this issue. I think it's because the
22 payment systems tend to focus on the visit or an acute

1 episode or something like that.

2 I suppose it's an old idea but the idea of

3 capitation for certain patients with chronic conditions,

4 which there's devil in those details, when is it chronic

5 enough or when are they sick enough, that maybe a capitated

6 model to support the development of that infrastructure of

7 mid-levels and others to help take care of the patients. A

8 lot of the daily interaction you have with patients with

9 chronic conditions really does help over time, so that their

10 weight isn't going up if they have congestive heart failure

11 or their diabetic control is better.

12 And then I think the other thing is some of the

13 payoff is not in 12 months. It's longer than that. So how

14 can we put a way of looking at all of this together that

15 isn't necessarily focused on budget neutrality over 12

16 months as we develop programs to better coordinate care,

17 particularly for those that are quite complex and are

18 significantly chronically ill?

19 I think that's an important principle, too.

20 There's a lot of gain to be made in diabetes, for example,

21 if we can look out beyond 12 months.

22 DR. KANE: I just wanted to make a comment or

1 reinforce comments about the accountable entity. Maybe we
2 can hopefully think a little bit about geographic entities
3 that aren't necessarily organized insurance plans, or in the
4 instance where there aren't large group practices having
5 some kind of geographic based integrating and measuring and
6 performance measuring entity that -- because one thing you
7 do see in a lot of these measures is that there is a lot of
8 variability by state. I think John made that and it's very
9 clear in some of the stuff I've seen. Like Minnesota has
10 great outcomes, Massachusetts tend to have great outcomes.
11 Some other states don't.
12 Perhaps some of the better solutions and the
13 better communications can happen at a more local level
14 geographically where people are held accountable for the
15 care at that local level. There's some examples of that.
16 There's a thing called Sparks where primary care is being
17 measured at four county levels in New England. There's an
18 organization that tries to go out and work with the
19 physicians in kind of a counseling and guidance and how to
20 set up program basis. They're all solo practitioner people.
21 But there's a geographic base that looks at how the care is
22 being delivered in that community and then tries to

1 intervene in an educational and a supportive way to improve
2 care coordination.
3 So I guess I'm trying to say how can we impose
4 really better infrastructure of the fee-for-service
5 marketplace, is what I'm getting at? I don't think the
6 individual doctor is necessarily the right accountability
7 unit because the patient does pass through multiple
8 practices sometimes and multiple sites. And it's not clear
9 the patient necessarily or even the family is the right
10 accountable unit. But there is some need for some local
11 geographic accountability to help orchestrate the
12 measurement, the reporting and the interaction and the
13 communication and the education. And that's stronger than
14 the old IPA where they all just got together to try to
15 negotiate better rates, but actually has a real incentive.
16 Maybe even it's like the old PROs but with more
17 provider education and support built into them.
18 But I think we really need to look at an
19 accountable entity that goes a little bit above the provider
20 and captures the local area's practice patterns and tries to
21 adjust those and deal with those.
22 Perhaps bonuses could be paid to a whole area in

1 that way, if they can achieve certain goals.

2 DR. NELSON: If Nick made this point, I apologize

3 because I only heard part of what you wanted to say.

4 Karen, I thought you were right on the mark when

5 you differentiate between the responsibilities that primary

6 care physicians have traditionally felt for care

7 coordination, and these other structured entities that are

8 being developed, and that involve case management and the

9 kind of a separate layer of caregivers.

10 I'd like to dilate on that point just a little

11 bit, because the disease management model clearly has a

12 place and probably saves money if it can focus on a subset

13 of patients that are heading for the rocks, either for the

14 ER or for hospitalizations. And so, the selection of

15 diabetes and congestive heart failure as those kinds of

16 vulnerable patients was very wise.

17 I think the proof of that pudding will be in those

18 projects, those demonstrations and pilots that are examining

19 this, either the group model or the disease management

20 demonstrations.

21 But there is another kind of care coordination

22 that is harder to evaluate and is more difficult to know

1 whether it's saving money although intuitively one would say
2 it has value. It's the kind of traditional care
3 coordination that comes with patients having a medical home
4 where they have someone who accepts the responsibility for
5 making sure that physicians to whom the patient is referred
6 receives the necessary information, gets the information
7 back from those referrals, coordinates the inputs that comes
8 from various other physicians who are all collaborating in
9 the care of the patient, and accepts some responsibility for
10 making sure that the patient and their family knows which
11 long-term care facility may be most suitable for them, makes
12 sure that the long-term care facility gets the information -
13 - although certainly discharge planners help with that. But
14 there needs to be somebody who goes and makes sure that it
15 gets there and is acted upon.
16 And all of those functions, which can't be
17 measured quickly in terms of decreased hospitalizations or
18 emergency department visits, nonetheless have a great deal
19 of value from the standpoint of quality care and have
20 traditionally been performed by diligent and devoted primary
21 care physicians who are willing to spend the time to do it.
22 The problem is they aren't being paid for a lot of

1 that time now. And that gets back to the point that I heard
2 Nick make, which was that among the variety of ways that we
3 can assign greater value to that and reward it appropriately
4 will be pay for performance strategies in which it's
5 measured and rewarded and can be monitored through surveys,
6 CAHPS surveys.
7 Did your doctor communicate with the surgeon that
8 he or she sent you to? And also, through some modified form
9 of retainer or capitation payment to take that into account.
10 MS. HANSEN: Let me condition my comments on the
11 fact that I spent about 25 years in integrated delivery
12 system and so some of the things that, I think, Alan you
13 just brought up and the idea of using mid-level or even
14 lower prepared individuals to do some of this care
15 coordination is about a community, whether you call it
16 geographic or an entity that's held accountable. But one of
17 the areas, Karen, that I think you mentioned about some of
18 the high risk, more chronically complex folks, are the
19 people I'm most accustomed to.
20 So it could be if, in a fee-for-service world to
21 take a look at the profile of individuals who are not only
22 having say congestive heart failure or diabetes, but the

1 whole set of comorbidities that may occur, coupled with
2 polypharmacy issues, as well as cognitive issues, if not
3 actually mental health issues. That these may be kind of
4 the profiles that are perhaps maybe what some of the disease
5 management companies are beginning to do with the matrix of
6 complexity, I guess I would call it, and seeing whether that
7 is really where the care coordination comes in.
8 Historically, in an integrated model that I've
9 been connected to, which was PACE, we didn't use the
10 physician really as the care coordinator. It really is
11 incumbent on other providers in the relationships to be able
12 to do it. In some cases, somebody who's more informal,
13 consumer-like, or somebody who's not necessarily even a
14 nurse practitioner. But it could be somebody else who
15 really understands the full picture but to make sure the
16 physician get the correct information.
17 The PACE models were evaluated by HCFA at that
18 time, and some of the Abt studies that came out that really
19 spoke to some of the cost savings to Medicare that really
20 occurred as a result of this integrated model. So that also
21 might be an old resource to take a look at relative to some
22 of the outcomes for Medicare savings.

1 MR. HACKBARTH: Others?

2 DR. MILLER: Since we haven't actually eliminated
3 all the time for this session, I wanted to just follow up on
4 two things.

5 First Arnie, I owed you a phone call on the Health
6 Outcomes of Seniors Survey. We did actually do a heavy
7 press on that to try to figure out what the issues were with
8 that, because you have asked about this a couple of times.
9 I apologize that I didn't get to you before the meeting.

10 We had these discussions with a couple of
11 different experts out in the environment and a bunch of
12 issues came up about the use of this. Here's my best shot
13 at them and I'm not expert enough to do it well.

14 There was a concern that the measures are so broad
15 and integrate so much of the population that they're hard to
16 discern any change in them. So what you're actually
17 measuring becomes a bit of an issue.

18 Just two other things because you should react to
19 all of this, that some concerns over the ability to parse
20 among populations and risk adjust across those populations,
21 so that you began to draw out meaningful changes.

22 And then I think also a third concern, which again

1 I won't articulate particularly well. The people that we
2 were talking to were saying in order to correct this beyond
3 getting the risk adjustment and the populations a little bit
4 more refined was the need to add more clinical HEDIS-type
5 measures to this in order to try and tease out what kinds of
6 changes in the quality of care that the population in
7 question was experiencing.
8 I just want you to know, Nancy, I'm going to come
9 over to you in a second and try and draw out your idea a
10 little further, so just heads up.
11 DR. MILSTEIN: If you look at the evolution of
12 performance measures in health care, it's not uncommon to
13 face these trade-offs between how clinically important a
14 measure is and how pristine it is from a validity point of
15 view. And usually related to that, how useful it is or
16 isn't to the providers actually managing the patients.
17 Typically, there's a trade-off between the
18 clinical importance of a measure and those other two
19 desirable traits of a measure.
20 Having been part of these wars and discussions for
21 a long period of time, I think the best answer, and one I
22 would encourage this commission to consider, particularly in

1 relation to this measure, is the idea of a diverse
2 portfolio, of some measures that are methodologically
3 pristine but have such a narrow footprint in terms of
4 managing the overall patient that they don't score frankly
5 all that well on clinical meaningfulness or meaningful to
6 the customer. But also not be shy about including some
7 measures that begin to directly get at what the customer
8 cares about, which is maximum ability to function in life,
9 given what is wrong with them at the beginning of the year.
10 Even if they, at the margin, have some acknowledged
11 imperfections in their methodologic validity.
12 I'm familiar with these concerns that
13 methodologists have about the Health Outcomes Survey, or
14 previously known as the Health of Seniors Survey. I think
15 the good news is there are ways of getting around it. And
16 particularly if we're talking about the subset of the
17 Medicare population that's sick enough to warrant care
18 management. For them, the expected deterioration in two-
19 year health status scores is substantial and completely
20 addresses this problems of well, there's not enough speed of
21 deterioration to detect differences between plans. That
22 certainly would not be the case for the sicker quintile of a

1 senior risk population where unfortunately the expected rate
2 of decline of health status over a two-year period is quite
3 large. Therefore, the ability to detect differences between
4 plans or between physician organizations would be much more
5 easy.

6 DR. MILLER: So sort of measuring off of an
7 expected trajectory.

8 DR. MILSTEIN: That's how Health of Seniors works.
9 If we do agree to go ahead and at least mobilize it for the
10 Commission to be able to look at, one of the things I would
11 like us to be sure to do is, in the original Health of
12 Seniors measure, the Medicare Advantage plans were
13 benchmarked on this measure against the Medicare fee-for-
14 service plan.

15 I'd like that commissioners have the benefit of
16 seeing what percentage of the plans actually beat Medicare
17 fee-for-service on this measure of ability to sustain
18 beneficiary health status, and what percentage fell short.
19 I think it will be favorable toward the plans, but let the
20 chips fall.

21 MR. HACKBARTH: Although in that context, you are
22 measuring broad populations, some of whom are very sick and

1 some of whom aren't sick at all. Isn't that the situation
2 where it would be most difficult to discern differences in
3 performance?
4 DR. MILSTEIN: Absolutely.
5 DR. MILLER: Just the other thing, Nancy. I feel
6 like a couple of times now you've moved towards an idea of
7 talking about something for an entity, for a geographic area
8 in a couple of our conversations. Once again, you went down
9 that road again.
10 I'm just wondering, if you want to, you don't have
11 to but I asked so it will be awkward if you don't. Do you
12 want to talk a little bit more about what you're thinking is
13 there?
14 Because this time it sounded to me -- I'm trying
15 to just get it. This time it sounded to me like well, maybe
16 there's an entity that -- and you used the old PRO as an
17 example -- but say an entity like that that's looking at
18 information, say different types of measures, looking at
19 different practice patterns, and then working with providers
20 to try and -- you know, you can improve your coordination
21 this or that way.
22 But then also towards the end of your comments, it

1 might have sounded like there might have been a little money
2 involved. I'm wondering if maybe you want to talk about
3 that?
4 MR. HACKBARTH: Can I just come back on that
5 question? It would be helpful to me if you could
6 distinguish what you're thinking about from say the disease
7 management demo, whatever it's called now. What's the
8 latest name?
9 MS. MILGATE: The latest is Medicare Health
10 Support.
11 MR. HACKBARTH: Medicare Health Support demo
12 where, as I understand it, you have a competitive bidding
13 for private entity. But once you have that private entity,
14 it's got exclusivity for a particular population of people.
15 So you don't have competing companies in the same
16 marketplace.
17 DR. KANE: I'm not sure I know that much about the
18 disease management competition but to me that would probably
19 be a select group of people who have advanced chronic
20 disease and hit risk assessment to the point where someone
21 wants to intervene in that last trajectory.
22 Whereas what I have in mind is for healthier

1 elders and healthier people in general and trying to keep
2 them healthy through either preventive screenings or quick
3 follow up before the diabetes or the hypertension turns into
4 renal failure.
5 There's a couple of models out there. And I guess
6 that's what I'm talking off it without knowing exactly how
7 to say it, because there are models that are in specific
8 context. But people would be quick to dismiss it because
9 they would say that context is not us. But in fact, there
10 are pieces of every model we could use in the fee-for-
11 service sector.
12 To be honest, the VA is the first model I had in
13 mind who, to do their transformation, organized themselves
14 into geographic regions called Veterans Integrated Service
15 Networks and started capitation on the basis, they were paid
16 on a decapitation basis but they had to hit a bunch of
17 targets around quality and cost of care. And in so
18 focusing, were able to achieve amazing things through
19 persuasion as well as a resource cap.
20 So obviously, there's other things going on there.
21 There's politics, there's all kinds of things going on
22 there. But it showed the amazing power of a geographically

1 focused entity with measures with limited power really other
2 than a budget, but limited power, but incredible amounts of
3 data and support so that they could actually go out and
4 persuade people to improve these measures.
5 So that's the VA. I sent you that case, and I
6 have more cases at a finer level if you'd like to see them.
7 The other example I have is this thing one of my
8 alums runs, which is a primary care and preventive screening
9 monitoring at a four-county level where they collect data, I
10 think from the physicians. They collect data from the
11 physician's office. Actually, I think they do it manually
12 and they're looking forward to having some electronic
13 medical records.
14 But in order to measure and then go back and
15 support physician and primary care practices, because those
16 doctors don't know what's going on either. That nice doctor
17 who knows all those things and monitors all of that, frankly
18 they don't have that kind of information flowing in and out
19 of their offices that easily.
20 This integrating organization integrates the
21 information and then goes back and tries to work with the
22 practices on what they can do either with nurse

1 practitioners or with whatever resources are out there and
2 tries to support them in managing the care of their patients
3 like good primary care doctors should but can't for a
4 variety of reasons, because a solo practice doesn't have the
5 information or the resources to really do what you described
6 as being good primary care doctor practice.

7 The way I'm thinking about payment there would be
8 there would be some kind of geographic payment bonus paid
9 when your whole area improves measurably in its coordination
10 and receiving the proper services, the proper prevention,
11 the proper care of hypertension, et cetera. Perhaps the
12 whole area would gain, everybody who had agreed to be in
13 part of this cooperative network of care improvement.

14 But I do think it needs to be geographically
15 concentrated because I think practice patterns are very
16 unique to specific geographies and I think that's part of
17 part of it. Minnesota doesn't really need much of this
18 because they score highest on everything, because of their
19 large group practices. But a lot of you geographies don't
20 have that. So you're trying to create an infrastructure
21 that puts those pieces into place without being unrealistic
22 in making all of these doctors join group practices because

1 frankly, they're not going to do it, at least not in the
2 short term.
3 Does that help?
4 DR. MILLER: [off microphone] I knew there was
5 more to it and I wanted to give you a shot to add to it.
6 DR. CROSSON: Just to point out that I think what
7 Nancy was describing there at the end is not very far off
8 from what we talked about last year, when we were talking
9 about using the update as an incentive. One of the options
10 that was presented was the idea of geographic. We discussed
11 small geography, and that could almost be a hospital and its
12 medical staff, and larger geographies but much smaller than
13 the entire country.
14 MS. MILGATE: Can I make one comment just about
15 this whole discussion?
16 I just wanted to say, in the interviews we have
17 heard a lot about the right number of people, beneficiaries,
18 you would need to have a sufficient number to sort of have
19 the economies of scale of hiring the appropriate care
20 managers, of having the information system. And both in
21 terms of a group practice saying this is kind of what
22 percentage of our overall population we actually identified

1 as needing these higher-level services, but also talking
2 about well, what about the individual physician out there
3 who may not have that number of patients and may not have as
4 much of the resources to actually manage their patients?
5 There have been a variety of strategies that have
6 been shared with us about how some external organization
7 that may be less or more formal would actually support the
8 physician in a smaller practice. And really talked about it
9 in terms of what we're trying to do is create population
10 based management but in a fee-for-service program
11 I'm hoping that this will help us explore that at
12 least under the construct of how could you encourage groups
13 of providers to form, with the definition of groups not
14 being necessarily a formally affiliated group practice but
15 perhaps you create some reasons for them to talk and
16 collaborate and put together some resources for this goal.
17 MR. HACKBARTH: You can imagine there's a
18 continuum of paths that you can go down, one obviously being
19 the capitated health system, Medicare Advantage, here's a
20 lump sum of dollars and you take the responsibility.
21 A second now within the context of fee-for-service
22 Medicare, which I think most importantly means continued

1 free choice for the beneficiary. They're not locked into a
2 system. You can, as John was suggesting earlier, use
3 various analytic techniques to define de facto delivery
4 systems that provide all or a very high percentage of the
5 care for a given pool of patients and reward them for their
6 performance on quality and cost.
7 The medical group demo would be an example of
8 that. The beneficiaries retain their freedom of choice but
9 they're in a system for most of their care and if the system
10 does well, the system is rewarded for that performance.
11 The third path being for people that aren't in any
12 sort of either real or de facto system, maybe because of the
13 configuration of the local community delivery system, you
14 could have an overlay, another party that is charged with
15 the responsibility of providing certain support services and
16 rewarded for its performance in doing that, and the
17 providers are rewarded.
18 I think it would be useful for us at some point to
19 sort of flesh out that continuum and what the pros and cons
20 are. It's a variation, as Jay said, of what we did after a
21 fashion in talking about SGR alternatives and options. But
22 we keep coming back to that. We did it at a very high

1 conceptual level, but it seems like we keep coming back to
2 it. And I think we need to maybe invest the time to go
3 through those more systematically and see if they point in a
4 constructive direction.
5 Do we have other comments on this topic?
6 Okay, thank you, Karen. Good job.
7 Next we're going to do back to back two mandated
8 reports. This, I think, is our last discussion on home
9 health agency case mix report which is due to Congress when,
10 Sharon?
11 MS. CHENG: December 8.
12 MR. HACKBARTH: So this is a brief discussion or
13 wind up. And then following that we will have a report on
14 the oncology site visit.
15 So home health, Sharon?
16 MS. CHENG: This is my final presentation on the
17 report that I introduced to you at last month's meeting on
18 the relationship between home health agency case mix and
19 their financial performance. I'm going to take a couple of
20 minutes of your time this afternoon to report to you the
21 results of a trend that you requested last month and to
22 touch base with you on the conclusions of the report.

1 In the MMA MedPAC was asked to look at the
2 relationship between case mix and financial performance and
3 find out whether or not there were systematic differences.
4 The role of the case mix adjuster in the PPS is to
5 predict differences in costs and then align the payments to
6 the costs. So ideally, an agency's average case mix score
7 would reflect the relative costliness of their case load and
8 would thus have no relationship with margins, all other
9 things being equal. If the case mix is not accurately
10 aligned with costs, then the PPS may underpay some agencies
11 underpay others, and thus would create the relationship. So
12 when we built this model, I suppose we were hoping that we
13 would not find a relationship.
14 Overall, the model predicted very little of the
15 variation in financial performance among home health
16 agencies. Though we might have hoped to find no
17 relationship, we found a statistically significant though
18 very small parameter estimate on the case mix variable in
19 the model. In this model we used a log of the payment-to-
20 cost ratio and of log of the case mix. So the way to
21 interpret that number is if you had two agencies and there
22 was a 1 percent difference in the ratio of payments to cost

1 for those agencies, there would be 0.2 of a difference in
2 their case mix
3 You'll recall that the scatter plot of data that
4 lies behind this model formed a somewhat amorphous cloud
5 that we were looking at. Our model did not penetrate that
6 cloud particularly well.
7 So you asked us, after looking at that cloud, to
8 trim some of the agencies that had the more extreme values
9 and rerun the model and see what happened. And so the
10 right-hand column there gives you the results of that trim.
11 We excluded 10 percent of agencies, the highest 5 percent
12 and the lowest 5 percent.
13 The appearance of several very small changes
14 suggests to me that it didn't make much difference. And the
15 statistical significance of the relationship between case
16 mix and financial performance does persist.
17 I think what you can take from this is that we
18 still have a very small weak relationship within a pretty
19 weak model.
20 So in our response to Congress's question, the two
21 models of financial performance that we have presented and
22 discussed suggest we really don't know what predicts the

1 differences in financial performance among home health
2 agencies.
3 Case mix statistically significant but small
4 relationship within a set of relationships that are weak
5 suggest that policymakers should neither make too much of
6 this relationship nor should they dismiss it.
7 So the conclusion of the report that I want to
8 touch base with you on would be that the findings suggest
9 that the case mix system could probably work a little
10 better. We shouldn't ignore this evidence and we should
11 continue to examine the system that Medicare is using to pay
12 for these services.
13 Since our last meeting we have heard from the
14 industry a little bit on our findings and the home health
15 industry has suggested that if we found a relationship
16 between case mix and financial performance that a full
17 update to their market basket would be in order. There is
18 lots of variation and we have noted in the past that there's
19 lots of variation among the financial performance of home
20 health agencies within the Medicare program.
21 However, raising the base payment would provide
22 additional surpluses to agencies that are already relatively

1 advantaged by the system. And the effect of raising the
2 base payment would have no effect on closing whatever
3 variation there is among the agencies.
4 We do need to continue our examination of this
5 PPS. We've noted in several past reports that the change in
6 incentives facing home health agencies between the time the
7 case mix system was developed and the time that we're
8 running this payment system now have probably changed the
9 relationships between costs and payments within this system.
10 And also, last year our examination of the average
11 number of minutes of care per episode within each case mix
12 group found indications that the system also probably needs
13 some refinement. In that work, we found far more variation
14 in the number of minutes within episodes than you would
15 expect if the case mix grouper accurately predicting costs.
16 What we'd like to do in future work after we close
17 up this report would be to move from this agency level look
18 at financial performance and case mix and try to get down
19 into the episode level relationships that are below it.
20 The mailing materials that you had this month were
21 essentially a draft of the report. I'd like to take your
22 input now on that report. You also have a form in front of

1 you if you'd like to see another version of that before we
2 send that out.
3 Right now we're looking for the green light and
4 also your discussion on either of these points.
5 DR. MILLER: One thing, Glenn asked me to clarify
6 this. I think this is really more for the public. I think
7 the Commission has been through this twice now, and so they
8 get it. So I'm going to say this just slightly differently.
9 The punchline here is that you would expect no
10 relationship between the case mix and the financial
11 performance. Case mix should increase payments on the basis
12 of the complexity of the patient. But the financial
13 performance of an agency might be driven by other factors,
14 competition in the area, the management of the agency, the
15 type of thing.
16 So when we went in and estimated this model, we
17 expected -- and this is based on the literature and just
18 kind of theory -- we expected the relationship not to be
19 present.
20 What we found first is that the model doesn't
21 explain financial performance very well, which is not a
22 surprise to us. But two, and this is Sharon's key point,

1 the case mix measure did not wash out. It wasn't
2 insignificant. It was statistically significant but the
3 effect was small.
4 And that's what leads us to the conclusion of this
5 and some other work that we've done suggests that it's
6 probably time to look at the calibration of this system
7 since it's been in the field now for five years.
8 DR. KANE: I guess I was particularly disturbed
9 about the quality of the cost of data. I think you kind of
10 have a garbage-in garbage-out problem to begin with. You've
11 eliminated a lot of your hospital -- you have your agencies
12 because the cost data looks like garbage from eyeing it.
13 And who knows what else is garbage?
14 I have two problems with that. One is that you
15 don't make any recommendation. I'm wondering if we
16 shouldn't try to make a recommendation about getting -- if
17 you're going to use this cost data at all or have it
18 reported, perhaps upgrade the quality of it somehow.
19 And also, if you are going to update, try to
20 update this case mix system and look at recent cost to
21 reflect more recent incentives, don't you think you still
22 need better cost data to do that?

1 Because right now you threw out almost a third of
2 the sample because the cost data was bad, which suggests --
3 and also the hospital based cost data sounds like you don't
4 have much confidence in it either.
5 So I'm wondering from an industry that had been
6 cost-based reimbursed up until 2000, how the cost data
7 deteriorated so rapidly, or whether all along it just
8 garbage. And then maybe what would we recommend if you're
9 going to continue to update the case mix and use the cost
10 data to help update it, what would we recommend to make it
11 not garbage-in?
12 MS. CHENG: Remember that not only did we change
13 from being cost reimbursed but we also changed very much the
14 product that was going on. You had changes in other payers.
15 What I heard a lot from the industry was that they
16 weren't going to be paid on the basis of this cost report
17 anymore, and to do it right under the new system would be a
18 real Cadillac accounting exercise. And so if it doesn't
19 impact your reimbursement, then you're not necessarily going
20 to make the investment to change to keep up with the new
21 payment system.
22 We have, in the past, made recommendations about

1 the cost reports and we floated a couple of ideas about
2 improving the data that's there.
3 I would say on the whole, and I tried to make this
4 distinction as I was looking at this work, building a model
5 like this, you want to be confident in the data from agency
6 to agency. I think that there were some issues there.
7 But if you back up, if you want to look at the
8 industry as a whole, then accounting practices from one
9 agency to the other aren't as important. And I think we can
10 still use this to get a picture of the industry as a whole
11 using the cost data that we have.
12 DR. KANE: Aren't the cost -- aren't the weights
13 for the case mix index ultimately -- originally, they were
14 tied back to some kind of cost differential. Ultimately, if
15 you're going to update it, you're going to need cost data to
16 update it, the way you do in the hospital PPS? And if
17 that's so, don't you need to have cost data believe it?
18 DR. MILLER: Sharon, the original weights, did
19 they come from the cost reports or they came from some
20 research that was done? The original cost weights?
21 MS. CHENG: Both. They took a sub-sample of the
22 cost reports and they put them through a super audit. So

1 they took 10 percent of the cost reports and they put them
2 through a specially audited system. And then they also used
3 some direct time and motion type studies rather than relying
4 on what I've got, which is just 15 minute increments. They
5 had people in there watching how long did the aide remain in
6 the home, how long did the nurse remain in the home. And
7 they also had information about what were those people
8 doing.

9 At the claims level, I've got information about
10 how long they were there but I don't know whether it was
11 teaching, did they change a wound dressing, did they do an
12 exercise? And so they had more granular data than is
13 currently in the claims stream.

14 What I'd like to try though would be to take the
15 information that I've got and see how close I can get to
16 some of those original observations and see if I can make
17 something out of it. It's a direction that I want to go. I
18 don't want to stop where I am now. But certainly concerns
19 about the data might slow us down.

20 DR. MILLER: I knew I had heard this story before
21 and I knew that we had had this conversation about where
22 this came from, because we had talked about some of this as

1 we were working through the report itself.

2 I mean something that we can do if you wanted to -

3 - and as Sharon has said, we have pointed these problems out

4 before. If you wanted to do something in the conclusions of

5 the report, because I knew part of this story was an audit.

6 Because that is one strategy you could take from the

7 existing cost reports is to say all right, for the next

8 generation of weights that we're going to do is we're going

9 to grind some sample of these things through an audit and

10 try and use that as the basis. Although, as Sharon pointed

11 out, there was also some additional information that went

12 into that.

13 Certainly, in writing up the conclusions to the

14 report, I don't want to conclude that without a broader

15 discussion, but we could include that in sort of our summary

16 and our conclusions at the end of the report, stop something

17 short of a voted-on recommendation, given where we are in

18 the process and all of that, but certainly make those

19 points. It's certainly in the spirit of things that we have

20 said about this issue in the past. It wouldn't be some great

21 deviation from where the Commission has been. If that would

22 get at some of your concerns, which are legitimate.

1 DR. SCANLON: Which is more important, the cost
2 report or the data on the patient and the services that they
3 received, in terms of trying to calibrate the episode
4 weights? While both are important, actually the cost
5 report, in some respects, is to get us to a price per
6 minute.
7 In terms of these relative weights, the more
8 important key actually may be the more detailed kind of
9 information that you don't have from the reports that are
10 coming in now on claims. That's a bigger effort, to collect
11 that kind of information because that was, in the past, a
12 special study. It would be something to recommend doing
13 that, it would involve more than to say that CMS should be
14 more concerned about what cost reports were submitted on a
15 routine basis.
16 MS. CHENG: In the course of doing this work, one
17 of the things that we did put together was to take all of
18 the agencies' cost reports that we have, look into their
19 claims files, build a claims file for each agency, and then
20 look at data to the detail of, on the episode level, what
21 kind of visits did they get? And then we could go into how
22 long were those visits? And we got a set of costs at the

1 episode level from that.

2 What we could do to check to see how much sense

3 that makes would be to see after building costs up like

4 that, how close do we get to the information that we started

5 off with after we decompose it.

6 So I think we could take a couple of statistical

7 stabs to get a sense of if we use the 15 minute increments

8 on the claims will we be off by a large amount? Would we be

9 close enough that we could start to look at these episode

10 levels? That's the statistical approach that I'd like to

11 try.

12 MR. HACKBARTH: As to adding this to this report,

13 this report is pretty narrowly crafted. As I recall it, we

14 were asked a specific question, we did an analysis. We will

15 be coming back to the issue about how to improve the case

16 mix system where all of these issues about having the

17 appropriate data are quite relevant. I don't think we need

18 to do much to change this report but rather bring those

19 issues up at the next step.

20 MS. CHENG: If we wanted to make a comment on the

21 cost report, that might also be something as we start the

22 payment adequacy work here that we could talk about. And

1 that starts for this sector next month.

2 MR. DeBUSK: Sharon, in preparing this report did

3 you get a pretty good feel for the OASIS assessment system

4 as to how it performed?

5 MS. CHENG: We did reach for some of that data

6 because one of the things that we heard was as we built this

7 model we wanted to look at the characteristics of the

8 agency. Some of the characteristics wouldn't be up at the

9 agency level but they would be descriptions of the case

10 load. So we used OASIS information to learn a little bit

11 more about how many patients had informal caregivers, about

12 their management of oral medications, and some other

13 indications of how complex they were, and then a sense of

14 how many ADL limitations.

15 So we did start working with that OASIS data. And

16 it was interesting. It was pretty readily available to use

17 in this kind of analysis. So I think we'll be able to turn

18 to that data source again.

19 DR. STOWERS: I have just of a broader question.

20 The way I remember this coming off the Hill as a

21 recommendation to us was the debate about the distribution

22 of payments and the profit margins or whatever, which was a

1 difference between those taking care of the post-surgical
2 hips and that kind of thing with a lot of physical therapy
3 versus those that are in the field taking care of the
4 chronically ill, multi-diagnosis, more on a medical level,
5 having the very low profit margins. And should there be a
6 redistribution.

7 Are we getting to that in this report? Do you
8 think it does? Because I know that's what Congress was
9 asking.

10 MR. HACKBARTH: That is. In fact, independently
11 we've raised that in our own records, as you're saying. So
12 that was the motivation for this.

13 Basically our report says this is just another
14 piece of evidence that suggests that there may well be some
15 distributive problems within the home health system and it's
16 time to take a look at it.

17 So we think this analysis reinforces the concerns
18 that we've talked about and we will be making further
19 recommendations to refine the payment system.

20 DR. MILLER: The reason we're going at it like
21 that is I think we've been sort of slowly accumulating
22 evidence that suggests that it's out of balance. And this

1 statistical result, one way you could explain it is at the
2 upper end of the HHRGs, the units that the home health uses,
3 that those represented the greatest opportunity for profit.
4 You crank the visits down, you had the greatest amount --
5 that could be one thing that explains it.
6 But I think seeing this, we now have to step back
7 and try and figure out a little more precisely, HHRG by
8 HHRG, to some of what Bill is talking about over here to try
9 and figure out okay, so what would we recommend happen here
10 inside the system? And how should the redistribution work?
11 And there may also be other -- I don't mean to say it that
12 way -- bells and whistles, but adjustments in the system
13 that Sharon has been thinking about.
14 MR. HACKBARTH: As Sharon indicated in her
15 presentation, people in the industry say well, you're saying
16 the system is not functioning well in terms of allocating
17 the payments. Therefore there ought to be a full update for
18 home health. That's something we can talk about at greater
19 length in the adequacy analysis for home health as we take
20 that up later on. That's not an issue that's implicated by
21 this particular report.
22 DR. KANE: There's a survey in here about

1 beneficiaries, and I'm not sure you can conclude that
2 beneficiaries have no access problems because what if the
3 big problem -- it's not adjusted for their case mix? So
4 unless you can do that in some way. I'm not sure the 10
5 percent or 11 percent who said they had a big problem and
6 the 12 percent who had a small problem, are they any
7 different case mix-wise than the ones that said they had no
8 problem?
9 In other words, you've got this in here as though
10 that's a uniform -- 77 percent have no problem. But we
11 don't know if -- that's not case mix adjusted.
12 MR. HACKBARTH: I think what we've said is our
13 hunch would be that yes, there are systematic differences.
14 It's not a random 11 percent that's having problems. It's a
15 particular type of patient. And that's one of the reasons
16 why it's urgent that we get the payment system more accurate
17 than it is right now.
18 DR. KANE: But it doesn't say that in the report.
19 DR. REISCHAUER: [off microphone] Is that a
20 hypothesis or do we know?
21 MR. HACKBARTH: What, that it's not a random
22 sample? It's simply a hypothesis, it may be an informed one

1 but still a hypothesis.

2 [Laughter.]

3 DR. MILLER: But I think to address both these
4 sets of comments, we can certainly put a few more words in
5 there that says of course, there could be a couple of things
6 driving this result. And we can make sure that that's
7 clear.

8 DR. SCANLON: I would want to add geography to
9 that. If you're 75 miles from the closest large town, there
10 may be an issue of getting home health care.

11 DR. MILLER: But on that one, for just a second,
12 I'm about to step out here into something I don't know,
13 Sharon, so be sure to catch me. We have looked at the
14 geographic access in our adequacy analysis and we don't
15 think that that's a huge -- you should pick up the rest of
16 the words here.

17 MS. CHENG: In fact, we did find that
18 beneficiaries in rural areas reported better access then
19 beneficiaries in urban areas areas. So that tends to
20 suggest that it's not distance.

21 We also in the past, and I'll bring you some more
22 information as we start payment adequacy again, we looked at

1 every zip code in the United States to find out whether we
2 could find a pattern in zip codes that weren't being served
3 by home health agencies. And when we did that we found that
4 nearly 99 percent of the zip codes in the United States had
5 been served by a home health agency.
6 So we did not find evidence there, at least, that
7 there were geographic access problems.
8 MS. DePARLE: Just to clarify, Dave and I were
9 talking about this.
10 When you say we've talked to beneficiaries, do you
11 really mean home health beneficiaries? I know we did the
12 work with hospital discharge planners around whether they
13 had difficulty getting placements with home health agencies.
14 But the type of beneficiary, in general, who would be placed
15 in home health, I guess I would have some skepticism about
16 their ability to report to us on access and that kind of
17 thing.
18 MS. CHENG: The CAHPS survey is conducted by CMS.
19 It's got between 100,000 and 200,000 beneficiaries in it.
20 They are all asked did you have a need for home health in
21 the past year? And then of those that indicated that they
22 had a need, then they were asked did you experience a

1 problem in acquiring it?

2 And so that's a beneficiary report of whether or
3 not those that identified themselves as having a need had a
4 problem getting the service.

5 MS. DePARLE: I don't know if we've done this
6 recently but we did a couple of years ago look at try to get
7 to the question of whether there was difficulty from a
8 clinical standpoint in getting placement. Because the
9 beneficiary's view of whether they needed it might be quite
10 different than a clinician's view of whether A, they need
11 it; or B, they were eligible for it under the law.

12 But the data is all consistent; right? The
13 hospital discharge planners also reported they didn't have
14 difficulty placing, except in some few instances as I
15 recall.

16 MR. HACKBARTH: Which is part of the evidence that
17 Dr. Reischauer was making fun of a few minutes ago.

18 Any others?

19 Okay. Thank you.

20 Next is the oncology site visits.

21 DR. SOKOLOVSKY: Although Medicare has covered
22 only a limited number of outpatient drugs under Part B, many

1 of those drugs are used to treat life-threatening
2 conditions, particularly cancer.
3 Medicare's payment for these drugs had been
4 increasingly rapidly, more than doubling from the year 2000
5 to 2003, to over $10 billion, which equals about 4 percent
6 of all Medicare spending.
7 As many studies showed, Medicare was paying
8 physicians at rates well above the acquisition costs for
9 these drugs, but paying less than the costs involved in
10 administering them.
11 The MMA changed the way Medicare pays for both the
12 drugs and drug administration services in a series of
13 changes that began in 2004 and are still continuing.
14 Because of the importance of the drugs to the treatment of
15 cancer, the Congress directed MedPAC to study the effects of
16 these payment changes on patient access to chemotherapy
17 services and the quality of care that they received.
18 As a part of the Congressional study, which as you
19 recall is due on January 1st, MedPAC staff, along with
20 researchers from NORC at the University of Chicago and
21 Georgetown University, have been visiting oncology practices
22 in different parts of the country. Although the information

1 we got from the practices is by definition anecdotal, it's
2 quite consistent and very timely
3 Today I'm summarizing what we were told by
4 interviewees, particularly those in physician offices, and
5 not presenting a MedPAC analysis of the payment changes.
6 While we did not see major changes in the way
7 chemotherapy is being provided to Medicare beneficiaries,
8 this report may begin to suggest areas where you might think
9 policy recommendations would be appropriate.
10 So what did oncology practices tell us? In
11 general, we found stability in the cancer care system. All
12 oncology practices continue to treat Medicare beneficiaries,
13 patterns of care are largely the same, and no one reported
14 access problems for Medicare beneficiaries. As we saw in
15 the claims analysis for 2004, the volume of chemotherapy
16 services provided to beneficiaries continues to rise in both
17 physician offices and hospital outpatient departments. But
18 practices did find the 2005 payment changes significantly,
19 in particular the payment changes for drugs, and they have
20 made changes in response.
21 In some markets, all the practices we visited
22 continued to treat all Medicare beneficiaries. But in other

1 markets, some physicians were routinely sending
2 beneficiaries without supplemental insurance to the hospital
3 outpatient department for chemotherapy. All of the offices
4 that we visited that were sending patients to the hospital
5 had begun this practice before 2005, but the number of
6 patients transferred seem to be increasing.
7 Let me tell you a little bit about these site
8 visits. As I mentioned last month, in 2004 we went to five
9 sites including both states and metropolitan areas. This
10 year we returned to many of the same practices and
11 interviewed others by phone. In this presentation again,
12 I'm reporting primarily what physician practices told us but
13 I'd be happy to answer any questions you might have on the
14 responses of hospitals and health plans.
15 Part of what we looked for in 2004 was to
16 understand the settings in which chemotherapy is provided.
17 More than 80 percent of chemotherapy services are provided
18 in the community setting and for Medicare that means they're
19 paid through the physician fee schedule
20 One thing we learned in 2004 was just how varied
21 the settings for chemotherapy are that are paid through the
22 system. Many of the practices we went to would be called

1 infusion centers, freestanding facilities with 20 or more
2 infusion chairs, some in private rooms, some grouped
3 together, additional examining rooms, labs. You need to
4 have a clean room for mixing the drugs, room for inventory
5 and other things. Sometimes the facility including imaging
6 equipment and affiliated radiation oncologists and was
7 called a comprehensive cancer care center. Other practices
8 could be located within a hospital in space leased by an
9 oncology group. Even smaller practices, however, that
10 provided chemotherapy still needed the infrastructure of the
11 infusion room, the protected space for mixing drugs, and the
12 inventory set up and a lab.
13 If we asked the question is there enough money in
14 the system to maintain beneficiary access to chemotherapy
15 services, our visits would indicate that the answer is yes.
16 If the answer is are we paying appropriately for
17 chemotherapy services, that's a much harder question to
18 answer, in particular because with physician practices we
19 don't have costs in the same way that we have cost reports
20 for facilities.
21 However, our site visits suggest that all
22 physician practices consider the 2005 payment faces

1 significant. And let me just remind you again of what those
2 changes were. In 2005 some payments increased while others
3 decreased. The most important change was that Medicare
4 began to pay for drugs based on 106 percent of the average
5 sales price, which in aggregate reduced physician margins on
6 drugs.

7 In 2004 CMS had increased payment drug
8 administration services and then added a transition payment
9 to those increased values. In 2005 CMS introduced 14 new
10 codes for drug administration but reduced the 2004
11 transition payment significantly.

12 CMS also added a project designed to measure the
13 effects of chemotherapy on patients. Beneficiaries are
14 asked to evaluate how chemotherapy has affected their levels
15 of fatigue, nausea, and pain. Answers to these questions
16 are coded using a four-point scale. All oncologists are
17 eligible to receive $130 per patient per day for asking
18 these questions. That's $104 in program dollars and a $26
19 copayment for beneficiaries

20 All physician practices we visited are
21 participating in this project. They all told us that this
22 additional money provided by the demonstration project

1 enabled them to maintain services to Medicare beneficiaries.
2 Just to give you a sense of the significance of
3 these payments, CMS estimated that all of the new drug
4 administration codes would increase payments by 5 percent
5 whereas the demonstration payments increase payments by
6 three times that amount, or 15 percent.
7 Hospital outpatient departments that provide
8 chemotherapy are not eligible to participate in this
9 program.
10 At the same time that we were told that these were
11 really important for maintaining services to Medicare
12 beneficiaries, most practices did not believe the projects
13 would lead to quality improvements or useful research
14 results. For example, the claim does not distinguish what
15 stage of cancer the patient has.
16 We heard from oncologists, on the other hand,
17 about other quality improvement projects that they are
18 participating in and I'd like to talk to you more about that
19 next month.
20 All oncology practices purchase their drugs
21 through group purchasing organizations but some were able to
22 negotiate better prices than others. While the majority of

1 offices reported that most drugs could be purchased at the
2 Medicare payment rate, all reported that they could not buy
3 a number of drugs at that rate and all reported that the
4 average margin on drugs was low. Practices had the best
5 margin where there was competition between name brand drugs
6 that were considered more or less clinically equivalent. In
7 those cases, competition allowed physicians to negotiate a
8 better price. They also had better margins in cases where
9 generic competitors became available during the year.
10 These findings, by the way, are consistent with
11 the recent IG report on the acquisition prices for chemo
12 drugs and I'll talk more specifically about this issue and
13 our own research on this subject next month.
14 Other issues also affected the ability of
15 practices to get drugs at the Medicare rate. Some of them
16 have to do with calculation of ASP and we can again talk
17 about that next month, but there were other local issues.
18 For example, in some areas practices paid a sales tax on
19 their drugs which came directly out of that margin.
20 Physicians' practices responded to the changes in
21 drug payment method. Practices are spending more time and
22 resources tracking drug prices and purchasing options. We

1 were frequently told that practices focused on drug prices
2 now in a way that they never had before the payment changes.
3 Practices closely monitor margins on each individual drug
4 and many practices have hired pharmacists to mix the drugs,
5 track drug prices and recommend drugs that the practices
6 might want to purchase on the basis of both price and
7 clinical effectiveness, although the final choice was always
8 the physicians'.
9 In 2004 it wasn't uncommon for us to be told that
10 the practice had, at any one time, about $1 million worth of
11 drugs in inventory on hand. This year every practice,
12 without exception, reported keeping much smaller inventories
13 of drugs. This allowed them to respond quickly to changes
14 in manufacturer prices and new Medicare payment rates. It
15 allowed them to keep less capital tied up. It allowed them
16 to pay more quickly for drug purchases which we've been told
17 is one of the most important sources of discounts under the
18 new ASP system.
19 One of the most significant changes was that many
20 practices now routinely purchase ancillary drugs on the
21 basis of price. For example, a practice would decide that
22 they were going to buy one drug to treat nausea and one drug

1 to treat anemia for all the physicians in the practice,
2 although particularly in the case of nausea, they would
3 typically keep another type of drug on hand because one drug
4 might not work for everybody.
5 We were not told of changes in chemotherapy
6 regimens based on price except that physicians were
7 sometimes hesitant to prescribe a new and expensive drug
8 that might not be governed by the local carrier.
9 Offices also made other incremental changes in the
10 way they ran their offices. Many offices reported some
11 staffing changes in 2005. There was some replacement of
12 highly paid clinical workers for other less highly paid
13 workers. For example, a practice might hire a pharmacy
14 technician to do some of the work that oncology nurses had
15 been doing mixing drugs. One practice hired workers to do
16 the coding for nurses so that the nurses could spend more of
17 their time on patient care. Many of the practices hired
18 financial counselors and their job was to work with
19 beneficiaries on estimating what their out-of-pocket
20 liability would be and seeing if they could find programs to
21 help them pay for any of the cost sharing, particularly for
22 the drugs.

1 Another change that we observed was a longer run
2 change. Some of the larger freestanding facilities, seeing
3 the payment changes coming over the past few years,
4 purchased PET scanning equipment for their offices. In 2005
5 they found that increased imaging was an additional source
6 of revenue for them.
7 Offices also reported that they were less likely
8 to appeal claims denials because of the time and resources
9 that were needed to mount an appeal and the uncertainty of
10 what the result would be. At times again, this did affect
11 the choice of treatment.
12 Recall that in 2006 Medicare is scheduled to
13 implement a Competitive Acquisition Program or CAP. Under
14 this program entities like wholesalers or specialty
15 pharmacies would compete to become designated Medicare
16 vendors for Part B drugs. At the beginning of each year a
17 physician would choose whether to continue in the same way
18 purchasing and billing for drugs or sign up to receive drugs
19 through a particular designated vendor. These vendors would
20 both purchase and dispense the drugs on the basis of
21 prescriptions written by the physician for their individual
22 Medicare patients. Medicare would pay the vendors directly

1 and the vendors would bill beneficiaries for their
2 copayments.
3 CMS has delayed implementing this program on the
4 basis of comments by both perspective vendors and
5 physicians, and right now their target is to begin the
6 program in July.
7 We found that all oncologists were aware of the
8 program and had serious concerns about the rule as written.
9 The concern we heard most often was that if a beneficiary
10 doesn't pay their copay in a timely fashion to the vendor,
11 the vendor could stop supplying the drugs. There was
12 uncertainty about what would happen to the beneficiary at
13 that point.
14 Other concerns that were raised, one was about
15 administrative burden. They felt that the burden would
16 increase. Physicians would have to write prescriptions for
17 each patient's drugs rather than now purchasing the drugs in
18 bulk on the basis of what the office was likely to need in a
19 given week or month. And there would be no payment to
20 offset this added cost.
21 Offices would also have to maintain separate
22 inventories for each patient covered under CAP. If a

1 patient couldn't receive their treatment on a given day,
2 which we were told is frequently the case, the physician
3 believed that the office would then have to mail the drug
4 back to the vendor. Offices would be tied to the vendor for
5 a year even if they were dissatisfied with the vendor's
6 performance.
7 And there were issues in rural areas where
8 chemotherapy is often provided through satellite clinics
9 that are only open about once a week. The rule says that
10 the CAP has to deliver the drugs to the place where the drug
11 is going to be used. Many of those offices don't have the
12 facilities in their satellite office to even mix the drugs
13 there and they bring it to the satellite office on the day
14 in which the beneficiaries are going to receive their care.
15 So to sum up, although no site reported that
16 beneficiaries are unable to get chemotherapy services, some
17 beneficiaries, particularly those with no supplemental
18 insurance, may have more limited choices. Some practices
19 again, at least since 2004, are sending beneficiaries
20 without supplemental insurance to the hospital. When
21 patients are sent to the hospital, if it's a community
22 hospital the physician continues to manage their care.

1 Office visits, sometimes the administration of some drugs,
2 some lab work and other services are still provided in the
3 office setting.
4 Although quality of care may be equivalent in both
5 settings, and we heard very contrasting reports about that
6 between what the physician said and what the hospital said,
7 the costs to Medicare are higher and beneficiary copays are
8 higher in the hospital.
9 In addition, treatment usually takes longer in the
10 hospital and there is some duplication of tests between what
11 has to be done in the physician's office and what has to be
12 done on the same day in the hospital.
13 I should add that now we've done two focus groups
14 of beneficiaries. And in those groups we came across two
15 patients who were shifted in the course of their treatment
16 from the physician's office to the hospital. One of them
17 spoke about the increased time and lack of care coordination
18 that she experienced, although she said she thought the
19 quality was probably equivalent. The other mentioned those
20 issues but also mentioned the increase copayments that she
21 faced.
22 A community hospital that was on the receiving end

1 of patients that are shifted to the hospital said they saw
2 more patients without supplementary insurance being shifted
3 this year although they do more than chemotherapy. They
4 also provide IV antibiotics treatment for renal patients.
5 They said that the bulk of the new cancer patients they were
6 seeing came in to get the more expensive drugs.
7 Again, I don't want to overemphasize this too much
8 because most of the offices we visited continued to treat
9 all Medicare beneficiaries.
10 So while I think that the main message of the site
11 visits is that Medicare beneficiaries continue to receive
12 chemotherapy, there are a few areas that you might want to
13 look at for possible policy options. These would include
14 policies to address the issue of beneficiaries without
15 supplemental coverage, policies that might improve the
16 working of both the ASP payment system and the CAP program,
17 policies that would allow us to collect cost data from
18 oncology offices, and policies to promote quality
19 improvement.
20 Next month I'll review some of our findings on
21 drug pricing and I'll discuss some of the quality
22 improvement projects that are currently underway in oncology

1 practices. But for now I would like your direction on
2 policy directions and also I'd be happy to answer any
3 questions.
4 MR. HACKBARTH: Our ability to discern the impact
5 of the new payment system on access is confounded by the
6 demo dollars. So we have lower payments for the drugs,
7 higher payments for administration, and then this third demo
8 piece which is quite large. Didn't the paper say 15
9 percent?
10 DR. SOKOLOVSKY: Yes.
11 MR. HACKBARTH: So what we're able to see from the
12 site visits was if you have the additional 15 percent, the
13 impact on access appears to be limited primarily to
14 beneficiaries without supplemental insurance. But we really
15 can't say much about what happens if and when the 15 percent
16 demo money disappears. Am I tracking that right?
17 DR. SOKOLOVSKY: Yes.
18 MS. DePARLE: To follow up on that, I thought
19 these findings were really interesting.
20 Is there a way to look at the hospital data? I
21 know it's lagged, but is there some way to quantify this
22 movement from the physician office to the hospital? And how

1 anecdotal it is based on your five site visits, as opposed
2 to being a more widespread phenomenon? Is there a way to do
3 that at this point?
4 DR. SOKOLOVSKY: We had the 2004 data and that
5 shows volume rising in both hospitals and physician offices,
6 but rising more quickly in physician offices. For 2005 we
7 hope to have some data on physician offices but I don't
8 think we'll have hospital data.
9 MS. DePARLE: Even so, any impact would be muted
10 probably by the additional demo payments you mentioned.
11 On the imaging, thought that was fascinating.
12 Can you give us any more color on what you were told about
13 why they installed imaging equipment?
14 DR. SOKOLOVSKY: I did, in fact, ask last year. I
15 spoke to oncologists in hospitals who I know were not
16 receiving additional revenue because of the PET scanning.
17 And I asked is this really a useful tool for you? Is it
18 needed? What do you think about it?
19 And he said well, the main purpose of the PET
20 scanning, as I understand it, is to help with the staging of
21 cancer and staging really leads to treatment. What he told
22 me was he could stage without PET scanning but it takes much

1 longer. And having it really was very helpful. So that's
2 really the only piece I can say.
3 The other thing I can say is that most practices,
4 with the exception of these really large freestanding ones,
5 essentially said this seemed like a great idea but they just
6 didn't have the room for it.
7 DR. REISCHAUER: A question, Joan, and an
8 observation. This is a very interesting presentation.
9 Do we know the rough percent of all oncology
10 services that are related to Medicare beneficiaries as
11 opposed to others?
12 DR. SOKOLOVSKY: We found on the site visits that
13 it was incredibly varied, from 60 percent to 20 percent, and
14 it does depend upon the population in the area and the
15 prevalence of different cancers.
16 DR. REISCHAUER: But we don't have a national
17 figure?
18 DR. SOKOLOVSKY: We have some for new the
19 prevalence is higher as you get older. And there's a very
20 large percentage of new cancers diagnosed each year that are
21 Medicare beneficiaries.
22 DR. REISCHAUER: We've gone in twice now and asked

1 questions of these providers and we see there are changes
2 going on. And we want to be careful to make sure that the
3 changes are related to the payment changes because change is
4 going on all the time. When you think about lower inventory
5 or substituting less skilled people from higher skilled or
6 counseling patients, I can spin out a story on why they
7 might be related to these changes. But I also can spin out
8 stories on how this was sort of the normal course of events
9 and these developments would have occurred anyway.
10 You take something like imaging with PET scans and
11 that was a new benefit, wasn't it? Didn't they expand --
12 DR. SOKOLOVSKY: The national coverage decision.
13 DR. REISCHAUER: -- the ability to do that, so
14 that it's happening shouldn't be a surprise and probably has
15 nothing to do with it.
16 DR. MILLER: I would also, though, distinguish
17 between a couple of changes, though. I think Joan, in
18 working through this with you and talking to you about
19 getting ready for this, there were very clear organizational
20 changes they were making in the office that were all about
21 tracking the changes, the prices and drugs more carefully
22 and purchasing. So maybe the PET is a little bit more gray,

1 but some of those changes --

2 DR. REISCHAUER: I think we want to do in what we

3 write is explain why this could be related.

4 MS. BURKE: Joan, it really was a very interesting

5 piece and I think will be an interesting issue to follow. I

6 have a question that I just want to make sure I understand

7 what's stated. And then I had just a couple of observations

8 of things I'd hope we'd follow-up on.

9 One, there is a statement that there was generally

10 a reported increase in volume of patients receiving

11 chemotherapy. I just want to make sure I understand that.

12 There is an actual increase in the number of patients or in

13 the number of treatments being given to patients?

14 Because the references then the use of more rounds

15 of chemotherapy and the use of new drugs. So is it the

16 volume of patients or the volume of services given to the

17 current patient load?

18 DR. SOKOLOVSKY: I believe that it's both but the

19 first round of claims data that we have is physician data

20 and that won't be able to tell us. When we get the

21 beneficiary level data, it will.

22 MS. BURKE: The reference wasn't clear to me in

1 the statement.

2 The couple of things that frankly really struck
3 me, one was in the discussion of the demonstration
4 authority, I think the point being made about the impact
5 that has in terms of masking or influencing sort of what's
6 happening in terms of access.

7 I was particularly struck by your reference that
8 most oncologists didn't believe it would lead to quality
9 improvement. And it would seem to me, setting aside the
10 question of how it impacts the access issue, that is a
11 fundamental question which is, is in fact, the demonstration
12 really going to prove any point?

13 This is the age old question if we demonstrate and
14 demonstrate, we never really get an answer out of the
15 demonstration. We just keep doing it. It seems to me that
16 is a particular issue I'd like us to continue to look at and
17 that is what really does happen? Does it, in fact, end up
18 having a real behavioral change in terms of what occurs and
19 the impact on the actual patient?

20 The other thing that struck me, a statement sort
21 of in passing in the text, was a reference to a number of --
22 in fact, the reference is specifically many practices

1 reported that they reduced health and pension benefits for
2 their employees.
3 I mean that is sort of an interesting side effect
4 if, in fact, as a result of the organizational changes
5 because of the impact -- I mean if, in fact, they're
6 tracking that specifically, that's not particularly an
7 outcome we'd want to encourage is that in order to adjust to
8 the fact they're getting less Medicare benefits that we're
9 going to cut your health and pension benefits for your
10 employees. Again, just sort of an interesting side note.
11 There can be a lot of reasons. Bob's point is
12 there could be a whole host of reasons that that's
13 happening, including the sort of general downward trend in
14 terms of -- particularly in small business with the coverage
15 availability.
16 But again, I think we need to be careful that we
17 don't either note this as a specific result of that
18 particular policy rather than the broader trend because that
19 is sort of a red flag, I think, that will be raised for a
20 host of folks.
21 But again, I think just a very interesting series
22 of questions that I think I will be very interested in, as

1 we go forward, in hearing more.

2 DR. REISCHAUER: Do we know for sure they are

3 getting less Medicare money?

4 MS. BURKE: No, we don't.

5 DR. REISCHAUER: Because we're hypothesizing that

6 that's what's causing it.

7 MS. BURKE: No.

8 MR. HACKBARTH: Just for the record, why don't you

9 address what's the aggregate level of payment now, compared

10 to what it was pre-change.

11 DR. SOKOLOVSKY: It will depend very much on what

12 happens to volume at the end of the year. I guess as we

13 have the 2005 data, we'll have a better handle on that. But

14 I don't think there's any doubt that the money that they're

15 getting for drugs is very much lower.

16 MS. BURKE: [off microphone] But combined with

17 the demo and everything else.

18 DR. REISCHAUER: Along those lines, it would be

19 interesting to know what has happened to beneficiary cost

20 sharing in the aggregate now versus before.

21 DR. SOKOLOVSKY: And that again would be very

22 difficult because the presence of these incredibly expensive

1 drugs that keep rising to the top. When you have a drug
2 that's $12,000 every two weeks and that wasn't even on the
3 market a year ago and now is really important, beneficiary
4 cost sharing is bound to be increased.
5 MR. HACKBARTH: Joan, could you just go back to
6 the previous question about the aggregate level of payment?
7 When you sum up the change in how we pay for drugs, the
8 increased payments for administration plus, at least
9 temporarily, the demo money, how does the aggregate level of
10 payment compare?
11 DR. SOKOLOVSKY: CMS's projection was that it
12 would go down except that it won't go down if volume
13 increases at historical levels. If volume and usage stayed
14 the same the number would go down.
15 DR. MILLER: Is that with --
16 DR. SOKOLOVSKY: With the demonstration payments.
17 But they project that, in fact, it will go up about 8
18 percent because they believe that volume will increase.
19 MR. HACKBARTH: How did they calculate the amount
20 of the demo payment? I'm just guessing that it was to hold
21 the level of payment constant if the historical rate of
22 growth continued. Am I being too cynical?

1 DR. SOKOLOVSKY: This is information that nobody
2 will share with me. I can't answer that.
3 [Laughter.]
4 DR. REISCHAUER: It would be the OMB requirement
5 sort of, so to play the game they'd have to do that.
6 MS. BURKE: Following up on the demo, what
7 percentage of physicians and patients are, in fact,
8 participating in the demonstration?
9 DR. SOKOLOVSKY: All of them.
10 MS. BURKE: So we know, in fat, that everybody is.
11 So they're all getting the $130 per patient.
12 DR. SOKOLOVSKY: Yes.
13 MS. BURKE: Per treatment. So again, I think
14 watching the volume, whether it's the number of treatments
15 or the number of patients, will also mean -- you know, what
16 volume indicator is moving will be interesting to watch.
17 DR. SOKOLOVSKY: We should have that number. We
18 will get that by code so we will be able to, in fact, figure
19 that out.
20 MR. BERTKO: Quick question for you on the
21 previous slide at the top. I understand the cost sharing
22 about those without supplemental insurance. I'm maybe just

1 not clear on why dual eligibles would be worrisome also
2 about cost sharing?
3 DR. SOKOLOVSKY: To give you one example, one of
4 the sites that we want to this time -- remember that for
5 dual eligibles, Medicaid does not have to pay the full 20
6 percent if their payment in full is below the 80 percent
7 that Medicare pays. We had one state where just this year
8 they reduced their 20 percent so that they now pay I believe
9 it's 16 percent of the 20 percent.
10 So that one physician was telling me she was
11 getting checks for 57 cents. Yes, 16 percent of the 20
12 percent. Again, that's very varied by state.
13 DR. SCANLON: I think we've been talking about the
14 right question. It's not really what's a sufficient amount
15 to maintain access but what's a necessary amount to maintain
16 access. I guess I'm hoping that next month, when we have
17 some more of this information from this IG acquisition price
18 study, that we can factor that in in terms of what's the
19 profit that's still available under ASP plus 6 percent.
20 Because my sense is that oncologists are major
21 purchasers of these drugs. If manufactures are reporting
22 adverse sales price, there's many oncologists that are going

1 to be able to get drugs at something close to average sales
2 price. I don't quite understand what the market is like if
3 they're not able to.
4 I was curious about when you said that they're not
5 able to buy some at ASP plus 6 percent. Because I'm
6 wondering what kinds of drugs you can't buy, if you're an
7 oncology practice, at that price?
8 DR. SOKOLOVSKY: I'm very excited to talk about
9 this but I probably shouldn't. I could talk about this part
10 for a day.
11 DR. SCANLON: I think this is part of the issue.
12 In terms of the demo, if we need a sufficient
13 amount of money to maintain access, I think one of the
14 principles we should have is that you pay for the service.
15 You don't try to put together some strange set of
16 circumstances where you end up, on average, it working out.
17 This was the principle that was behind the AWP reform, was
18 we shouldn't be overpaying for the drugs when we weren't
19 paying right for the service.
20 So going back and figuring those things out
21 correctly. I think, should be one of the things that is an
22 outcome here.

1 It's not only the issue of what's the price for
2 the demo, the $130 and where that came from, but what's the
3 design in terms of why would there be an effect? The
4 questions are asked but what's the follow-up, in terms of
5 saying okay, we're going to have an intervention?
6 The last thing I'd like to comment on, which you
7 mentioned that you got this response from some of the
8 practices which was disturbing, was that they said that when
9 the Medicare prices change, the choice of drugs can change.
10 When we were doing the AWP work, the oncologists
11 all said that the margins on drugs didn't matter in terms of
12 treatment choices. I think this is something that I hope
13 that wasn't too prevalent for them to say that because it's
14 not good news to hear something like that.
15 DR. SOKOLOVSKY: Could I clarify that a little
16 bit? They were very good that this was again not for the
17 chemotherapy drugs. These were for the drugs to treat
18 nausea, to treat anemia, the drugs around the chemotherapy
19 drugs. They all said that it did not affect the
20 chemotherapy regimen.
21 DR. SCANLON: Okay.
22 DR. MILLER: We are planning to come back

1 specifically, and I'm looking at Joan to not get too far out
2 in front here, to give you different ideas to think about if
3 you want to do something about quality and tie payment of
4 quality, something that's more rational. We are going to do
5 that right; Joan?
6 DR. SOKOLOVSKY: Yes, we are. And I guess there
7 are two things I'd like to say about that. One is that the
8 specialty societies are, in fact, talking not only to us but
9 also talking to CMS about ways in which there could be more
10 significant ways of rewarding them for quality or for
11 providing quality data.
12 The other thing that I wanted to say about that
13 was, just to be fair, there were some practices who said
14 when CMS released the aggregate findings on the percentage
15 of patients who had felt their nausea wasn't controlled and
16 so on, they used that to benchmark their own practices --
17 these were the ones that had electronic health records --
18 and reported that back to their physicians and actually
19 discussed, is there anything that we can do about that.
20 DR. SCANLON: But that was voluntary; right?
21 DR. SOKOLOVSKY: Yes.
22 DR. MILSTEIN: I think Joan and the staff have

1 done a valiant job of trying to extract meaning from a
2 fundamentally ill-designed demonstration. Bob has made a
3 number of comments that this could be interpreted a million
4 different ways.
5 I wonder if this is the opportunity, in terms of
6 thinking about the next time we have a discussion about a
7 Medicare demonstration project and trying to extract meaning
8 from this, maybe this is an opportunity for us to point out
9 the flaw in the process. I'm thinking specifically about
10 whether or not we might want to use this as an occasion to
11 consider recommending as part of this report the generic
12 principle of a set of evaluation design standards and
13 dashboard domains that ought to be routinized in any CMS
14 demo that Congress authorizes if they are to enable so-
15 called evidence based policy making.
16 Because this could not be a better illustration of
17 how fundamental flaws in demonstration design lead to an
18 inability on our part or anybody else's part to meaningfully
19 understand what did this do quality? What did this do to
20 overall efficiency? What did this do to patient
21 satisfaction?
22 The underlying design of the evaluation does not

1 enable a meaningful interpretation of whether or not the
2 needles moved in which direction.
3 MR. HACKBARTH: There's one piece of this that is
4 the demonstration and that's the additional $130 per
5 treatment. That was actually not mentioned in the
6 legislation. That was something that CMS did on its own.
7 Congress legislated the changes and the payments for drugs
8 and the payments for administration.
9 And I think -- and correct me if I don't have this
10 right, Joan. But I think what happened was as the
11 implementation came near, CMS was concerned that there would
12 be an effect on access and they came up with this
13 demonstration as a way to basically hold the system harmless
14 more or less. It's characterized as a demonstration but it
15 was not organized as a demonstration in a meaningful sense
16 of the term. You're absolutely right about that.
17 Is that a fair statement?
18 DR. SOKOLOVSKY: Absolutely right. And it wasn't
19 in the proposed rule. It was announced, I believe, in
20 November of last year.
21 DR. MILLER: Just a small thing, this is an
22 administrative action on the part of CMS but it wasn't

1 without pressure from the broader political system.

2 DR. MILSTEIN: Can I reframe my suggestion? That

3 irrespective of the federal origin of an attempt to evaluate

4 anything, whether it's the administration or the Congress

5 through legislation, that my suggestion be something we

6 might want to carry forward into our report.

7 MS. HANSEN: This is perhaps an embellishment on

8 the population that did experience changes, and that's the

9 dual eligibles. You mentioned that one state has a bit of a

10 copay now. But does this connote a shift of dual eligibles

11 who used to go to private physician offices now being

12 redirected to hospitals?

13 DR. SOKOLOVSKY: It's very difficult for me to

14 answer that on the basis of the five sites. It seemed in

15 metropolitan areas as if many of the duals were already

16 going to hospitals, the safety net institutions or academic

17 institutions. And it seemed in more rural areas that they

18 were being treated in private offices and are still being

19 treated in private offices.

20 MS. HANSEN: So when we look at that, and I was

21 looking about the people who were affected, it was really

22 relative to these five sites?

1 DR. SOKOLOVSKY: Yes.
2 DR. WOLTER: I really would like to see whatever
3 quantitative data you can come up with, Joan, on how these
4 changes have shifted dollars, how much reduction in the drug
5 payment is there relative to how much increase in the
6 administrative side. I don't know if we can bring that down
7 at all by some other unit measure or not. But that would be
8 interesting to get some sense of the size of that.
9 One other point I wanted to make is, at least in
10 my view, one of the unique things -- not entirely unique
11 about oncology but somewhat unique, it does exist in a very
12 few other specialties and may be developing now in some
13 others, is that an unusually large percentage of the
14 practice income is related to the drug acquisition and
15 payment.
16 That sets up interesting incentives and it , I
17 think, is part of the issue that we're dealing with here.
18 When you make a change in these payment mechanisms, when
19 that large of a percentage of your practice income is
20 involved, it's a huge change to your practice. And so I
21 think that's partly what we're dealing with here.
22 I would also say, having recently pulled some of

1 the available data on practice income and salaries reported
2 by various size oncology groups, I'm struck by the fact that
3 we surely shouldn't be seeing any access problems yet. And
4 I think that's really one of the sets of issues that we're
5 dealing with here
6 I do recognize that a change of this magnitude is
7 difficult for a small practice and we need to be sensitive
8 to that. On the other hand, I really Bill hit it on the
9 head when he said ideally we should pay for the service, not
10 for the profitability inherent, in this case in an ancillary
11 drug. That's really what we should be striving to do in the
12 Medicare program.
13 MR. HACKBARTH: Good point.
14 Just one last question.
15 What do we know about the trend in ASP? Are the
16 prices going down? Are they going up? Is there anything
17 that we can say about how the new payment system seems to be
18 affecting the drug market place?
19 DR. SOKOLOVSKY: In those areas that I talked
20 about before, where there is competition and where there is
21 generic increase, ASP is very much going down. I guess
22 that's the big difference that I see between the old AWP and

1 this system. The physician always had that margin in those
2 cases, but now Medicare does see that savings.
3 In the most expensive drugs, the price has been
4 very stable and the margin between purchases -- now, seem
5 I'm going into all my stuff for next month.
6 The margins between what purchasers pay is very
7 limited. It's not exactly everybody pays the same price but
8 it's pretty close to it. And the price has not moved very
9 much. There are other prices that are going up.
10 Again, maybe I'm too much into it but I could
11 actually tell you a story about each one of those drugs, and
12 I'll try not to next time.
13 MR. HACKBARTH: We're going to talk about that
14 were next month and what's happening at the price side.
15 DR. NELSON: Help me understand what the poor
16 patients who don't have supplemental insurance, and are on
17 the really high-priced drugs, what they're doing? Who's
18 advocating for them? If they aren't dual eligibles and
19 don't have supplemental, it seems to be they're in a tight
20 spot.
21 DR. SOKOLOVSKY: This is one of the issues why I
22 said that practices have hired financial counselors and in

1 some cases social workers to work with those patients to get
2 a sense of what their liability is beforehand. And then
3 manufacturers have different patient assistance programs and
4 sometimes they can get manufacturers to help with that
5 copay.
6 It's a very uneven system right now and that is
7 one of the things that we might want to address.
8 DR. REISCHAUER: Of course, the irony is if they
9 were under Part D it would be free as of January.
10 DR. NELSON: Absolutely. And if the social worker
11 or financial assistance person is helping them sell their
12 house, I'm not sure that's a hell of a lot of comfort.
13 MR. HACKBARTH: Thank you, Joan.
14 We're now going to turn to the first of several
15 discussions we're going to have today and tomorrow morning
16 that are the beginning of our payment adequacy analysis.
17 The first sector that we're going to look at is dialysis
18 and, as the commissioners know from reading the material,
19 the first step in all of these sectors, including dialysis,
20 is to look at the non-financial information that we use as
21 part of our adequacy analysis, access, quality, access to
22 capital and so on.

1 And then later, as we move towards December, for
2 each of the sectors we'll go back and look at the financial
3 information as well.
4 Dialysis, Nancy?
5 MS. RAY: Thank you. I'm here to present
6 preliminary results of our assessment of the adequacy of
7 outpatient dialysis payments in 2006.
8 Spending for dialysis and the drugs administered
9 during dialysis is projected to be more than $7 billion in
10 2006. Although spending for dialysis is considerably
11 smaller relative to other providers such as doctors and
12 hospitals, MedPAC's assessment is important to Medicare for
13 three reasons, or at least three reasons. One, nearly all
14 ESRD patients are entitled to Medicare benefits. ESRD is
15 Medicare's only disease entitlement. 93 percent of all
16 dialysis patients are entitled to Medicare either as the
17 primary or secondary payer.
18 Two, dialysis is provided to the majority of
19 patients with end-stage renal disease. The other option,
20 kidney transplantation, is limited based on the number of
21 kidneys donated each year. And three, MedPAC's assessment
22 is important to ensure that patients continue to have access

1 to high quality care.

2 Moving on to our indicators of payment adequacy,
3 recall that our adequacy assessments for dialysis, as well
4 as for the other sectors we consider -- hospitals,
5 physicians, SNF and home health, center around six
6 indicators: beneficiaries' access to care, providers
7 capacity to meet patient growth and demand, quality of care,
8 providers access to capital, growth in the volume of
9 services, and payments and costs. For this assessment it
10 will be for 2006.

11 For today's presentation I will be focusing on the
12 first four indicators and later this fall I will be
13 presenting analyses looking at the growth in the volume of
14 services and our margin assessment.

15 We routinely monitor local economic issues that
16 may affect beneficiaries' access to care. We do so by
17 monitoring accounts published in local newspapers and
18 announcements on renal web sites. In the past, we have seen
19 that state CON laws and rising real estate prices have
20 affected beneficiaries' access.

21 The most recent local economic issue I'd like to
22 discuss with you is that this summer the largest national

1 chain announced the closure of five facilities in the
2 Washington, D.C./Baltimore area. About 100 patients were
3 affected by these closures and they are all receiving care
4 at other facilities.
5 Moving on to another local issue, that would be
6 hurricanes Katrina and Rita. It has affected several
7 thousand dialysis patients. The American Kidney Fund and
8 other nephrology organizations are distributing funds to
9 affected individuals.
10 On the federal government side, CMS has simplified
11 administrative requirements. In fact, one of the large
12 dialysis chains announced yesterday that CMS is granting
13 emergency certification of four facilities in Texas. CMS
14 will also reimburse facilities for providing dialysis in
15 alternative settings.
16 We will continue to monitor regulatory and
17 legislative initiatives and how they affect beneficiaries'
18 access.
19 During the past decade a number of facilities have
20 closed. A disproportionate number of these facilities that
21 have closed are nonprofit and hospital-based. At issue is
22 whether certain groups of patients are disproportionately

1 affected by these closures. We flagged this issue for you
2 last year and later this fall we intend to present to you a
3 patient level analysis that will help us answer the question
4 are certain groups -- elderly, African-Americans and dual
5 eligibles -- more likely to be treated by facilities that
6 closed compared with facilities that remained in business?
7 Well, who is caring for dialysis patients? What
8 types of facilities are these? In the past 15 years an
9 increasing proportion of providers are for-profit,
10 freestanding and owned by a national chain. There were four
11 large national chains, and they were all for-profit,
12 freestanding and publicly held, and they account for 70
13 percent of all facilities.
14 Over time dialysis providers have consolidated.
15 Most recently two mergers were announced. The first and the
16 fourth largest chain is intending to merge. I've just been
17 informed that the merger of the second and third chain has
18 occurred, it's final. So once both of these mergers have
19 been completed, now two chains will account for about 70
20 percent of all freestanding facilities.
21 Looking at where facilities are located, 25
22 percent are located in rural areas. This proportion has

1 remained relatively constant over time. The rate of growth
2 of facilities in rural and urban areas is similar, about 5
3 to 6 percent per year.
4 What does this all suggest? One, dialysis is an
5 attractive business to for-profit companies. Two, there are
6 efficiencies and economies of scale in providing dialysis
7 care.
8 Providers appear to have the capacity to meet
9 patient demand. During the past decade the number of
10 facilities increased by 5 percent per year. Hemodialysis
11 stations have increased by about 7 percent per year and the
12 number of patients have increased 5 percent per year.
13 Other indicators suggest that some providers have
14 unused capacity. For example, between 2002 and 2003, same
15 store growth -- that is the growth in the number of
16 treatments provided by facilities in business in both years
17 -- increased by 5 percent on average.
18 The quality of dialysis care continues to improve
19 for some measures. Recent CMS data show trends similar to
20 last year's data. Adequacy and anemia status continue to
21 improve. We focus on dialysis adequacy and anemia because
22 researchers have shown that dialysis patients not getting

1 enough dialysis or not having their comorbidities like
2 anemia under control cost more than patients receiving
3 adequate dialysis and with their anemia under control.
4 Patients' nutritional status remained unchanged. And
5 there's been some small change in the use of AV fistulas.
6 AV fistulas are the type of recommended vascular access for
7 hemodialysis patients.
8 In addition to the CMS data, we used CMS's Compare
9 database to look at whether or not there is differences in
10 dialysis adequacy and anemia status by provider type. Here
11 we found no differences. We looked at adequacy and anemia
12 between for-profit, nonprofit, freestanding and hospital-
13 based chain and no chain and urban and rural.
14 Providers appear to have sufficient access to
15 capital. We looked at a number of indicators that suggest
16 this conclusion including providers' ability to obtain
17 private equity for purchasing new acquisitions, their
18 operational ratios for their publicly traded companies and
19 Wall Street reports.
20 There's two new developments here to consider.
21 The first are the hurricanes. As of the end of September,
22 more than 30 facilities remained closed. It remains to be

1 seen how this will affect their bottom line. In the short
2 term, facilities are incurring revenues. For those
3 facilities affiliated with a chain, and 75 percent of them
4 are, the losses may be offset by patients going to
5 affiliated facilities. Again, we will monitor the
6 developments here.
7 And two, are CMS's proposed regulatory changes.
8 CMS is continuing to implement the MMA and they're proposing
9 to revise the wage index and geographic classification
10 areas. They will be revising the add-on payment and
11 revising drug payment.
12 In conclusion, we find that beneficiaries' access
13 appears to be good. Quality is improving for some measures.
14 Providers have sufficient capacity to meet patient demand
15 and have adequate access to capital.
16 Later this fall, I intend to present to you an
17 analysis looking at whether certain groups face systematic
18 problems accessing care. We will assess the growth in the
19 volume of dialysis services and drug spending and hopefully
20 we'll have 2004 data for that. And we will compare
21 Medicare's payments to providers' costs in our margin
22 analysis.

1 I'd be happy to take your questions.
2 MS. BURKE: One of my favorite topics. A terrific
3 piece again, remarkably interesting to watch what's going on
4 with the program.
5 I had a couple of questions that may be things
6 that, as we go forward, we may want to look at it and
7 understand. One was in the trends in the ESRD population,
8 your reference to -- you know, the trends that we're
9 watching in terms of the number of people dialyzing at home,
10 for a whole variety of reasons. But one of the points
11 that's made is that physician training may be having a
12 direct influence on that. I'd appreciate, as we go forward,
13 understanding what particularly is going on there and what
14 might or might not be something we would address or suggest
15 in terms of looking at that trend and whether we think
16 that's a good thing or not.
17 Secondly, the whole discussion around the
18 hurricane victims. I think it will be interesting for us to
19 understand in retrospect, so we understand for purposes of
20 planning going forward, although it's really not largely in
21 our purview. That is, in fact, what happened to these
22 patients? Where, in fact, did they end up? Were they

1 quickly picked up? Was the system able to accommodate them
2 as they moved out of the area into other areas? Whether
3 they ended up in the chains and were easily transferred,
4 what happened to their records? Just an impact of
5 understanding whether the infrastructure, in fact, supported
6 them.
7 And then finally, there is a discussion in terms
8 of the shifts in the services offered by facilities. This
9 has been something that I've wondered about over the years
10 and continue to be concerned about. That is your reference
11 that only a fifth of the facilities offer treatments after
12 five o'clock at night, and whether or not, in fact, over
13 time people haven't begun to realize that, in fact, given
14 the nature of this service that this is something that is
15 atypical and that nine to five over the long term just may
16 not make sense.
17 And I was struck that that continues to be the
18 case and to what extent that is, in fact, an inhibitor in
19 terms of people's capacity to return back to the work force
20 and a whole series of issues with a chronic illness, whether
21 the delivery system, in fact, is responding to that in a
22 reasonable way and how inhibiting that, in fact, is.

1 Some of these patients are, in fact, long term
2 disability and, in fact, that's not an issue. But for some,
3 in fact, arguably it could well be an issue. And I wondered
4 to what extent that is an inhibitor and how we might
5 influence that going forward as well.
6 MS. DePARLE: I agree with Sheila. The data about
7 home hemodialysis was very interesting, and particularly
8 when coupled with the point that you just made about the
9 availability and access to some facilities. It would make
10 sense, I think. I don't think this has been examined in
11 some time.
12 This was thought to be the thing that people would
13 want. Why is it declining when it might enable more people
14 to work and be more active? And are there things from a
15 policy perspective, and I think you've already pointed out
16 in this paper that there are, such as the reimbursement for
17 drugs and those sorts of things and the training of
18 physicians and clinicians around it where we might be able
19 to have an impact?
20 The other one is on nutritional status. This is
21 my fourth year here, so I guess it's the fourth year I've
22 heard that that's a problem. I would like to see us take a

1 more proactive role in making a recommendation around that.
2 As I recall, we've discussed maybe very briefly
3 that there are issues around the reimbursement for
4 nutritional supplements in dialysis. It seems as though
5 there's probably a link there. I guess I'm hypothesizing
6 there, perhaps without sufficient evidence.
7 Anyway, I would like to see us look at that and
8 see whether we could make a stronger recommendation around
9 that because it is such an important factor.
10 MS. BURKE: Glenn, can I just follow up on that
11 real quick with just one other issue?
12 This is something that I actually e-mailed Nancy
13 about earlier in the week. I don't really know yet the
14 breadth of the issue. But an issue has arisen apparently,
15 we think, but I've asked Nancy and I'll get back to her on
16 it, regarding Epo.
17 The question that's arisen is that there is some
18 suggestion that there may be a move in Florida to
19 essentially require the role of pharmacists in the context
20 of the self-administration of Epo. This is something we did
21 in 1990 where we essentially allowed for the self-
22 administration to essentially avoid patients that were on

1 home hemodialysis from having to go to a hospital to get
2 Epo, which was sort of counter to the whole point of people
3 who were managing themselves at home.
4 So we passed it. It has been, I think, relatively
5 effective in terms of avoidance of sort of inpatient use
6 where it wasn't necessary.
7 There is now some suggestion that, in fact, there
8 may be an attempt to try and intervene in some fashion or
9 involve pharmacists in requiring them to be involved in the
10 self-administration. I don't really know, this is something
11 that's come by way of someone who's worked in this world for
12 a long time who contacted me.
13 And so I've mentioned it to Nancy and it may be
14 something worth tracking or following to figure out what, in
15 fact, is going on, which would be counter to the whole point
16 which is to allow people who are able to manage themselves
17 independent of having to use any institutional facilities
18 for that purpose.
19 So we'll track that but it just seems kind of an
20 odd thing.
21 MR. HACKBARTH: Any others?
22 Okay, thank you.

1 Next is SNFs.
2 MS. LINEHAN: Good afternoon. I'm going to talk
3 about payment accuracy in skilled nursing facilities.
4 SNFs the most common post-acute care destination
5 with about 13 percent of hospital discharges going to a SNF.
6 Spending in 2003 was a little over $14 billion for almost
7 2.5 million covered stays. SNF spending is about 6 percent
8 of total Medicare spending.
9 There are three main SNF-related topics I'm going
10 to discuss today. First is payment adequacy where we
11 continue to see the same patterns of supply of facilities,
12 volume of services and quality of care that we've seen in
13 the past few years.
14 The second is measuring quality in skilled nursing
15 facilities. We're working to identify and analyze measures
16 of individual facility quality that might be used in pay for
17 performance. I'll also review CMS's planned nursing
18 facility pay for performance demonstration which they
19 unveiled a couple of weeks ago.
20 Before I talk about those two issues, though, I'm
21 going to review some changes that CMS made to the payment
22 system that are going be context for our upcoming payment

1 adequacy analysis.

2 As always, the impact of payment policy changes
3 will be factored into our analysis of payments and costs.
4 Four major changes affect payment for 2006. First, SNFs got
5 a full market basket update. There were nine new case mix
6 groups added. That triggered the removal of some temporary
7 payment add-ons, and the weights for all skilled RUGs were
8 also increased.

9 The net effect of these combined is going to be a
10 0.1 percent increase in payments between fiscal year 2005
11 and 2006. There will be some distributional changes.
12 Hospital-based SNFs will see more of an increase than
13 freestanding SNFs, according to CMS's impact analysis.

14 In our comment letter, we raised concerns about
15 the refinement that CMS ultimately implemented in the final
16 rule. I'm going to review the outline of our comments
17 generally and take on questions on anything you might have
18 specifically about our comments.

19 We noted that the refined payment system with the
20 new payment groups still does not have a mechanism for
21 targeting payment but non-therapy ancillary services. The
22 new payment system continues to distribute payment for these

1 services in the same relative manner as payments for nursing
2 services.
3 Second, the rule made no change to the policy of
4 basing the therapy portion of the payment on the amount of
5 therapy provided or estimated to be provided.
6 And third, CMS added money into the payment system
7 by increasing weights for all RUGs, but that money again
8 isn't targeted towards non-therapy ancillary use. And the
9 magnitude of the increase didn't seem to be determined
10 analytically. So I'm going to move on to some of our
11 payment adequacy analysis now.
12 First I'll discuss changes in the supply of
13 providers of skilled nursing facility services. The supply
14 of facilities declined somewhat for the first few years
15 following the implementation of the PPS in 1998. But since
16 2001, the total number of facilities has crept steadily up
17 to nearly 1998 levels. The increase in total facilities
18 providing SNF care between 2004 and 2005 was about 0.3
19 percent or about 40 facilities. But you'll likely notice
20 that hospital-based SNFs have continued to leave the program
21 at the rate of about 8 percent per year while freestanding
22 facilities entered. So the mix of freestanding and

1 hospital-based facilities has changed over time.

2 Now I'll turn to the volume of services as
3 measured by use in payment. Here we see the cumulative
4 increases in payment and service volume measures from 1999
5 to 2003. Volume, as measured by total days and admissions,
6 increased by varying rates from year-to-year. Total
7 payments increased 50 percent between 1999 and 2003. You'll
8 likely notice that the average payment per day increased
9 between 1999 and 2001 and then fell for two years in a row.
10 This decrease in 2002 and 2003 reflects the expiration of
11 two temporary payment add-ons at the end of fiscal year
12 2002.

13 In spite of this, total payments still grew during
14 the period as a result of the volume increases.

15 As I noted in the paper, continued growth in the
16 volume of SNF services, even with the elimination of two
17 temporary payment add-ons and facility occupancy rates,
18 suggests continued access to care for Medicare
19 beneficiaries. The OIG has conducted another study of SNF
20 access talking to hospital discharge planners, but has yet
21 to release their findings. We're hopeful that the study
22 will be released this fall, so we'll have details on that in

1 December as long as they release the study.

2 We have two sets of quality measures we use for
3 assessing changes in the quality of SNF care. The first is
4 the Nursing Home Compare measures published on CMS's web
5 site. These data show that on two measures that median
6 facility score has not changed over the period of time we
7 can measure and shows decline in the median facility pain
8 score, which indicates improvement on this measure.

9 As you may recall, we raised concerns about using
10 these measures for evaluating the quality of individual
11 facilities because of the timing of the data and the focus
12 of the MDS where these data come from as a long stay patient
13 assessment instrument. In addition, a recent study for CMS
14 found that the pressure ulcer measure is not a valid quality
15 indicator. But I show these because these are the available
16 quality measures that are sort of out there.

17 I'm going to turn to some more details about our
18 quality agenda now.

19 We have another measure of SNF quality we
20 examined, which is the changes in re-hospitalizations within
21 30 days for five potentially avoidable conditions. As we
22 showed in the March report and I discussed in your mailing

1 material, the national average rates of rehospitalization
2 for electrolyte imbalance, respiratory infection, congestive
3 heart failure, sepsis and urinary tract infection increased
4 between 1999 and 2002. But recall that these are very small
5 increases in low incidence events.
6 We're going to update these rates through 2004 and
7 possibly for the first half of 2005 for December.
8 As part of our ongoing work to provide more
9 information about available SNF quality measures, we're
10 further exploring measures, including the readmission
11 measure, to see whether it may be appropriate for assessing
12 the quality of care provided by individual SNFs.
13 Given the small SNF patient population in many
14 facilities and the low incidence of these events, we have a
15 project to assess how many SNFs have adequate Medicare
16 populations to produce stable measures and allow decisions
17 between facilities based on quality scores on these five
18 potentially avoidable hospitalizations and also a measure of
19 discharge to the community within 30 days.
20 We're also exploring the concept of different
21 quality measures for different patient types within SNFs
22 such as physical therapy patients or stroke patients and

1 whether measures exist or need to be developed.
2 Finally, we are following the design and
3 implementation of CMS's nursing facility pay for performance
4 demonstration -- and I mean nursing facility, they're
5 talking about the entire facility not just the Medicare
6 coverage stays.
7 Now I'm going to review the outline of the pay for
8 performance demo that was rolled out on September 20th.
9 This was sort of the public unveiling of this demo and CMS
10 had an open door forum and is taking public comment,
11 stakeholder comments, on the design. They also have a
12 technical expert panel working to advise them on the design
13 of this demo.
14 It's going to begin no earlier than next fall and
15 last for three years. The design that they envision will --
16 they'll select three to four states, and they haven't
17 determined the methodology of how they're going to pick
18 those states. But when they do that, they are then going to
19 ask for facilities within those states to volunteer to
20 participate in the demo. And then those facilities will be
21 assigned to a treatment and control group. All Medicare
22 patients in the facility will be measured.

1 The potential payment under this demo will be
2 derived from Medicare savings that will be from avoided
3 hospitalizations or things like avoided ER visits. And then
4 the payment will be distributed to facilities for attainment
5 and improvement on the quality measures.
6 The quality measures that they discussed, there
7 were several MDS-based measures, state survey information,
8 staffing levels and stability, rates of avoidable
9 hospitalizations, and they discussed using other measures
10 such as process measures, quality of life and resident
11 satisfaction measures. But they weren't entire clear how
12 those were going to be operationalized.
13 As I just said, the design discussed at the open
14 door forum is still being refined and we'll continue to
15 follow the demo and present details as it's refined.
16 This concludes my presentation and I'll take any
17 questions you have on the payment adequacy factors I
18 discussed, as well as the demo or any of our quality
19 initiatives
20 DR. NELSON: How many facilities?
21 MS. LINEHAN: In the demo? They said a few
22 hundred, so three to four.

1 DR. CROSSON: I wonder, are there in fact
2 geographic differences in the supply of skilled nursing
3 facility beds? I don't know if this is something that's
4 been looked at. And has there been any attempt to look at
5 that in terms of how they're paid?
6 MS. LINEHAN: I don't know the answer to that
7 question. I know there's geographic differences in the
8 occupancy rates. Counting beds is always a little tricky.
9 I sort of touched on that in your mailing material. But
10 that's something we could certainly look at, I think, at
11 least on the facility level, maybe on the bed level.
12 DR. SCANLON: There is a big difference and it's
13 been a long-standing difference. It goes back to even
14 before Medicare and Medicaid began. There's a variation in
15 terms of nursing home use and subsequently in terms of
16 skilled nursing facilities in states. And it's about maybe
17 a threefold variation across states.
18 DR. MILLER: [off microphone] End-user supply.
19 DR. NELSON: That correlates to CON, doesn't it?
20 DR. SCANLON: It sometimes correlates to CON, but
21 some states have not used CON but they've also used their
22 rate setting in terms of Medicaid. Because we talked

1 earlier about Medicaid's role in this. Medicaid is involved
2 in the payment for about two-thirds of nursing home
3 residents. Even though it's a smaller share of revenue,
4 it's two-thirds of the patients. So that's the dominant
5 influence.
6 Let me just say one other thing, the skilled
7 nursing facilities have leveled out some because of
8 prospective payment and Medicare's change in coverage
9 policies. But historically it was a real problem for
10 Medicare to get the participation in some states because
11 they just weren't interested in terms of the small volume
12 payer. They were certainly happy with their private pay and
13 their Medicaid patients.
14 DR. CROSSON: I appreciated the national look at
15 it but sort of anecdotally over the years, I know we have
16 had very differential experience in the ability to access
17 SNF beds based on supply in different parts of the country
18 and it has seemed to stay that way.
19 So the question is is that something that we ought
20 to look at? We look at that with respect to other payment
21 modalities.
22 DR. SCANLON: I guess the issue there is that

1 you'd have to overcome the overall problem of nursing home
2 supply. Obviously, you're in California and it's one of the
3 unique places in the country, in terms of nursing home
4 supply, because it's one of four states that has a flat rate
5 system and it affects both the number of homes that exist as
6 well as the types of services that they provide.
7 As I said, we've seen these levels of supply stay
8 relatively stable over a 30 year period. In fact, what's
9 happening today is the supplies are declining roughly
10 nationwide across the board because instead of seeing
11 nursing homes being built, we're seeing assisted living
12 facilities being built. The variation has remained. I'm
13 not surprised that you've have a continuing problem in
14 different places and better luck in others.
15 MR. HACKBARTH: One of the problems that we
16 encounter in applying our payment adequacy framework to
17 different sectors is that Medicare varies in the degree of
18 its influence in the financial performance and ability to
19 access capital. Because we're talking about a relatively
20 small share of the patients in nursing facilities,
21 Medicare's impact on the ultimate financial performance of
22 these is less than say in the hospital sector.

1 DR. MILSTEIN: If hospital SNF beds are closing
2 down at the same time this is happening, that may imply a
3 somewhat sicker group of patients entering non-hospital
4 nursing homes. Is this being tracked? And are there ways
5 of detecting that above and beyond the RUG classification?
6 DR. MILLER: Actually, some research that we did I
7 want to say two years ago now suggested that there's two
8 concepts to keep in mind. There's the notion of what the
9 case mix measures are and how complex or less complex those
10 are. But there's other kinds of measures in terms of
11 function, cognitive and physical function, do you have
12 somebody else in the family who's with you, are you younger,
13 fewer functional impairments, that type of thing.
14 What you actually find is that there is a huge
15 distribution, sort of sorting of patients that in the
16 hospital-based SNF they take the younger, less functionally
17 impaired, they have a family member, higher income, that
18 type of thing. But they tend to go into the RUGs that might
19 have a higher case mix. Even that, I'm not sure I'm
20 remembering that correctly. The high therapy stuff.
21 So it's sort of they go to the high RUG but it's
22 the patients that, if you kind of woke up in the middle of

1 the night, you would think would be the less complex,
2 depending on how you're thinking about it.
3 MR. HACKBARTH: The hypothesis or a hypothesis is
4 that if it's a patient that's more complicated and may need
5 non-skilled nursing care that they move them out of the
6 hospital-based facility into a freestanding facility where
7 they can just switch from the skilled side to the unskilled
8 side.
9 DR. MILLER: I thought Arnie's point was so if the
10 hospitals are closing down, aren't the freestanding getting
11 more complex patients. And I was going to contrast --
12 MR. HACKBARTH: What I was trying to do was it
13 looked to me like Arnie was surprised at how the patients
14 were sorting, that the younger more likely to go home were
15 in the hospital-based facilities. And a hypothesis about
16 why that may be is that the patients who might need long-
17 term care are more likely to be moved into a skilled
18 facility that also has a long-term care facility, as opposed
19 to kept in the hospital.
20 DR. MILLER: Nick you may have views on this. It
21 seems like you've talked about it. I also think that the
22 hospital-based SNFs are sort of more oriented towards okay,

1 you've just had some kind of procedure or something like
2 that. And so I'm going to intensively work on you to get
3 you back on your feet, sort of a therapy.
4 But on the other hand, if you have sort of trach
5 or swallowing problems or those kinds of things which are
6 longer types of therapy, that tends to move more to the
7 freestanding.
8 DR. MILSTEIN: Maybe I can reframe my question.
9 Holding case mix constant, do we have evidence whether over
10 this period of time patients entering freestanding SNFs are
11 sicker or the same or less sick?
12 MS. LINEHAN: We would only look at RUGs and I
13 don't think it's sensitive to these kinds of issues that
14 Mark's raising about do you have somebody at home? Are you
15 younger? It's not capturing those kinds of things that
16 actually make a difference.
17 I mean, you could look at that but you couldn't
18 get it from looking at what case mix groups the patient's
19 in.
20 DR. MILSTEIN: We do have routine measures of
21 these other signals, the severity of illness, beyond RUGs?
22 Or we don't?

1 DR. MILLER: I'm trying to remember, when we had
2 that work done, where they were drawing that information
3 from and whether that was easy for us to get our hands on,
4 or whether that was something they constructed themselves.
5 This is some research that we had done.
6 MS. THOMAS: I think they used administrative data
7 to do it. I don't think they did any kind of survey or
8 anything like that.
9 I guess another point to make is the length of
10 stay is quite different in the two facilities. It's much
11 shorter in the hospital.
12 We actually have two studies that we planned for
13 this spring to look at transitions between SNF and the long-
14 term care. We're also going to do some site visits in this
15 area. So we should able to shed more light on this
16 question.
17 DR. WOLTER: It's really kind of on the same
18 point. I do have some concerns about the rather large exit
19 of hospital-based SNFs and I don't think that this issue of
20 allocation of cost explains the negative margins in and of
21 itself. It may be that hospitals just have more cost and
22 that you could be critical of that. But I think hospital-

1 based SNFs do tend to run significantly negative margins in
2 my experience.
3 I think there is a bit different product there,
4 and again this is anecdotal, but the freestanding SNFs in
5 our market have told us they hope we don't close our SNF
6 because they don't feel prepared to take those patients.
7 When we did LTCH visits last year or the year
8 before, we heard from some of LTCHs that there were not SNFs
9 in their area anymore who could be alternative sites of care
10 for some of the patients who now are being sent to LTCHs.
11 So that's another variable. Are there more hospital-based
12 SNFs exiting in markets where there might be inpatient rehab
13 or LTCHs available, as opposed to markets where they're not?
14 So it's really complicated to analyze all this.
15 But I do worry that there may be something different going
16 on in the hospital-based SNFs and that if we could find a
17 way to look at that it would probably have some utility.
18 DR. MILLER: I think we've had this exchange
19 either in phone calls or in other venues. I think one thing
20 that we're going to try and address, because one of the
21 other items that Kathryn has on her agenda, as you know
22 there's been the discussion about rethinking the SNF payment

1 system more broadly, those kinds of issues.

2 One of the issues I think we should take up when
3 we think about that, and I'm sure there could be different
4 views on that, is whether we think about whether the unit
5 that we're paying should be modified. So if you think about
6 it, picking up on Sarah's point, the fact is that they have
7 very different lengths of stay. If you began to start
8 thinking about paying on an episode base, maybe some of
9 those inequities and some recognition of the product
10 difference could be captured in that way.

11 It does implicate other issues, so I don't want to
12 say that that's where we're going. But I could see that
13 being one of the ideas we bring to you to consider. And it
14 may begin to overcome some of the concerns you have. That
15 would be the idea anyway.

16 DR. REISCHAUER: I just had a question about
17 whether we knew anything about the mechanism for the
18 payments for the P4P demonstration, whether they were going
19 to be tied to the savings generated by the individual
20 facility or all of the facilities in the state or in the
21 nation? Or how sure you would be that you were going to get
22 a payment back for the behavior changes that you're about to

1 begin?

2 MS. LINEHAN: You're not sure you're going to get

3 a payment back because there has to be savings to get a

4 payment, at least under the current conception.

5 My understanding of how this would work is it's

6 determined within the state. The pool is determined within

7 the state. So if there's not savings within your state,

8 then you don't get a payment.

9 DR. REISCHAUER: So you could do a bang-up job and

10 generate a whole lot of savings, but because your

11 compatriots didn't, you're out.

12 MR. HACKBARTH: That does seem like an odd design

13 for a demonstration.

14 DR. REISCHAUER: The problem is probably the

15 sample size. How do you measure the savings from facility

16 X? They're random, jumping all around. But maybe you could

17 do it for a chain within a state or something like that.

18 DR. MILLER: Well, it seems like an odd design,

19 and maybe it's a unit and measurement type of issue, what's

20 the right unit and what's the right measurement. When we

21 started, a couple of years ago, thinking about pay for

22 performance and you go out to the private sector and you

1 talk about how does it work?

2 It is so ingrained in their thinking that, of
3 course, the place you get the money is from the savings you
4 generate from the quality changes, that they blew past it in
5 our conversations and they would talk about the measurements
6 and everything. And we'd say well, where are you getting
7 this money? And they would say well, from the savings you
8 generate.

9 So it's odd, but in the private sector that's a
10 lot of the way --

11 MR. HACKBARTH: But it's one thing to say I'm
12 convinced that if we do this over the long term and we
13 improve the measures and people invest in quality because of
14 the new incentives, we're going to save money. That's one
15 proposition.

16 Here it's a much tighter feedback loop. If there
17 is no savings this year or if your competitor does a poor
18 job, you don't get a reward. I think that's a very
19 different proposition, a very different dynamic. At first
20 blush it seems like a self-defeating one to me.

21 DR. MILSTEIN: This also harks back to prior
22 discussions we've had today. For me it's, in some ways, a

1 case, based on listening to this design, as to why it may be
2 helpful for us to go beyond our broad statement about moving
3 forward to P4P and begin to recommend basic principles.
4 Because if we look at this design and statewide performance
5 and it has a number of the design characteristics I think
6 are all causing us to shake our heads.
7 And I think similarly the discussion we had about
8 if you're going to move forward with any kind of demo to
9 sort of make sure that you've got it set up in a way that
10 you can draw reasonable conclusions. I'm not clear what the
11 control group would be here, given the fact that the whole
12 state is in on the experiment.
13 So it's further reinforcement for ideas that have
14 emerged from two prior discussions today.
15 MR. HACKBARTH: When we considered pay for
16 performance for SNFs last year, it was the one sector that
17 we looked at and said that it's really not -- we don't have
18 the appropriate measures yet. We recommend, and I think we
19 attached some words like urgent and whatnot, that the
20 Department, the Secretary invest in the development of
21 improved measures.
22 Is there, independent of this demonstration which

1 doesn't sound like it's designed to test new measures per
2 se, is there work ongoing to develop better measures of SNF
3 quality?
4 MS. LINEHAN: There was a report that Abt did for
5 CMS, that I think came out earlier this year, where they
6 looked at additional set of short stay measures. But
7 they're all MDS derived. So we would have, I think, some of
8 the same issues with the measures that we had with some of
9 the other MDS derived measures, that there are a lot of
10 patients the you can't measure because for several of the
11 measures you have to have a 14-day stay. And a lot of SNF
12 patients don't have a 14-day stay.
13 So there is potentially an expanded measure set
14 from the three measures that they currently have on the
15 Nursing Home Compare. They're MDS derived, so we might have
16 similar issues with those.
17 MS. DePARLE: Dave, is it your coalition that was
18 working with NQF on some long-term care measure or quality
19 measures?
20 MR. DURENBERGER: You mean recently?
21 MS. DePARLE: I thought so. There's a commission
22 or something?

1 MR. DURENBERGER: It's either a commission or
2 something, but I don't know that we're working on measures.
3 MS. DePARLE: You're not working on measures with
4 NQF?
5 MR. DURENBERGER: No.
6 MS. LINEHAN: The other component of this is that
7 since this is a nursing facility demonstration, they will be
8 using not just the limited set of SNF measures, but the long
9 stay patient measures. So they're all mixed together there.
10 So they have more measures, but they're not all for SNF
11 patients. They're for the entire facility, Medicare
12 population in the facility, the Medicare patients,
13 regardless of whether they are under a Part A covered stay.
14 DR. KANE: To change the subject a little bit,
15 unless we want to go on about the measures.
16 I'm just curious to understand how we measure
17 capacity and the adequacy of capacity in SNFs because one,
18 my understanding is that what goes on in the SNFs has been
19 changing pretty dramatically over the last few years, where
20 truly the end of the former acute stay now are no longer in
21 the long stay places, and the long stay patients are no
22 longer in the SNF anymore.

1 And also, that there are substitutes for the SNF,
2 at least the old SNF, assisted living and home health and
3 other facilities. And I'm just wondering if you're thinking
4 about adequacy of capacity or adequacy of access, can you
5 really look at it just in terms of the SNF itself? And even
6 there, there's long-term and there's short term.
7 I guess my feeling of -- I'm not getting a sense
8 of how you can look at adequacy and capacity if you're just
9 looking at SNF and not distinguishing both the substitutes
10 for SNF and the fact that SNF is both a short-term and a
11 long-term now. And should we be concerned, in particular,
12 about whether the short-term piece is appropriate and
13 whether the SNF is the right place for it, and those kinds
14 of questions.
15 Because I hear from my provider groups that the
16 short stay SNF patients are really sick and really scary and
17 very different and taking over more and more of the SNF,
18 while the other people are being pushed to other locations,
19 particularly assisted living places. And is that
20 appropriate? So the whole continuum, it seems to me, you
21 have to look at, not just the one piece.
22 That's actually more of a question.

1 MS. LINEHAN: I'm just trying to get a handle on
2 what you're saying. It sounds like this is more of a pay
3 and post-acute care issue. I don't think we'd consider
4 appropriateness of the setting when we do our adequacy
5 analysis.
6 MR. HACKBARTH: I was just going to say we also at
7 least used to have the survey of the hospital discharge
8 people for both SNF and home health, so there was an
9 implicit judgment on their part about whether a particular
10 patient needed SNF and whether they had problems placing
11 them.
12 But as we've discussed several times, the
13 judgments about who's a SNF patient or a home health patient
14 or a long-term care hospital patient, it's all very must
15 dependant on what resources are available in the community.
16 That shapes how providers assess patients. It's not like
17 there are clear national uniform standards.
18 MR. SMITH: [Inaudible.]
19 DR. SCANLON: I was going to respond a bit.
20 I think the notion that case mix and nursing
21 facilities has been increasing has been something that's
22 been talked about for a long time. Every time that I've

1 ever looked at it, it was always increasing but not at a
2 rapid rate. I think that's probably still somewhat true.
3 But over time, we've had this very significant
4 shift. Someone up in your area wrote a paper once where have
5 all the beds gone? Because we should have had something
6 like 100,000 to 200,000 more nursing home beds today than we
7 actually do. And it's because they've gone to assisted
8 living and the people needing less care end up being served
9 there.
10 At this point Medicare -- we saw the numbers this
11 morning, 12 percent of nursing home revenues, since they pay
12 more a slightly smaller share of patients. So out of the
13 roughly 1.7 million beds, there's something like 10 percent
14 of them are medicare patients. So I think we can talk about
15 the issue of access.
16 Is there someone who's too severely ill to be
17 served in a nursing home? That's a different kind of a
18 question because there's still a lot of people that are
19 skilled patients who may not need that intensive of a set of
20 services. They need a skilled service, either nursing or
21 therapy every day, but they may not be that complex of a
22 patient.

1 MR. HACKBARTH: Any others?

2 Okay, thank you, Kathryn.

3 We'll have a brief public comment period.

4 Okay, thank you.

5 We will reconvene the public meeting at 9:30

6 tomorrow.

7 [Whereupon, at 4:57 p.m., the meeting was

8 recessed, to reconvene at 9:30 a.m. on Friday, October 7,

9 2005.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Friday, October 7, 2005
9:49 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. "PETE" DeBUSK
NANCY-ANN DePARLE
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: Good morning. The first topic

3 this morning is a background discussion on Medicare and

4 clinical lab services.

5 MS. KELLEY: I want to start by briefly

6 summarizing what we're going to talk about.

7 Lab tests are a vital component of modern medical

8 care, as you know, and will only become more important in

9 the future. But there are concerns that Medicare is not

10 being accurately for these services. I'll get into this in

11 more detail, but in a nutshell, Medicare's payments are

12 based on charge data from 1983, and the method for

13 determining payments for new services is inefficient and

14 likely to generate inaccurate rates. Improving Medicare's

15 payment methodology is important because the clinical lab

16 benefits are almost $6 billion in 2004 and it's climbing, on

17 average, about 9 percent per year.

18 This raises two questions for Medicare: what's

19 the program buying for these increased expenditures, and how

20 can Medicare's payment method better promote efficiency?

21 I'll start with some background on what these

22 services are. Clinical lab services are tests on specimens

1 taken from the human body to diagnose disease or assess
2 health. The FDA classifies lab services according to their
3 level of complexity. The least complex tests, called waived
4 tests, are defined as simple laboratory examinations and
5 procedures such as a dipstick urinalysis for glucose, fecal
6 occult blood test, and spun hematocrit blood tests for
7 anemia. These are tests that can be performed at home or
8 that are so simple and accurate as to make errors unlikely.
9 By comparison, moderate complexity and high
10 complexity tests require higher levels of expertise. The
11 FDA classifies these tests based on seven factors, such as
12 the level of knowledge and training required to perform the
13 test, the stability of the details, and the ease of
14 preparation, and the amount of independent interpretation
15 and judgment required.
16 Medicare beneficiaries receive a growing number of
17 tests each year. In 2003, each beneficiary on average
18 received 13 lab tests, an increase of almost 12 percent
19 since 2001. This is due in some part to the fact that
20 Congress has in recent years broadened coverage for lab
21 services and also added a welcome-to-Medicare visit that
22 also might generate lab tests as well.

1 At the same time, the range and complexity of lab
2 tests is expanding. In particular, the field of molecular
3 diagnostics, including genetic testing, has experienced
4 dramatic growth. In addition, innovations in laboratory
5 equipment and techniques and the introduction of information
6 technology have made testing more efficient and automated.
7 Finally, the growing interest in pay-for-performance may
8 also increase the importance of tests in the future.
9 Lab services are furnished by labs located in
10 hospitals and physician offices as well as by independent
11 labs. Services may also be furnished in labs located in
12 dialysis facilities, nursing facilities, and other
13 institutions, but frequently these services are covered
14 under other Medicare benefits. As of August 2005 there were
15 more than 192,000 labs in the U.S. The number of labs has
16 grown, on average, about 2 percent per year over the last
17 decade.
18 Physician office labs account for about half of
19 all labs, but they furnish a much smaller proportion of
20 total lab services. They perform about one-third as many
21 tests as independent labs, for example. Physician office
22 labs are also much less likely to perform moderate and high

1 complexity tests.

2 Prior to 1988 only labs that engaged in interstate
3 commerce were regulated by the federal government, so many
4 labs went unregulated. Under the Clinical Laboratory
5 Improvement Act of 1988, or CLIA, CMS now certifies all
6 providers of lab services based on the complexity of the
7 testing they conduct. Labs performing high complexity tests
8 must meet stringent personnel requirements.

9 Medicare covers medically necessary lab tests when
10 ordered by a physician to diagnose or monitor disease.
11 Medicare does not cover routine screening tests unless
12 directed to do so by changes in law. This slide shows the
13 screening tests that Congress has mandated coverage for.
14 With the exception of Pap tests, these have been added or
15 expanded within the last seven years.

16 In contrast to most other Medicare-covered
17 services, there's no beneficiary coinsurance requirement for
18 lab services. The Congress has at time considered applying
19 a 20 percent coinsurance. Such a policy would equalize cost
20 sharing between clinical laboratory and other Part B
21 services and would reduce program spending. But because lab
22 services are ordered by physicians and not initiated by

1 beneficiaries, adding coinsurance might not encourage more
2 prudent use of services and it could pose a financial
3 barrier to low income beneficiaries who lack supplemental
4 coverage. In addition, the cost of collecting the
5 coinsurance may sometimes exceed the coinsurance amount.
6 Repeated reductions in Medicare payment rates
7 resulted in declining overall program spending for lab
8 services throughout the 1990s, particularly for services
9 furnished in independent and physician office labs. Since
10 1999, Medicare expenditures for lab services have climbed an
11 average of 9 percent per year, despite the fact that
12 payments have been updated only once since 1997. In 2003,
13 Medicare payments for clinical lab services reached an
14 estimated $5.8 billion or 2 percent of total program
15 payments.
16 There are several concerns about the lab payment
17 system. First, the relationship between costs and payments
18 is questionable. Medicare sets payments prospectively for
19 each lab service with separate fee schedules established for
20 each of 56 geographical areas. Payment rates were initially
21 set for more than 1,000 tests in each carrier's area based
22 on what local labs charged in 1983. Payment rates have not

1 been regularly updated.

2 National limits, called the national limitation
3 amounts, were established for each service. Beginning in
4 July 1986, the NLAs were set at 115 percent of the median of
5 all local fee schedule amounts for each service. Since that
6 time the NLAs have been ratcheted down to their current
7 level of 74 percent of the median of all local fee schedule
8 amounts. Medicare pays the lower of the geographical area's
9 fee schedule amount, the provider's charge, or the NLA.
10 According to a 2000 report by the Institute of Medicine, the
11 vast majority of lab services are paid at the NLA. Overall,
12 it seems unlikely that payments beat much resemblance to
13 costs.

14 Another problem with the lab payment system is the
15 method used to establish rates for new tests. When newly
16 developed tests are used by labs, CMS assigns payment rates
17 based on their similarity to existing tests. If there are
18 no similar existing tests, CMS relies on carriers to
19 independently set rates for the first year of use. This
20 process is intended to promote the development of payment
21 rates that reflect each carrier's local market. Each
22 carrier researches and sets its own payment amount using

1 information such as cost data from manufacturers and payment
2 data from other carriers and private payers.
3 Once carriers set their payment rates for a new
4 test, the median rate is identified and the national
5 limitation amount is set at 74 percent of that amount. So
6 the payment rate could be well above or below the cost of
7 providing the service. There's no mechanism for
8 subsequently reviewing payment rates for new tests or for
9 established for that matter. In that same 2000 report, the
10 IOM recommended revisions to this rate-setting process,
11 including the establishment of a regular review of rates for
12 new services after a period of time allowing for diffusion
13 of technology and stabilization of costs.
14 Another problem with the payment systems arises
15 from claims denials. The IOM reported wide variation in
16 denial rates by regional carriers. In 1998 denial rates for
17 the 100 highest volume lab codes ranged from 6 percent to 39
18 percent with some codes in some regions having denial rates
19 of more than 50 percent. We don't know the specific reasons
20 for these denials, but most often Medicare Part B claims are
21 denied when they do not satisfy Medicare's clinical
22 necessity requirements. This is a particular problem for

1 labs since the ordering physician is responsible for
2 specifying the medical need for a test. When a claim is
3 denied the lab is not paid. The ordering physician is
4 unaffected, even if the reason is one of lack of medical
5 necessity, and labs are prohibited from billing Medicare
6 beneficiaries directly.
7 In terms of future work the Commission has a
8 number of options. Staff plans to examine patterns of
9 spending since 2000 to better understand the reasons for
10 recent growth. Since some of this is undoubtedly due to
11 benefit changes mandated by Congress we'd like to parse that
12 out. We also will monitor CMS's demonstration of
13 competitive bidding for lab services. The MMA mandated this
14 demo which will determine whether competitive bidding can be
15 used to provide lab services at lower rates while
16 maintaining quality and access to care. CMS is currently is
17 the design phase of the process.
18 We can also explore ways to improve the current
19 fee-for-service system, looking at ways to rationalize the
20 fee schedule methodology and the process for setting rates
21 for new services, such as carrier consolidation and
22 regulatory approaches. This would still leave us without

1 information needed to evaluate the adequacy of Medicare's
2 payment rates. We could attempt to address this data
3 deficiency by examining alternative sources of data such as
4 the V.A., FEHBP, or private payer data. Eventually the
5 competitive bidding demo may provide information about the
6 relative costs of lab tests.

7 Finally, we can explore wholesale changes to the
8 way we pay for lab services. Competitive bidding would be
9 such a change, but the Commission might also consider
10 bundling lab payment with payment for physician services.
11 To this end, staff can examine whether certain types of
12 tests tend to be associated with specific physician
13 services.

14 So in conclusion, spending for lab services is
15 growing and is expected to continue to do so, which places
16 pressure on Medicare to improve its payment system. We're
17 seeking your guidance on additional information analyses you
18 might like to see as you consider how to make these
19 improvements.

20 MR. HACKBARTH: Arnie.

21 DR. MILSTEIN: Thank you. I actually learned
22 quite a few things I didn't know before. Three suggested

1 areas of potential content for the discovery phase of this.
2 I'm going to frame it in terms of goals, program objectives.
3 First is, I at least would be interested in
4 understanding whether or not the volume of these services
5 appears to bear some relationship to value to Medicare
6 beneficiaries. I'd be interested in knowing, for example,
7 using the Dartmouth Atlas, looking the areas of the country
8 where quality is quite good, and patient satisfaction is
9 good, and patient functional status is good, what's the use
10 of lab services in those parts of the country compared to
11 the average U.S. region? And using that as our frame of
12 reference, what appears to be the average percentage point
13 opportunity to right-size lab services, if any?
14 Secondly, I'd be interested in this question of
15 efficient unit cost or unit price for a lab. Is there any
16 information on -- understanding that we're paying 74 percent
17 of fee-for-service -- that gives me one frame of reference.
18 But I'd be interested in knowing has anyone done analyses of
19 what lab services cost as a percentage of commercial rates.
20 Relevant to Congress' interest in us begin to pay for
21 efficiently provided services, I'd be interested in knowing
22 what the most efficient quartile is on a unit price basis.

1 How much of a savings would it represent over current
2 average cost of producing a lab service?
3 Lastly, in terms of our quality of care dimension
4 that we try to apply when we evaluate all questions, I'd be
5 interested in knowing -- I understand that CLIA is
6 monitoring quality of all except in-office physician labs or
7 most in-office physician labs. Has anyone done any research
8 over the last several years on the quality of in-office
9 physician laboratory testing?
10 DR. REISCHAUER: I found this very interesting but
11 it raised more questions than it answered, and I think maybe
12 some of this is lack of data. I'm thinking, what are we
13 after here? One question is, are we paying wrong, in a
14 sense, individually? And the answer is almost surely, yes.
15 But we pay wrong for lots of things.
16 Then the question is, are we paying too much on
17 average? We might be paying wrong, too much in some places,
18 too little in others. There's no real way to ferret out an
19 answer to that question. I'm trying to think of how you
20 might figure that out. You look at -- the independent labs
21 have no ability to boost the volume because they aren't
22 ordering it. They're just collecting it and doing their

1 thing.

2 So maybe what we should be looking at is the
3 extent to which the volume of services is shifting from
4 physicians' offices to the independent labs, or the other
5 way around, and from hospital outpatient departments to
6 independent labs. There are other factors involved,
7 convenience, speed, but if might tell us something about
8 whether there's rent here in the system in an overall sense.
9 It's always nice to get the prices right, issue by issue,
10 but we shouldn't lose an immense amount of sleep if on
11 average we're paying about right and there's no real excess
12 profit involved here.

13 MR. HACKBARTH: Would it also be helpful to -- I
14 think of the ESRD analysis that we do, and one of the things
15 that we would look at is the industry, the industry
16 dynamics. If there is a lot of merger activity among the
17 large-scale labs and capital flowing in, that would be an
18 indicator of whether there are rents. Although as is true -
19 - it would be true in this case but not -- actually it's
20 true in ESRD also. There's the question of how much of it
21 is private profit, if you will, profit from treating private
22 patients are supposed to Medicare. But a little bit more

1 understanding of the industry dynamics would be helpful to
2 me.
3 MR. BERTKO: So let me continue to ask questions
4 along Bob's lines here because it was a good start and it
5 prompted me to think about several things.
6 First of all, I have to wave the newspaper in
7 front of you from last week and say, Medicare direct bills,
8 but they cite here condo labs, and the question is, is that
9 a problem or should this be rule out that says it's really
10 not a problem? When I follow up that thought, one is to go
11 to your slide here and the table and say, that's a snapshot.
12 You gave the number 2 percent growth. I presume that the
13 number of labs grew at 2 percent and then the question
14 becomes, what's the differential rate of growth in physician
15 office labs versus the total?
16 Then following up a comment of Arnie's, we may
17 have to disaggregate further, and I point you to the episode
18 testing project that is going on. I've seen at least in our
19 experience some evidence that the vast majority of
20 physicians perhaps are standard on this but there may be
21 some for whom, by specialty, by person almost or grouping,
22 are much higher usage on lab tests than others. So they

1 differ or are very off the community mean on that. So the
2 data presumably will be available for you to look at and it
3 might be even targeted down to that level.
4 Then going over to the unit cost side -- and this
5 is ancient information from 10 or 15 years ago when I was a
6 consultant -- the charges across site of delivery or lab
7 tests varied enormously. Now we're paying on NLA and I'm
8 assuming here that you could actually try to get closer to
9 what Bob was talking about by looking, for example, at these
10 large reference labs, assuming we want to provide for
11 efficient providers and at least get some view of their
12 economics across everything, knowing that Medicare is
13 probably going to be such a substantial part that if the
14 economics are good overall, they must be good for Medicare.
15 At least that's the inference that I would draw, and then
16 see where you go from there.
17 MR. WINTER: A couple of comments is response to
18 your comments. We do actually plan to use the episode
19 measurement research to look at variations in use of labs
20 for different kinds of episodes, different specialists,
21 different geographic areas. That's definitely something
22 we're interested in, as well as other diagnostic tests like

1 imaging.

2 The first thing you mentioned was about the
3 article in the Wall Street Journal last week about the
4 pathology condominiums, so-called. I can address what the
5 IG has said about that briefly.

6 Just to give everyone a bit of background, the
7 article talked about arrangements between lab companies and
8 certain physicians, particularly urologists, GIs, and
9 dermatologists, in which the lab company establishes a
10 building with lots of rooms in it and each room is a
11 separate lab. And a physician practice owns or leases that
12 lab space. The lab company provides usually the equipment,
13 the technicians, the pathologists to read the samples that
14 are sent in by the physician practice. So the physician
15 practice bills Medicare or the payer, and then pays the lab
16 company a fee for providing the equipment, and the space,
17 and the technicians, et cetera.

18 So this seems to be a way to comply with the
19 letter of the Stark law and the in-office ancillary
20 exception which permits physicians to provide services like
21 clinical labs -

22 MR. HACKBARTH: And there's a spread between the

1 amount that the physician has to pay the lab from the amount
2 that they get from Medicare, which is attractive and draws
3 the business to the lab.
4 MR. WINTER: That's right.
5 DR. REISCHAUER: Which suggests that we're
6 overpaying.
7 MR. WINTER: That appears to be a signal that
8 rates could be too high, to put it conservatively. So it
9 appears to be a way to comply legally with the in-office
10 ancillary exception, but there are some questions raised by
11 these kinds of arrangements because they're often in a
12 different state than the actual physician's practice, and
13 there are often substantial profits.
14 MS. DePARLE: These are supposed to be in the
15 office but they're in a different state?
16 MR. WINTER: Yes.
17 MS. DePARLE: That complies with the Stark law?
18 That doesn't make sense.
19 MR. WINTER: The way is works is, the physician
20 might be in Missouri and they own or rent a lab, one of
21 these lab condominiums in Texas in a building with lots of
22 other labs owned by different physician practices. The lab

1 company, they provide the pathologist, the technicians, and
2 they rotate among the different lab condos in their building
3 and do the tests on the samples sent in by each physician
4 practice. Each physician practice then bills Medicare and
5 pays the lab company a fee. And as long as it's a space
6 that they control, that is only their space, then it appears
7 to comply at least with the letter of Stark.
8 However, there was an IG advisory opinion that
9 looked at one of these proposed arrangements between a
10 physician practice and a lab company and they said, this
11 could violate the anti-kickback statute, which as we know is
12 different than Stark but attempts to get at these same kinds
13 of arrangements, because in effect the lab company is
14 sharing profits with a physician practice in exchange for
15 referrals. That was what the IG said.
16 They did not issue a formal opinion with regards
17 to Stark because only CMS can issue advisory opinions with
18 regard to Stark. But they did note in a footnote that it
19 appears to be problematic with regard to Stark because the
20 physician practice has very little ability to monitor the
21 actual operation of the lab given that it's off-site,
22 perhaps in a different state, that the technicians and

1 pathologists are rotating among different labs. So they
2 raised questions about these kinds of arrangements under
3 Stark. But CMS has not issued a formal opinion about these
4 arrangements under Stark.
5 DR. KANE: I had a few questions but I am glad
6 you're doing the episode-based analysis because that seems
7 like the only way you can get a handle on appropriateness of
8 the volume.
9 One of my questions is, are the carriers just
10 Medicare fees or are these general fees for all payers?
11 When you say they're using their fee schedule I didn't quite
12 understand whose fees. These 56 carriers are the
13 intermediaries or are they just -- they're the
14 intermediaries.
15 Are they setting these fee schedules based on some
16 rules that Medicare gives, or do they have --
17 MS. KELLEY: The original fee schedules were
18 developed based off their own charges, and they were set in
19 1983. So since then new tests have come online, But again,
20 each carrier region sets its own.
21 DR. MILLER: That they take an average of that and
22 they take the 74 percent. And then the other point you made

1 is when a new test comes on the carrier does its own
2 research to establish a price for the test. Then that gets
3 averaged across all of the carriers, and 74 percent of that;
4 is that right?
5 MS. KELLEY: That's right.
6 DR. KANE: 74 percent of the median.
7 MS. KELLEY: Of the median, across all the areas.
8 DR. KANE: So you're already paying only the
9 bottom 30th percentile of the rates.
10 MR. HACKBARTH: So as a practical matter we
11 basically have a national fee schedule since everybody's up
12 against the national limit amount.
13 MR. MULLER: That's what the IOM found, that it
14 does appear as if most services are paid at the national
15 limit amount.
16 DR. KANE: It has to be by definition of the way
17 you set --
18 MR. DeBUSK: Is that increased annually?
19 MS. KELLEY: It's only been increased once since
20 1997.
21 DR. REISCHAUER: Twice in the last 15 years.
22 DR. KANE: So theoretically, the way you're doing

1 this you should be paying below what it costs them given --
2 so the national labs, the four or five or whatever there are
3 out there, how do they do financially and what proportion of
4 their business is Medicare and does anybody keep track of
5 that?

6 MR. BERTKO: Nancy, given that this got derived
7 from usual and customary, and at the time -- again, I
8 reference this obsolete information I had -- we had a three-
9 to-one ratio back about 1990 between certain kinds of
10 facilities and statewide reference labs. So if you think
11 that continued but moved down, 74 percent of the median
12 could, theoretically, still be okay, and that's the question
13 for these guys to find out.

14 DR. KANE: So are you going to look at some of the
15 big companies and see how they do financially?

16 MS. KELLEY: Definitely.

17 DR. KANE: The only place that you can think that
18 there's incentives in Medicare for efficient lab use is on
19 the inpatient side in that there's a DRG limit? Is there a
20 way to compare, if the test is a similar test, is it the
21 same fee or cost? Can you do anything --

22 MR. HACKBARTH: You're talking about rates per

1 unit of service as opposed to volume?

2 DR. KANE: Yes. Are there inpatient-outpatient

3 overlaps where you can compare the rates?

4 MR. HACKBARTH: I'm sure there's some overlap in

5 tests.

6 MR. WINTER: The problem with the DRG is that the

7 payment is set for the entire bundle of services provided

8 and I don't know how we could disentangle the cost for each

9 particular service.

10 MR. HACKBARTH: You'd have to go to the hospitals

11 and find out what --

12 DR. KANE: Yes, you'd have to go inside to --

13 MR. WINTER: When they're done in outpatient

14 departments they're paid under the clinical lab fee

15 schedule.

16 DR. KANE: But it's the same lab. Quest is still

17 doing both sets and I'm just wondering if there's a

18 differential on what they charge for the inpatient versus

19 the outpatient. Has anybody looked at the inpatient-

20 outpatient --

21 DR. MILLER: Yes, I think we get your point, which

22 is, can we look inside either the inpatient or the

1 outpatient prospective payment system and see if we can
2 derive a price from that to look at comparatively what's
3 going on? I just want to caution us. I think getting down
4 to the level within those systems could be difficult. But
5 that doesn't mean that we won't be doing other things, which
6 they alluded to, which are going to private sectors to try
7 to figure out what at least they're either paying or what
8 kinds of charges they're seeing, or whether we can go do
9 some of this by going to the hospitals directly and trying
10 to get some of that information.

11 But those are always hard roads to get down and
12 often produce inconsistent information, but we will try.

13 DR. CROSSON: I think I may just be reiterating
14 what Bob said before but it seem almost like there's two
15 issues here and almost two separate analyses which are
16 analogous to some of the other issues we've talked about
17 before, for example, specialty hospitals.

18 One is the degree to which there's a malalignment
19 between payment and underlying cost, irrespective of the
20 issue of ownership of control, which might influence how
21 much is paid. Then the second one, which was just referred
22 to and again has some analogous elements to it, is the

1 question of whether some proportion of the volume increase
2 that's now going on is in fact related to the relationship
3 between the ordering of the test and then the ownership and
4 control over the profit, and to what extent that relates to
5 relative malalignment of payment versus cost. So I think
6 we've almost been through this before in the last year and
7 you could imagine an analysis coming on both of those issues
8 MR. MULLER: The lab business is historically one
9 with very high fixed costs, very low marginal costs,
10 sometimes approximating zero. But with the genetics
11 revolution, as your chapter points out, we're getting into
12 an era, just as we do in drugs, where the cost of some of
13 these tests get to be quite considerable and the marginal
14 costs are quite high. So I think one of the things I's urge
15 you to look at is the emerging evidence on that, especially
16 in the detection of diseases that were not detectable
17 before, and as we've seen in other areas that we look at,
18 this can only accelerate. So you're going to get the kind
19 of specialization here that we've seen in the imaging area
20 and the drug area. So this is one where I think we're going
21 have an accelerant again.
22 Again, when the fixed costs-marginal costs

1 relationship, as it has been historically, there's a lot of
2 focus on consolidation and really -- and you've seen that
3 with the creation of all these national labs, and the local,
4 individual labs get driven out, except for the physician
5 office that's highlighted up there. But I would start
6 looking at that data because I think you may have to do it,
7 as you have in the past, with some case studies and examples
8 and so forth. But I think you're going to find some
9 explosive growth there, and the same kind of confluence of
10 patient interest in having these tests done, supplier
11 interesting in providing tests that were not available
12 before, physician interest, obviously, in meeting the needs
13 of the patient. So I think those things are coming together
14 in this area.
15 DR. REISCHAUER: On that point, my guess would be
16 that when a new test comes online, a complex new test, then
17 you go out and you survey what the cost or charges are for
18 this, you get a number that's fairly high and then over time
19 this falls like a stone, because of new technology and
20 familiarity with it. And the extent to which we go back and
21 revisit this, maybe just moving to the 74 percent of the
22 median is enough. Maybe it's too much.

1 MS. DePARLE: Thanks for delving into this topic.
2 It's obviously something that is small relative to Medicare
3 spending but given that we and perhaps the agency hasn't
4 looked at the pricing in about 20 years it does seem that
5 it's probably a good time to look at it. I had a couple of
6 questions about this chart, to follow up on John.
7 How do we count the Quest and Lap Corps of the
8 world?
9 MS. KELLEY: They're independent labs.
10 MS. DePARLE: But they're big companies. Are they
11 one? Are they 100?
12 MS. KELLEY: No, this would be each individual
13 lab.
14 MS. DePARLE: So each individual site that they
15 have, as Ralph said, some in hospitals some in other
16 locations would count?
17 MS. KELLEY: Yes. This is based on the actual
18 site of service so hospital labs are considered to be a
19 hospital labs, if they're based in the hospital.
20 MS. DePARLE: On the subject of more information
21 about them, I'm confident there's a lot of very granular
22 information out there from Wall Street on at least those two

1 companies and their Medicare versus other payers and how
2 that is handled.
3 MS. KELLEY: We can look into that.
4 MS. DePARLE: I think Glenn or John said this but
5 I would be very interested in seeing more -- or maybe it was
6 actually Bob -- about the growth of the physician office
7 labs, and if we can look at that over time.
8 MS. KELLEY: Yes, that's an interesting point
9 because after CLIA was put into place with the more
10 stringent requirements, there was quite a drop in the number
11 of physician office labs. We've seen that creep back up and
12 some of that may just naturally moving back as people figure
13 out how to deal with the regulations, but there could also
14 be something else going on there as well.
15 MS. DePARLE: I think we talked about the
16 something else going on. One of the something elses was
17 what the Journal highlighted, which I did not see, and that
18 was going to be my next question.
19 MR. MULLER: -- just the usual incentives we
20 talked about, but the peep technology has advanced quite a
21 bit so you can now buy these little miniature sets for a
22 small amount of the money versus a big amount of money.

1 MS. DePARLE: On that subject, is there a way to
2 separate out -- we've been interested in the quality of the
3 testing, a couple of my colleagues have asked about that.
4 Is there a way to separate out the CLIA scores by side of
5 service and show how --
6 MS. KELLEY: Yes.
7 MS. DePARLE: -- show how the different sites are
8 doing?
9 MS. KELLEY: Yes.
10 MS. DePARLE: Because we've also said that for
11 pay-for-performance and those sorts of payment schemes in
12 the future the labs could be important.
13 Ariel, on the Wall Street Journal article, I
14 hadn't read it and obviously it's quite intriguing. It
15 sounds as though the arrangement that's being described,
16 putting aside the Stark law, is similar to the one that we
17 made a recommendation on with respect to imaging in our
18 January-March report. As I understood it, the equipment is
19 owned by someone else and is leased to the doctors; is that
20 right?
21 MR. WINTER: It can vary. Sometimes the physician
22 can own the equipment and the lab company simply provides

1 the technicians and the pathologists. In other cases they
2 may provide everything, the space, the equipment and the
3 technicians.
4 MS. DePARLE: In the latter case, isn't that the
5 very situation we criticized and recommended that CMS
6 proscribe in our March report?
7 MR. WINTER: It's different, although it relates
8 to similar kinds of incentives. Are you referring to our
9 recommendation on nuclear medicine?
10 DR. MILLER: No, she's referring to the --
11 MR. WINTER: Surrogate ownership.
12 MS. DePARLE: Surrogate ownership, yes.
13 MR. WINTER: So that's a little bit different
14 because we're talking about a relationship between a
15 physician and a freestanding entity that they don't control.
16 But there's an incentive for them to make referrals to that
17 entity because they're renting equipment or services to that
18 entity and getting a per-unit fee whenever they refer a
19 patient for a there.
20 This is different because technically speaking
21 this lab is part of the physician's practice, so it's not a
22 freestanding entity. It's part of their practice. The

1 question is, is it really integral to their practice or is
2 it just legally part of their practice and someone else is
3 actually running the show? They're similar in that they
4 both create the potential for financial incentives that
5 could influence referral decisions by the physician.
6 DR. MILLER: I think that there a suggestion when
7 you were going through your talk that that was the potential
8 and why I think you're reacting to, isn't this situation
9 similar, because you said the footnote was this situation
10 may arise. There may be a potential here that referrals may
11 be influenced by this. In that sense, while the example
12 back in the specialty report was that triangle and it was a
13 stand-alone entity, the same incentive overlaps even though
14 the structure is different. I think that's what we're
15 trying to say and I'm not saying it well.
16 MR. SMITH: There's the potential here of combined
17 perverse incentives. There's the self-referral incentive
18 that Stark speaks to, and then there's the promiscuous use
19 incentive which is there regardless of ownership. But both
20 operate and they reinforce each other in a case where the
21 doctor has a financial interest, either with a fee-sharing
22 arrangement or an ownership arrangement in the diagnostic

1 lab.

2 MS. DePARLE: I agree and I find it very troubling
3 and the commissioners who were at our retreat two years ago
4 will remember that we heard about the beginnings of this
5 then. So it sounds as though it's gotten to be a bigger
6 practice.

7 MR. WINTER: We can certainly look into the self-
8 referral angle of this. It's probably worth mentioning that
9 most of the clinical lab tests paid for by Medicare or not
10 done in physician office labs. I can give you closer to the
11 exact number but it's fewer than 10 percent. So most are
12 done in independent labs or hospital-based labs.

13 DR. STOWERS: Mine is kind of an antique point a
14 little bit, but when CLIA hit, a lot more physician labs
15 were doing a lot more things. They had the profiles and
16 that kind of thing, and we did the CBCs, chems and the whole
17 thing. So that by the time I would say another couple of
18 patients I could walk back out and have the results and be
19 able to give that immediately to the patient and start
20 therapy for that particular patient.

21 I'm just curious, because I've never seen it
22 quantified, but we all lived through it in those days of

1 instead of fighting the CLIA we would stay with the waived
2 lab and we would start referring out a lot of that. So
3 there suddenly became a considerable increase in the number
4 of E&M visits and that kind of thing. When possible you
5 would call the results to the patient, your cholesterol is
6 doing okay, stay on the same medicine. But often it would
7 change therapy waiting on the lab results, especially in
8 diagnostic workups. And even though we saved some on going
9 to the reference lab which was a little more economical,
10 there were considerable higher physician charges overall
11 that related out of that.
12 I'm just curious if that's ever been quantified,
13 or at least taken into consideration that CLIA brought on
14 not a savings in going to the other labs, but a considerable
15 cost on the physician increase, and the patient having to
16 wait on the results, because the physicians lost the
17 independence to have that information immediately available.
18 So I think it was amount to big dollars over time and I just
19 think that at least needs to be somehow mentioned in this.
20 MR. HACKBARTH: Yes, are you aware of any research
21 on that, Dana?
22 MS. KELLEY: I'm not aware of any research on the

1 association of those two. I think the impetus for CLIA was
2 less about saving money and more about providing more
3 oversight of labs. There were a lot of concerns about
4 quality. So I don't know of any research that's looked into
5 that but we can certainly --
6 DR. STOWERS: But at least even from the medical
7 standpoint there was a trade-off on quality, because it's
8 going to be a day or two or three to get labs back and
9 you're suspecting a bleed of some kind or something like
10 that, I think there was a quality trade-off and I think
11 there was a huge physician cost trade-off that occurred
12 during that time that I think at least need to be looked at
13 a little bit further.
14 MR. HACKBARTH: Anyone else?
15 Okay, thank you very much.
16 Next we have two payment adequacy discussions back
17 to back. Each of these is a new area for us to assess
18 payment adequacy. We will begin with inpatient rehab
19 facilities.
20 DR. KAPLAN: As Glenn said, we have two post-acute
21 sectors that have new prospective payment systems, and post-
22 PPS data is now available. Our objective is to include

1 these two sectors in our assessment of payment adequacy this
2 cycle. Technical issues, such as a small sample size or
3 other issues, might keep us from reaching that objective,
4 and I just want to point that out now because we're working
5 with the data now but we don't have a good idea yet as to
6 whether there are issues with it.
7 Inpatient rehabilitation facilities also known as
8 IRFs, and they have one of the new PPSes. The IRF PPS began
9 January 2002. Today I'm going to give you information on
10 three of the six factors that we used to assess payment
11 adequacy, and hopefully bring you more evidence in December.
12 We see slow growth in the number of IRFs entering the
13 Medicare market. We see faster growth in the volume of
14 cases between 2002 and 2004. And we see that IRFs appear to
15 have access to capital.
16 IRFs provide intensive physical, occupational, and
17 speech therapy on an inpatient basis. In 2004, Medicare
18 spent $6 billion on IRF care, and Medicare represents about
19 70 percent of IRF patients.
20 On the screen you see a map that has green
21 triangles that represent the hospital-based IRFs. The red
22 dots represent the freestanding IRFs. As you can see,

1 they're concentrated in the eastern and southern United
2 States.
3 To be paid as an inpatient rehabilitation
4 facility, IRFs must meet the conditions of participation for
5 acute care hospitals and other conditions. For example,
6 they must have a medical director who is a specialist in a
7 rehabilitation and provides care to patients on a full-time
8 basis. They also must have a pre-admission screening
9 process to determine whether patients they're admitting are
10 appropriate for IRF care. And to be admitted, patients must
11 be to tolerate and benefit from three hours of therapy per
12 day.
13 The 75 percent rule is one condition that
14 inpatient rehabilitation facilities must meet, and the new
15 75 percent rule is controversial because patients formerly
16 treated in IRFs are no longer considered appropriate for IRF
17 care. The 75 percent rule requires that 75 percent of
18 admissions to a IRF must have one or more specified
19 conditions. You see on the screen the conditions.
20 The old rule, which was frequently called HCFA-10,
21 because it had 10 conditions, was in place from 1984 to
22 2004. In 2004, CMS removed polyarthritis from that list and

1 added three arthritis-related conditions, which you can see
2 in the box on the right side of the screen. Polyarthritis
3 was the rationalization or the condition that was used for
4 joint replacement patients, which is the largest category of
5 patients in 2004, representing 27 percent of Medicare cases.
6 Under the new rule, a joint replacement patient is
7 appropriate if both knees or hips have been replaced, the
8 patient is aged 85 years or older, or has a body mass index
9 greater than 50. That's a higher standard than the
10 definition for morbidly obese.
11 At the same time that CMS changed the conditions
12 and the rule, it phased in the rule. IRFs not in compliance
13 with 75 percent rule will be paid acute hospital rates. For
14 example, the acute hospital rate for a stroke patient is
15 $4000, the IRF rate ranges between $8,000 and $34,000. For
16 the December meeting we'll try to estimate the impact of the
17 new 75 percent rule on inpatient rehabilitation facilities.
18 On the screen you see a schematic for the
19 prospective payment system for IRFs, and just a few
20 highlights. It's a per-case or per-discharge based system.
21 The case mix adjustment is based on diagnosis, functional
22 status, cognitive status, age, and comorbidities. Payments

1 are adjusted for facility characteristics such as location
2 in a rural area, proportion of low-income patients treated,
3 and teaching status. And payments are adjusted for high-
4 cost outliers and also for short stays. The base rate is
5 almost $13,000 for 2006.
6 Now we're going to move to the three factors I
7 talked about earlier. On the screen you see the rate at
8 which IRFs have entered the Medicare program. As I said
9 earlier, you have hospital-based IRFs and you have
10 freestanding IRFs. Hospital-based IRFs represent 80 percent
11 of the facilities and 66 percent of the discharges. If IRF
12 PPS payments are adequate we would expect IRFs to enter
13 Medicare. They are entering at the same rate as
14 beneficiaries, about 2 percent per year since the PPS was
15 implemented.
16 If PPS payments are adequately we would expect an
17 increase in volume. As you can see on this chart, between
18 2002 and 2004 the volume of cases increased at 6 percent per
19 year. Medicare payments increased even faster at 15 percent
20 per year. The average length of stay was decreasing before
21 the PPS and has continued to decrease after the PPS.
22 If payments are adequate we would expect a sector

1 to have access to capital. As I said before, 80 percent of
2 IRFs of hospital-based and they have access to capital
3 through their parent institution. Freestanding IRFs also
4 appear to have access to capital. For example, a new
5 company has raised $40 million in private equity funding and
6 plans to eventually build 36 IRFs in Western states over the
7 next five years. The five sites they've announced so far
8 are in cities without IRFs at this time.
9 So to sum up, we see that IRFs are entering
10 Medicare at the same rate as beneficiaries, the volume has
11 increased rapidly, and IRFs have access to capital. In
12 December I'll provide you with more information and I'm
13 happy to take your questions now.
14 MR. HACKBARTH: Sheila.
15 MS. BURKE: This is a question that applies to
16 this issue as well as it might well apply to our next issue
17 which is long-term care hospitals. I continue to try to
18 grapple with the geographic distribution that has arisen in
19 this case as well as in the other, and I wonder what's
20 happening to the rest of the country. Where are these
21 people being treated? There's a strange circumstance that
22 has this enormous intensity in largely narrow areas of the

1 country and I find that troubling. I'm not sure what it
2 tells us, but it would be interesting to have an overlay of
3 the distribution of the specialty hospitals, long-term care
4 hospitals and these hospitals. Have we looked at that and
5 looked at the underlying question in terms of what's taking
6 place? I can't believe nobody in the middle of the country
7 is having their hips replaced.
8 DR. KAPLAN: Let me go back to the map a minute.
9 I don't think it shows up very well on there but there are a
10 number of IRFs in the center of the country, and there are
11 bunches of them in California, the San Francisco area and
12 the Los Angeles area and a few spotty other places. I think
13 we can bring you beds per 10,000 beneficiaries in December
14 by region and that might give you a little better feel. We
15 can overlay the long-term care hospital beds and the IRF
16 beds together, and specialty hospitals. We could also do
17 SNFs, et cetera.
18 MS. BURKE: That would certainly be helpful to
19 understand. There just seems to be this growing trend of
20 certain things happening in narrow places and I'm just
21 trying to get a sense broadly about what's going on.
22 DR. KAPLAN: Okay.

1 MS. HANSEN: The first part was the same area of
2 questioning that Sheila just asked, but the second part has
3 to do with the clinical outcomes of the people who can get
4 these services. With the gradual decreasing length of stay
5 and the fixed payment, that just leads one to think then
6 there's a greater profit margin afterwards. But are the
7 clinical profiles showing that the results of clinical
8 outcomes similar over time, or is there also a benchmark of
9 discharge?
10 DR. KAPLAN: As part of payment adequacy
11 assessment we do track change in quality and I will be
12 bringing information on FIM gain and the change since the
13 PPS. We have no pre-PPS information on that but we can
14 bring you since the PPS. It's called FIM gain.
15 DR. MILSTEIN: I'd be very interested in having
16 information within this report that would enable me to
17 better understand the incremental value proposition
18 associated with these facilities. Clearly there are many
19 parts of the country in which patients are getting their
20 rehabilitation not in these facilities. What do we know
21 about whether or not patients in these facilities do better
22 than many Medicare patients that don't have access to these

1 facilities? Maybe if we do have our episode-grouping
2 software up and going by the time this report is issued,
3 what impact are these facilities having on total cost per
4 episode both -- and I guess for chronically ill patients
5 over a year or two period, not just the episode of
6 treatment?
7 DR. MILLER: Let me just take you back for a
8 minute. We did do some work in our June report and the
9 analysis there was directed at two things, looking at cost
10 and looking at outcomes. It was looking at skilled nursing
11 facilities, IRFs, and the reference point in all of the
12 analysis was relative to people who went home or got no
13 follow-up care. Again, just characterizing the results --
14 since it's been several months it won't be precise -- the
15 way it worked was that patients who did the best were
16 patients who went home for their therapy, IRFs were next and
17 SNFs were next.
18 The differences were small in some respects but
19 there was a huge issue, however, just raised by that very
20 hierarchy of how well you could actually sort out the
21 selection of the patients across the sites, and there was a
22 huge -- we worked very hard methodologically to remove that

1 but ended up with a conclusion that while we found these
2 results, we would have preferred different measures to look
3 at the outcomes, which weren't precisely available to us,
4 and there was still this selection issue overhanging the
5 whole analysis. That was the state of our art.
6 Then to Jennie and your question, we're going to
7 try to look at FIM score specifically for this area and see
8 how they're changing.
9 MR. HACKBARTH: Part of the context for that
10 research was it was an illustration of our frustration with
11 inadequate information to assess performance in the post-
12 acute settings, and part of our discussion about having a
13 common instrument of that sort of stuff.
14 DR. MILSTEIN: I guess maybe I'm suggesting that
15 since we do have information that might enable a more
16 nuanced quality analysis, in addition to answering Jennie's
17 question about change over time as length of stay is
18 changing, also perhaps more information on comparative
19 patient outcomes across these different choices,
20 appreciating the fact that we don't feel fully satisfied in
21 our ability to adjust for patient selection differences.
22 DR. KAPLAN: There is a very small amount of

1 research that's taken place comparing similar patients in
2 different settings. It is not the newest research and it is
3 not since the prospective payment system. But I can also
4 bring you some of that information as well.
5 DR. MILLER: I'm not disagreeing with this comment
6 but I also want to be really careful here because I think
7 when you look across these settings what's really stark is
8 how sharp the selection is. This is not subtle. You see
9 very different patients go to very different places. So if
10 you look at just raw quality outcomes I think you can really
11 end up reaching the wrong conclusion here.
12 So this is not a disagreement. We will definitely
13 try to churn this. But I want to caution that what you will
14 be looking at will hide, often, what the underlying
15 distribution of the patients are.
16 MS. BURKE: Mark, to that point, I think that
17 underscores for me again my desire to understand, because of
18 this odd geographic scenario, which again I remember being
19 very similar to the odd distribution in the other specialty
20 areas. Exactly what do we know? What about the selection
21 of patients? What about the quality indicators? What about
22 the long term impact, the readmission rates? All of those

1 issues that when you in contact look at the totality of what
2 the patient has faced and what the program has incurred in
3 terms of cost. So I think you're exactly right, the more we
4 can understand what is it about the selectivity, what is it
5 about the nature of those patients, and what happens to them
6 in the other half of the country where they may not have the
7 same choices? Does that assume that everybody west of the
8 Mississippi, except in a few states, isn't getting care? I
9 think it really presses the question.
10 MR. HACKBARTH: One of the things that we have to
11 keep reminding ourselves of is that the capability of the
12 institutions varies depending on what the resources are in
13 the communities. So a SNF in a community that also has
14 inpatient rehab facilities and long-term care hospitals
15 might look very different from a SNF in that part of the
16 country where those specialized institutions don't exist.
17 MS. BURKE: One hopes that might be the case but I
18 think that's a very legitimate question as to whether that
19 is the case.
20 MR. DeBUSK: Pertaining to that, this chart is
21 hard to read. Is this distribution really that unusual,
22 Sally?

1 DR. KAPLAN: That's why I offered to bring you
2 beds per 10,000 because I think it's really difficult to
3 look at this chart. We know that the average bed size for a
4 hospital-based facility is 20 beds. The average bed size
5 for a freestanding is, I believe, 60 beds. So just looking
6 at facilities doesn't tell us as much as looking at beds,
7 which is why offered to bring beds to you in December. As I
8 said, we can also look at just IRFs or we can look an
9 overlay with the other post-acute facilities.
10 MS. BURKE: I'm assuming there are some border
11 issues. Particularly the freestanding, you see them loaded
12 into certain areas. The distribution of the hospital-based
13 is a little broader. And presumably there are people that
14 move across borders. Louisiana seems to be particularly
15 blessed.
16 DR. REISCHAUER: Was.
17 MS. BURKE: It was particularly blessed, less so
18 now. The eastern part of Texas seems to be blessed in a
19 number of ways or was. But again, I think the beds will be
20 important to understand. But again, the distribution -- I
21 may be remembering incorrectly but it seems to me we've been
22 here before and it looks like the specialty hospital

1 distribution.

2 MR. HACKBARTH: In terms of certain areas being,
3 as you put it, blessed, that's true. But if you think back
4 to the distribution of specialty hospitals and long-term
5 care hospitals, there weren't nearly the number of those
6 that there are of these in the Northeast, so that's a
7 difference in the pattern.

8 DR. REISCHAUER: The LTCHs are heavily there, and
9 I'm not sure why specialty hospitals should be in this game
10 at all. It's really LTCHs and IRFs and maybe SNFs. I was
11 wondering if there's just really a simple way of doing this,
12 if there is a high correlation as Sheila suggests. You look
13 at the LTCH distribution in the next chapter and New England
14 is 26 beds per 10,000, West South Central which is Texas,
15 Louisiana is 16, and then the Pacific is three. So you have
16 these huge differences.

17 If the IRF is like that, you could sum the two of
18 those and it's not like the incidents of either these
19 conditions or the severity of these conditions varies
20 tremendously across census regions. So you don't have to
21 worry about our patients going to the right place. Then you
22 look for Arnie's thing which is some outcome measure,

1 readmission or whatever, in just a very crude sense. This
2 isn't, obviously, a definitive analysis but it's taking huge
3 discrepancies in per-10,000 availability of these things and
4 seeing if anything pops up in terms of an outcome measure.
5 MR. MULLER: I think we discussed a year or two
6 ago in the LTCHs, I think the New England is more historical
7 accident of all those chronic care facilities. But I think
8 the rest of the country is germane to the point that you're
9 making.
10 MS. HANSEN: The whole aspect of the rest of the
11 country, you just wonder that if people have strokes in
12 other places, do they recover? So that just is like a
13 consumer's question in looking at the distribution of
14 resources.
15 The other thing I just want to point out, because
16 it's not something that comes on your radar but is a cluster
17 of providers is medical adult day health centers, which is
18 not a Medicare benefit at this point but does serve dual
19 eligibles, and there are thousands across the country that
20 have that and are distributed. So It's just there are other
21 ways perhaps also to do that in addition to the questions
22 that were brought up.

1 MR. HACKBARTH: Anybody else?
2 Okay, thank you, Sally, and begin when ready.
3 DR. KAPLAN: Now we're going to talk about long-
4 term care hospitals. They have the second new prospective
5 payment system and it began in fiscal year 2003. We've been
6 concerned about growth in this sector in the past and we are
7 still concerned because rapid growth continues. For
8 example, Medicare spending between 2001 and 2004 grew at 25
9 percent per year.
10 We studied long-term care hospitals a couple of
11 years ago, you may remember. It was in our June 2004
12 report. We recommended that CMS and Congress collaborate on
13 implementing new criteria to define long-term care hospitals
14 and their patients. At this time CMS has not implemented
15 our recommendations.
16 Today we're going to focus on payment adequacy and
17 I'm going to present four of the six factors that we used to
18 assess payment adequacy. The number off long-term care
19 hospitals increased rapidly under the PPS. The volume of
20 cases increased more rapidly. Medicare spending increased
21 more rapidly than volume, and beneficiaries' access has
22 increased. Long-term care hospitals also appeared to have

1 access to capital.

2 To be a long-term care hospital they must meet the
3 conditions of participation for acute care hospitals and
4 have an average length of stay greater than 25 days for
5 their Medicare patients. In 2004, Medicare spent $3.3
6 billion on long-term hospital care and Medicare represents
7 about 70 percent of long-term care hospital patients.

8 On the screen you see the top 10 long-term care
9 hospitals diagnoses. As you can see they are pretty widely
10 dispersed. Only one diagnosis has more than 5 percent of
11 the long-term care hospital cases. However, five out of the
12 10 top DRGs are respiratory related.

13 I'm going to show you a series of maps. On the
14 screen you will see a map that has very light blue
15 triangles. These are the long-term care hospitals that
16 existed prior to October 1983. Now we're going to add the
17 red dots. These are for the long-term care hospitals that
18 entered the Medicare program between October 1983 in
19 September 1993. I'm trying to give you an idea of how the
20 growth has been.

21 Now we had some pink triangles, quite a few pink
22 triangles as you might notice, which are long-term care

1 hospitals that entered the program between October 1993 and
2 September 2003. As you can see there are lots of pink
3 triangles and they're concentrated in some states. For
4 example, Louisiana, Texas, Ohio, Michigan, Indiana, and
5 Pennsylvania.

6 Now we've added green stars. They are long-term
7 care hospitals that have entered the program since September
8 2003. About half of these long-term care hospitals are
9 located in market areas that had no long-term care hospital
10 previously and half are located in areas where there already
11 was a long-term care hospital.

12 Now let's talk a little bit about the PPS. It
13 started, as I said, in fiscal year 2003. There was a five-
14 year phase-in, but there also was an option to choose 100
15 percent PPS payments rather than a transition into the
16 prospective payment system. As of 2004, 93 percent of long-
17 term care hospitals had chosen to take the 100 percent
18 option. The fact the lion's share of long-term care
19 hospitals chose that option suggests that PPS rates are
20 attractive.

21 On the screen you will see a schematic of the
22 long-term care hospital PPS. The high points are it's

1 discharge based. The case mix groups are the same DRGs as
2 are used in the inpatient PPS. However, the LTC-DRGs have
3 different weights that based on long-term care hospital
4 patients' costs. The PPS adjusts for high cost and short
5 stay outliers. The base rate is $38,000.
6 Now let's move to the factors that we use for
7 payment adequacy. First you see the entry of long-term care
8 hospitals into the program. If PPS payments are adequate we
9 would expect long-term care hospitals to enter Medicare, and
10 as you see on the screen they've grown rapidly since 1990.
11 That's the red line. And it has accelerated under PPS,
12 especially for hospitals-within-hospitals which is the green
13 line.
14 Growth in hospitals-within-hospitals resulted in
15 CMS establishing a new policy, hopefully to ensure that
16 hospitals-within-hospitals don't act like hospital-based
17 units, which aren't allowed, and that decisions are based on
18 clinical and not financial factors. The new rule limits to
19 25 percent that share of cases a hospital-within-hospital
20 can admit from its host hospital. For cases greater than 25
21 percent, hospitals-within-hospitals will be paid IPPS rates.
22 There's going to be a phase-in of this policy over three

1 years and there are exceptions for rural hospitals-within-
2 hospitals and for some urban ones.
3 If PPS payments are adequate we would expect
4 volume to increase. As you can see, the number of cases
5 increased 12 percent per year between 2001 and 2004.
6 Medicare spending increased 25 percent per year. In the
7 last year from 2003 to 2004, which is not shown on the
8 screen, spending increased 28 percent.
9 So how did beneficiaries' access to care change
10 under the long-term care hospital PPS? The number of long-
11 term care hospitals increased, as you've seen. The bed
12 supply increased nationally by five beds per 10,000
13 beneficiaries. The volume of unique beneficiaries using
14 long-term care hospitals increased at 13 percent per year.
15 From these increases we conclude that beneficiaries' access
16 to long-term care hospitals has increased under PPS.
17 If PPS payment is adequate, long-term care
18 hospitals will have access to capital, and they appear to
19 have it. Two large chains make up 40 percent of the
20 industry, both purchased a major part or all of their stock
21 holdings this year.
22 To sum up, under the long-term care hospital PPS

1 the supply of long-term care hospitals has increased
2 rapidly. The cases and spending increased dramatically.
3 Beneficiaries' access to long-term care hospitals increased.
4 And long-term care hospitals appear to have access to
5 capital.
6 The trends we see in these factors are clearer
7 than what we saw for the inpatient rehabilitation facilities
8 but we need to see more evidence before reaching a
9 conclusion.
10 I'm ready for your questions and comments.
11 MR. HACKBARTH: Sheila.
12 MS. BURKE: Sally, if you could help me understand
13 the rationale behind establishing 25 percent as a number.
14 One would assume that if we could accurately measure or
15 identify those characteristics that would qualify someone
16 for using these assets that an arbitrary cap would be at
17 odds with that philosophy. So what was behind 25 percent?
18 Where do we believe we are in terms of accurately
19 identifying the characteristics of a patient who is more
20 appropriately in a long-term care unit rather than in a
21 traditional acute care facility?
22 DR. KAPLAN: I can't say where the 25 percent

1 figure came from. We recommended, as I said earlier, that
2 CMS and the Congress collaborate to establish criteria to
3 define the hospitals and also the patients that are
4 appropriate for the long-term care hospitals. CMS has a
5 study that RTI is doing at the moment that is to basically
6 determine the feasibility of implementing our
7 recommendations. So we commented on the proposed 25 percent
8 rule when it came out and basically our comments were that
9 we didn't think this was a great idea, that decisions need
10 to be made on a patient-by-patient basis and that our
11 criteria would do that and that was a better solution.
12 That's where we are.
13 MS. BURKE: What's the timing, do we know, on --
14 DR. KAPLAN: The report is in process.
15 Theoretically, the research has been expanded is what I
16 hear. The report is due to CMS I believe -- CMS has
17 basically set in other rules that they plan to discuss RTI's
18 report in their proposed rule. The proposed rule should be
19 out in February.
20 DR. MILLER: To tell you one other thing, the
21 industry seems to have also embraced that position.
22 Obviously, the exact details I'm sure would perhaps need to

1 be discussed further, but they seem to have a position that
2 the notion of a criteria, uniform criteria on what kinds of
3 patients should come and what kinds of facilities, what
4 would constitute a facility, and that certain patients may
5 be inappropriate for these facilities and better in other
6 post-acute care settings seems to be something to they're
7 saying now as well. So there may be some traction on this
8 if CMS comes out and starts to propose something.
9 MS. BURKE: Just to follow that up with one
10 additional question. One wonders then if in fact we can
11 agree on criteria. This applies to this broader question of
12 these things that are separating themselves out from acute
13 care hospitals. But one wonders if we were assume that we
14 could identify those criteria, what would occur in its
15 application in geographic areas where in fact there are no
16 assets? Where effectively, if we agree, if the base rate is
17 $38,000 or whatever it happens to be, that we agree that
18 there are criteria that would argue that a patient needs an
19 additional set of resources that are only available in that
20 kind of a setting. What happens, theoretically, in the rest
21 of the half of the country where they don't have access?
22 Does that mean that from a policy standpoint we need to

1 think about whether or not we need to being to reimburse
2 differently in a different setting?
3 The underlying question is, the presumption is you
4 identify a category of patients with particular needs that
5 can only be served, arguably, under this scenario, in a
6 facility that has a set set of services. What happens when
7 half the country doesn't have those services?
8 DR. MILLER: Here's how I would try to answer
9 that, and let me preface by saying I'm sure it will be
10 inadequate. Just I like to set standards before I head out,
11 and then meet them.
12 [Laughter.]
13 DR. MILLER: It's absolutely fair, and remember
14 how some of this goes. This is this constant struggle of
15 dealing with, we have an immediate problem in front of us,
16 what are we going to do with long-term care hospitals? And
17 this bigger problem that we try to grapple with, many times
18 but most recently in the June report of, what you really
19 need here is a payment system that looks at the patient,
20 says these are the resources you need, and pays. If that
21 happens in a hospital step-down unit, if it happens in an
22 advanced SNF or a whatever, that that would be the right

1 place to be.

2 Then we would find ourselves retreating to, in the

3 absence of that, this is how the whole long-term care

4 hospital discussion went, can we set some patient and some

5 facility criteria as a second, maybe even a third best,

6 solution to it? But your point is really well taken, but

7 this is why we're trying, at least in the post-acute world,

8 to get above the setting.

9 MS. BURKE: Again I don't want to drag this out

10 now, but I think as a policy matter going forward, I think

11 there is a fairly fundamental question here. Because if in

12 fact we want to do what you suggest, which I think

13 theoretically makes sense, which is to look at the patient

14 irrespective of the setting and say, these are the

15 appropriate assets to care for a patient with these

16 circumstances and we will pay for that service to be

17 delivered, it flies in the face of a delivery system that

18 essentially has half the country arguably incapable of doing

19 that, or we begin to pay at a rate that is in excess of what

20 the stated cost is in a particular setting.

21 DR. REISCHAUER: You're just arguing that they go

22 somewhere else before so --

1 MS. BURKE: No, that's the question.
2 DR. KANE: Don't you have to look at -- this is
3 where the SNF stuff, who's in the SNF still in those
4 locations and whether you have two completely different
5 geographic systems for long-term care. The payment system
6 should maybe reflect -- if the SNF patients in the Northeast
7 are empty of all these long-term care patients now and that
8 would have implications for their cost structure and their
9 payment rates.
10 MS. BURKE: But you're going to find -- I think, I
11 don't know this. It may be too many years in Kansas, but I
12 think you're going to find that there are parts of the
13 country where in fact it is not at all clear that if we
14 argue that there are a certain set of circumstances that
15 have to be present for someone to be adequately and
16 appropriately cared for, that those assets aren't available.
17 DR. KANE: But they could be available in a SNF.
18 MS. BURKE: Maybe.
19 DR. KANE: But not in the geographies where the
20 long-term care hospitals --
21 MS. BURKE: Possibly.
22 DR. KANE: My aunt had a stroke. She went through

1 three different sites of care in the Northeast. Perhaps in
2 Arizona she would have stayed in one place.
3 MS. DePARLE: But we might not be paying the SNF
4 enough. I think that's important --
5 MS. BURKE: Yes, My point is --
6 DR. KANE: The payment has to reflect that.
7 MS. BURKE: Correct. So if suddenly the base rate
8 for SNF patients is $38,000 a year --
9 DR. KANE: It should be going down, yes.
10 MS. BURKE: That's an interesting question. I
11 mean in 25 days.
12 DR. KANE: I also thought we didn't -- what does
13 long-term care mean? I thought Medicare didn't cover long-
14 term care. Where's the transition from here to real long-
15 term care? What do they do to these people after --
16 MR. HACKBARTH: That's thrown in just to confuse
17 matters.
18 DR. REISCHAUER: I might have misheard you, Sally,
19 but did you say that 40 percent of the industry is too large
20 chains?
21 DR. KAPLAN: I did.
22 DR. REISCHAUER: So then a lot of the hospitals-

1 within-hospitals are run by a different entity is what
2 you're saying?
3 DR. KAPLAN: Exactly. That's correct.
4 DR. REISCHAUER: That's interesting.
5 DR. KAPLAN: They lease the floor or a wing --
6 DR. REISCHAUER: I guess you never do cease to be
7 amused by these things. I just wondered if anybody has
8 looked at hospitals-within-hospitals, I mean LTCHs and the
9 others, and tried to see whether they're outlier payments
10 are lower than situations where -- this could be a situation
11 where we're trading off direct payments for outlier payments
12 for these kinds of things.
13 DR. KAPLAN: We did look at that when we did our
14 long-term care hospital study. Now mind you, this is all
15 pre-PPS. We found that the hospitals-within-hospitals
16 actually had more outlier patients than the freestanding --
17 people who had been outliers in the acute care hospital
18 before they came. So it was counterintuitive. You would
19 expect that the hospitals-within-hospitals would have fewer
20 outlier patients, but we actually found that they had more.
21 DR. REISCHAUER: In that regression did we control
22 for profit, non-profit?

1 DR. KAPLAN: That was not a regression. That
2 actually was --
3 DR. REISCHAUER: Just a tabulation?
4 DR. KAPLAN: Yes, exactly.
5 MR. HACKBARTH: One of the points that we made, as
6 I recall, in that report was that if you want to address
7 this area you not only need patient criteria, you need
8 appropriate rates, but you also need to look at the outlier
9 payment system for inpatient care. What we need to do is
10 synchronize those perhaps better than they are synchronized
11 today.
12 DR. KAPLAN: We actually found that SNFs and acute
13 care hospitals were substitutes for long-term care
14 hospitals. I just wanted to point that out. That it's not
15 just SNFs that are a substitute. Long term we would like to
16 redo that study on long-term care hospitals but the data
17 aren't going to be available for a while.
18 MS. HANSEN: Some of the areas have definitely
19 been covered, but I wondered, if we have the average length
20 of stay that we could also convey as to what is still
21 covered, even though it is a PPS system, whether we have any
22 information on average length of stay.

1 DR. KAPLAN: I think it's on the chart.

2 MS. HANSEN: I'm sorry, I missed that. Then the
3 other question I had was, relative to this whole concept of
4 bricks and mortar, whether it's within hospitals-within-
5 hospitals or freestanding facilities, is it a situation
6 where so much capital actually goes into that whole effort
7 as compared to getting the clinical results for the patient?

8 In the long-term care arena I think people are
9 also aware, even though we're not hearing it, but the
10 concept has started to move where the money follows the
11 client. There's an episode of care, that you figure out
12 what the ballpark pricing is, and then that person has
13 choice. Which then addresses this issue that if you have a
14 stroke in Wyoming and you need to get to a certain level of
15 function, you don't have a long-term care hospital or you
16 don't have some of these hospitals-within-hospitals, you
17 still can get better if you have the resources.

18 But that's a whole different approach that is
19 coming from another been arena where, again, you have to do
20 the patient characteristics, you have to have the quality of
21 care and so forth. But at the end of the day it's like,
22 what result does that person have for what average cost?

1 That becomes a much more portable approach to the individual
2 rather than only looking at bricks and mortar. I wonder if
3 that has been looked at as a way of -- it's just a very
4 different approach, but it's a way of dealing that you don't
5 have to have physical structures all the time that you have
6 to develop.
7 DR. MILLER: Let me reinforce that a little bit.
8 I'm forgetting where this fell in the process, whether we
9 had done this by the time we had written the June report or
10 whether it was a discussion at the planning session. But we
11 brought in a set of experts, people who do research in the
12 area, that type of thing, and had lots of conversations
13 about methodological issues, selection, measurement, that
14 type of something. But also at the end, what are people
15 thinking about policy directions? This is precisely the
16 type of thing that they were talking about.
17 And if you could get a set of common metrics,
18 build the payment around the patient and then let -- this is
19 probably going to upset some people in the public audience
20 but in the end these silos wouldn't necessarily need to
21 exist. The patient would just move through some type of
22 post-acute care and it wouldn't be so much, I'm now moving

1 from an IRF to home health as much as there would just bee a
2 continuous process, depending on the complexity of where you
3 are in your recovery process. I can't remember if at that
4 point we had gone through that and written some of that up
5 in the chapter or if that was after.

6 MS. THOMAS: It was after the chapter.

7 DR. MILLER: But I think we did talk about it at
8 the planning session. So this concept has entered our mind
9 and we are going to try to pursue it.

10 MR. HACKBARTH: Isn't that part of the reason that
11 getting to a common assessment instrument is so important?
12 That gives us, first of all, the ability to more carefully,
13 accurately assess the current performance of the different
14 types and then also potentially build a patient-centered
15 payment system. That's the immediate first hurdle, or one
16 of the first hurdles is to get a common assessment
17 instrument.

18 MR. SMITH: Very briefly. I think the
19 conversation between Jennie and Mark anticipated what I
20 wanted to say. But, Sheila, I think we've got the where
21 they go if they can't go to a long-term care hospital
22 question that you raised. But the important corollary to

1 that -- and I think it doesn't do any good to answer the
2 first question unless we answer the second, which is how do
3 they do? There's no particular reason to assume that we've
4 got the $38,000 an episode in a long-term care hospital
5 right. Folks are rushing into the market, length of stay is
6 down, and prices are up. So there's every reason to believe
7 that maybe you can buy this for less in a SNF or even in an
8 acute care facility or perhaps with home health care in a
9 different marketplace. So we need to collect both sets of
10 data.

11 DR. WOLTER: I'd just like to reinforce the issue
12 of trying to come up with a classification system where we
13 can follow the patient really does make a lot of sense. In
14 my experience there are some hospital-based SNFs that take
15 care of patients who otherwise would go to the IRFs or the
16 LTCHs -- not all, but some. I think in my experience also,
17 the industry is looking at the same maps we are and there is
18 expansion being planned into the Northern Rockies. I know
19 that is happening as well. So this is a rapidly evolving
20 field.

21 MR. HACKBARTH: And it gets progressively more
22 difficult to do something about it as it --

1 MR. MULLER: I'd just reiterate that the
2 facilities are much fungible than perhaps we've implied and
3 a lot of it has to do therefore with the payment policies
4 that caused them to be created. What a surprise. But you
5 can, by adding some therapy services to a SNF or having a
6 higher dose of assistance in home care, you can get closer.
7 So we shouldn't be left with the impression these things are
8 such distinct categories.
9 Really to Sheila's point, my guess is, as Nancy
10 said, these patients are in hospitals and in SNFs in parts
11 of the country where there aren't as many dots. Then the
12 question is, what kind of supplementary resources are needed
13 to cover the patient? Therefore I think all of us are
14 saying, what are the outcome measures that really would then
15 dictate what the right policy is for these patients?
16 DR. MILSTEIN: I think we're making the same point
17 as before, it's what are the clinical outcomes and what are
18 the financial outcomes denominated over the whole episode.
19 MR. HACKBARTH: Anybody else?
20 Okay, thank you, Sally.
21 So we're now to our public comment period. We're
22 about five minutes behind. I ask the people coming to the

1 microphone to keep in mind that commissioners do have
2 airplanes to catch and its raining quite hard right now, so
3 getting to the airport may be a little bit more difficult
4 than usual. So please keep your comments as brief as
5 possible, and if someone before you in the queue has made
6 the same basic point please don't reiterate it at length.
7 Simply do so in a summary fashion.
8 MS. ZOLLER: My name is Carolyn Zoller. I'm with
9 the American Medical Rehabilitation Providers Association.
10 Distributed to you earlier today was a press release from
11 our organization highlighting the concerns we have regarding
12 a recent report on the impact of the 75 percent rule which I
13 believe the staff has already received and the
14 commissioners, if they don't have it, will receive, referred
15 to as the Moran Company report.
16 We are very concerned about, as you consider
17 payment adequacy, a collision between the impact of the 75
18 percent rule with the current payment system and the
19 changing cost structure of the facilities. We'll be happy
20 to speak with staff in more detail about this. We've
21 highlighted this issue to CMS before and it was acknowledge
22 in their final rule.

1 But we would also ask the Commission as it
2 considers this to consider taking action supporting pausing
3 the 75 percent rule at the level of 50 percent so that the
4 impact can be further examined, needed research can be
5 accomplished, and there can be a fair discussion about the
6 definition of a facility.
7 We'll come back to you on the longer-term issues
8 of cross-site post-acute care issues.
9 Thank you.
10 MR. MONGILLO: I'm David Mongillo. I'm with the
11 American Clinical Laboratory Association. ACLA represents
12 the independent labs at both the local, regional and
13 national level, and clearly we have an interest in the topic
14 of improving payment for clinical lab services.
15 We thought the presentation this morning was very
16 concise and informative and the committee discussion was
17 very thoughtful. There is one area that I'd like to comment
18 upon and elaborate on. It has to do with the discussion of
19 the Wall Street Journal article that had to do with pod
20 arrangements and condo lab arrangements.
21 The important thing to note there is that those
22 arrangements have no relevance to the discussion of

1 improving payment for clinical lab services. Those
2 arrangements really, as was pointed out, are between
3 urologists, dermatologist, gastroenterologists and
4 pathologists who are reading those tissue biopsies. Those
5 services are paid for through the physician fee schedule, so
6 they really do not relate to our discussion this morning.
7 That being said, there is a direct billing aspect
8 to those arrangements. ACLA has been on record since
9 Medicare required direct billing, in support of that, and
10 ACLA also was working with the government to try to find
11 ways to shut down those pod arrangements that are actually
12 skirting the intent of federal regulations such as the Stark
13 law. So I wanted to bring that to your attention.
14 Also there are three statements that were made in
15 the meeting brief that was provided to the commissioners in
16 advance of the meeting. The three statements that I want to
17 just briefly touch upon had to do with -- the first was
18 payment rates for laboratory services have been updated
19 periodically for inflation.
20 As was pointed out, the fee schedule was
21 established in 1983. It was legislated at that time with
22 the provision that there would be annual updates in the fee

1 schedule based upon the Consumer Price Index. In 1997, the
2 fee schedule was frozen for five years through 2002; no
3 update. In 2003, there was a 1.1 percent update, and
4 following that in 2004, the fee schedule was again frozen
5 until 2008. So we question whether that -- we just want you
6 to have the context of the periodic update concept.
7 It was also pointed out today about the national
8 limitation amount, which is really a ceiling or a cap on the
9 laboratory payment at 74 percent. That started in the
10 legislative law at 115 percent and it's now been reduced to
11 74 percent. Those two concepts together, no updates or
12 limited updates, a cap on the national limitation amount is
13 really a not sustainable clinical lab payment system.
14 The second statement that was made in the brief
15 had to do with spending for clinical lab services, that it's
16 increased considerably in the recent past. We think that
17 there are very bona fide reasons for that, the increased
18 growth in spending. One, enrollment. There is increased
19 growth by the number of Medicare enrollees. We also think
20 that there's been additional recognition of the need to
21 adhere to clinical guidelines. Lab tests play an extremely
22 important role in that. In fact there's evidence that 80

1 percent of the guidelines that are focused on the critical
2 diseases in the United States utilize laboratory testing.
3 Thirdly, Congress recognized as was pointed out,
4 new screening tests. I already pointed it out so I won't go
5 into it. And there's a concern about defensive medicine.
6 There may be increased ordering of lab tests because of
7 skyrocketing malpractice costs and the need for physicians
8 to practice defensive medicine.
9 There's also something that wasn't really brought
10 up that I think is important. We think it's an artifact in
11 the data appearing or could be. If you look from about
12 1998, that's when the medical necessity rules went into
13 place. It could be that this growth we're seeing is not
14 really utilization growth but an understanding of the
15 compliance rules to provide medical necessity data that in
16 fact just allowed the labs to be paid for services that they
17 weren't paid for because of the complexities of the medical
18 necessity requirements. So that could just be an artifact
19 and not really an indication of increased growth.
20 Many examples that we could provide about being
21 paid at the national limitation amount. We think there's
22 just a lot of reasons why that has to be re-looked at.

1 Particularly that's true for genetic tests. The Secretary's
2 advisory committee on genetics, health and society has
3 underlined that as an important consideration. That tests
4 just aren't getting paid at the NLA amount, particularly
5 genetics. We certainly want to work with you as this is
6 developed and design a system that will accommodate these
7 important tests.
8 Thank you for the opportunity.
9 MR. SPIEL: Good morning. My name is Steve Spiel.
10 I'm here representing the Federation of American Hospitals.
11 I want to speak for a brief minute about the inpatient
12 rehabilitation facility study that we commissioned jointly
13 with the American Hospital Association which was referenced
14 by one of the earlier public speakers, and it was performed
15 by the Moran Company. We will be providing that to you.
16 Just to preview the findings, because it speaks
17 very clearly to patient access to services as opposed to
18 facility access to capital, which staff indicated is still
19 adequate. We're concerned about patient access to these
20 facilities. As the Moran report documents, in the first
21 year following implementation of the 75 percent rule the
22 Moran report indicates a 30 percent drop in Medicare

1 admissions for the 77 percent of the facilities for which
2 the Moran report did obtain specific patient data.
3 Extrapolating those findings to the remaining universe of
4 IRFs and you come to some 40,000 fewer patients receiving
5 services in IRFs following implementation of the 75 percent
6 rule.
7 So I just wanted to preview those findings and am
8 happy that Sally and staff is going to be reporting to you
9 more fully on the impact of the 75 percent rule in December.
10 Thank you very much.
11 MS. LEE: Good morning. My name is Teresa Lee and
12 I represent the Advanced Medical Technology Association or
13 AdvaMed, which represents the medical device industry.
14 AdvaMed's members constitute more than 1,300 manufacturers
15 of all sizes, including in vitro diagnostics firms.
16 Among the topics I heard you discuss is what is
17 the Medicare program getting for the increased expenditures
18 in lab services. We at AdvaMed believe that the best way to
19 answer this question is to consider the value these tests
20 provide. The spending for in vitro diagnostic tests you
21 referred to, which approximately 1.6 percent of Medicare
22 spending, influences between 60 to 70 percent of health care

1 decisions. We think that in addition to focusing on yearly
2 budget outlays, this group should consider the return on
3 investment that these tests provide by enabling physicians
4 to prescribe safer, less invasive, and more effective
5 treatments.
6 About a year ago, AdvaMed commissioned the Lewin
7 Group to study the factors associated with the innovation,
8 adoption and diffusion of diagnostic tests. This report has
9 recently been published and we think you might find this
10 report valuable as you continue your work. We will provide
11 you with copies of the report. AdvaMed commissioned the
12 report to serve as a source document to both inform various
13 audiences about the diagnostic industry, and to identify and
14 describe barriers that exist hindering innovation and
15 patient access.
16 Another topic you raised concerns whether or not
17 Medicare's payment methodology promotes efficiency. The
18 Lewin report found the current Medical clin lab fee schedule
19 to be archaic, inconsistent and severely flawed. According
20 to Lewin, methods used to set payment levels for new tests
21 failed to reflect the relative value of diagnostics to
22 health care sending inefficient market signals to

1 innovators, clinicians and payers. It's worth noting, as
2 was mentioned before, that the clin lab fee schedule has not
3 been updated for inflation in 13 of the past 15 years.
4 Price-setting processes for new tests are not governed by
5 published rules nor are they supported by evidence or
6 rationale and are not subject to appeal or reconsideration.
7 And there is no means to correct errors once they become
8 apparent. This fee schedule, we believe, is a poor
9 foundation for promising tests.
10 As your staff mentioned, the IOM published a
11 report on this fee schedule in 2000. The report, which
12 called for a series of fundamental reforms in Medicare's
13 clin lab fee schedule, most of which have gone unaddressed,
14 concluded by saying that we have the opportunity to fix the
15 current payment system for clin lab services averting the
16 possibility of a crisis in the future. Payments for some
17 individual tests likely do not reflect the cost of providing
18 the services and anticipated advances in lab technology will
19 exacerbate the flaws in the current system. Problems with
20 the outdated payment system could threaten beneficiary
21 access to care and the use of enhanced testing methodologies
22 in the future.

1 AdvaMed believes that the current Medicare payment
2 system for tests is a poor foundation for new tests and that
3 the anticipated advances referenced in the IOM report are
4 here today. Both device innovation and patient access are
5 threatened if we do not correct the way new tests are valued
6 and priced.
7 Thank you and we look forward to working with the
8 Commission.
9 MR. BOOTH: Hi, my name is Jeff Booth. I'm
10 outside counsel to the Clinical Laboratory Management
11 Association. We have a membership of about 5,000 members
12 who are directors, supervisors, managers and health care
13 executives in all settings where clinical laboratory
14 services are performed. I would just like, first of all, to
15 echo and share and concur with the comments made by my
16 colleagues in the clinical lab industry on the points they
17 raised. I would just like to raise a few additional points
18 that they did not discuss.
19 First of all, one of the issues you raised today
20 is with respect to copayment. I would just like to concur
21 with the statements made by Ms. Winter as to why copayment
22 will not work for clinical laboratory services, and to

1 remind the Commission that we addressed this issue two years
2 ago in Congress and Congress rejected it, so I'd hope that
3 you would do the same.

4 Likewise on competitive bidding, this is something
5 industry has objected to since the mid-1980s. We feel that
6 it actually achieves the opposite result in being anti-
7 competitive by reducing the number of suppliers in the
8 marketplace. And there are reasons why there are those
9 suppliers. We're also very concerned about the effect on
10 patients in terms of access to care and the impact on
11 quality as a result of it. So we continue to remain
12 concerned about competitive bidding.

13 In addition, you talked about bundled payment for
14 clinical laboratory services. The OIG proposed this in the
15 early 1990s and it was rejected by the industry by both
16 physicians and clinical laboratories, largely because it was
17 insensitive to physician utilization of services, it was
18 insensitive to the volume of services used by +different
19 physician specialties, and also failed to account for
20 technology changes that would result in introduction of new
21 technology and it discouraged that. So we remain concerned
22 about that as a methodology.

1 As you look at the issue of volume of services, I
2 get concerned as I hear the discussion continuously focus on
3 independent labs. But when you look at the marketplace and
4 you look at testing is shifting, in fact the shift is now to
5 POLs and to hospitals. There's reasons for that that have
6 to do with the consolidation of the industry combined with
7 the fact that physician access to hospitals and patient
8 care, and patient access to draw centers offered by
9 hospitals that carry better turnaround times for the
10 patients. So therefore I think you need to examine the
11 reasons and the shift in volume and why that's occurring
12 rather than focus singularly on the independent laboratory
13 sector of the industry.
14 Lastly on behalf of CLMA, we remain committed to
15 revisiting the clinical laboratory fee schedule. We do
16 believe it's archaic. We do believe it's time to basically
17 revisit it and come up with a new payment methodology.
18 However, we believe that should occur in a forum where all
19 parties are represented, where all voices are heard. We
20 have proposed to CMS that that be done in the form of a
21 negotiated rulemaking as a way to bring all voices together
22 to come and revisit the fee schedule because it is outdated

1 since it's based on data that was first generated in 1983.

2 Therefore we remain committed to working with the

3 Commission on revisiting this issue and would be happy to

4 work with you in any way possible in the future. Thank you.

5 MR. HUNTER: Mr. Chairman, members of the

6 Commission, good morning. My name is Justin Hunter. I am

7 vice president of government and regulatory affairs for

8 HealthSouth. We own and operate 95 freestanding inpatient

9 rehabilitation hospitals in more than half the country, so

10 we appreciate this opportunity to address you today.

11 I want to briefly reiterate just to say that they

12 should be reiterated, the concerns that were expressed by

13 Ms. Carolyn Zoller and Mr. Steve Spiel with respect to the

14 75 percent rule. I won't belabor the point, I think both

15 of them adequately spoke to it.

16 As the Commission continues to evaluate the

17 margins and payment adequacy of inpatient rehabilitation

18 hospitals we would respectfully urge you to carefully take

19 into account and consider what we view as some major and

20 material refinements to the prospective payment system that

21 went into effect earlier this year, including among those

22 changes to the CMGs or the case mix groups.

1 There has been a good deal of interesting
2 discussion that occurred earlier this morning and I want to
3 briefly touch upon several items. Research. There was
4 question raised about outcomes and quality of patients that
5 are treated in IRFs and other settings. Wonderful question.
6 Perfectly legitimate question in today's environment.
7 Unfortunately, very little research exists to adequately
8 address the question. That point was borne out most
9 recently by a panel held in February by the National
10 Institutes of Health. It was demonstrated that there is
11 scant research in the published literature on an
12 international basis that gets at these kinds of questions.
13 The National Rehabilitation Hospital is currently
14 conducting, prospective in nature, to evaluate the efficacy
15 and outcomes of post-acute rehabilitative care for lower
16 extremity joint replacements, knees, some hips, provided in
17 the IRF and SNF settings. It's kind of an IRF v. SNF
18 comparison. Hopefully that will provide some much needed
19 data and evidence to address the issues that are confronting
20 orthopedic issues and matters with respect to the 75 percent
21 rule.
22 Post-acute care payment IRF payment versus acute

1 care payment. Dr. Kaplan made the statement in her
2 presentation on IRFs that if you don't satisfy the 75
3 percent rule the IRF is then paid the acute care rate. I'll
4 go back to the map that became a subject of discussion in
5 the IRF presentation. Many of those green dots are IRF
6 units located in acute care hospitals. For those facilities
7 that don't satisfy the 75 percent rule it would be very easy
8 to convert those IRF beds into acute beds and pay them acute
9 rates.
10 Those red dots were freestanding rehab hospitals.
11 And to be paid the acute care rate you have to satisfy the
12 state and federal requirements of an acute care hospital.
13 Freestanding rehab hospitals do not provide a number of
14 services that are required in the acute setting, and is a
15 real question and concern in our minds as to what would in
16 fact happen if a freestanding rehab hospital did not satisfy
17 the 75 percent rule. We question whether we could in fact
18 receive acute care rates. That's an issue that needs to be
19 considered more fully going forward we believe.
20 Finally, post-acute care, IRF, SNF, LTCH, H-
21 squared, home health, all of these different signs above the
22 doors that have silos and distinct payment systems. Money

1 follows the patient was mentioned earlier. We're very
2 interested in that concept. As the Commission knows, or as
3 Commission staff knows, we believe a demonstration is in
4 order to pursue an attempt to look at the feasibility of
5 being able to provide inpatient rehab, LTCH, SNF, and home
6 health services under one roof. It sounds easy. It's
7 rather complicated. But we believe it can be done and
8 should be done. Post-acute integration in our minds is the
9 future of post-acute care. We embrace it. We look forward
10 to continue working with the Commission, with Congress, and
11 with CMS to pursue strategies and alternatives to move us
12 toward that objective.
13 I want to reiterate thanks and gratitude to the
14 Commission and to the Commission staff for this opportunity
15 and we look forward to continuing to work with you. Thank
16 you, all.
17 MR. WATERS: Good afternoon. My name is Bob
18 Waters and I'm pleased to appear before you today
19 as a representative of the American Association of
20 Bioanalysts. This is a national association which is
21 comprised of the owners, the directors and technologists who
22 work in local community clinical laboratories. We are not

1 the large national laboratories, but in fact we are small,
2 local community laboratories. We provide essential services
3 to many segments of the Medicare population that are
4 increasingly not being serviced by other sectors,
5 particularly services to folks in nursing homes.
6 There are three points that I'd like the
7 Commission to carefully evaluate as it looks at laboratory
8 spending. First of all, the premise or the statement that
9 there is great concern about increased laboratory testing
10 and the fact that this might be viewed as a negative. I
11 think that needs to be examined. It's not necessarily true
12 that more laboratory testing, volume and revenue-wise, is a
13 bad thing. Congress recently authorized several new
14 screening tests because they thought it was a good thing for
15 people to get these tests early and often. And appropriate
16 screening and diagnosis of a patient is essential to patient
17 care and can reduce costs downstream. That has to be
18 evaluated carefully and thoughtfully. It's not just an
19 issue of what's happening on the laboratory expenditure side
20 of the equation.
21 Secondly, Medicare payments for laboratory tests
22 have largely been controlled. It was stated several times

1 during today's program that the fee schedule in essence is a
2 national fee schedule. It's largely been fixed. There's
3 only been two increases in the CPI increase in the last 15
4 years, and the national cap has been ratcheted down to 74
5 percent. We have controlled cost in that area in terms of
6 the price per test that's paid. In fact for many tests the
7 payment today is less than it was 10 years ago.
8 It leaves open the issue of volume. There are two
9 things that would drive up volume. One would be
10 demographics and the other would be utilization, and those
11 are fair things to take a look at. But I think the analysis
12 should proceed along those lines.
13 In fact to give you an example, and this is
14 actually a related laboratory issue outside of the fee
15 schedule but is one that you should also look at that gives
16 a glaring example of the situation we're in.
17 My organization is very concerned about the
18 specimen collection fee. The specimen collection fee was
19 set at $3 nearly 20 years ago. It is never, ever, ever been
20 increased. There are two factors that go into picking up a
21 specimen. It's your equipment, needles. In that
22 intervening time we've moved to safe needles. They cost a

1 lot more than old needles because of OSHA blood-borne
2 pathogen standards and other things. And it's the price of
3 sending out a phlebotomist. I dare say the cost associated
4 with sending out a phlebotomist has increased in the
5 intervening 20 years. We would like the Commission to take
6 a look at that and see if that's something that could be
7 adjusted, and we'd like you to evaluate the fee schedule in
8 its totality.
9 Third, laboratory services. When you examine
10 laboratory services there seems to be sometimes a search in
11 this area to find that one segment of the market, that one
12 place where maybe the costs are less than the fee schedule.
13 We think that's a dangerous approach. A good example is the
14 way that CMS is currently looking -- and Congress has set up
15 the review for competitive bidding. We have excluded major
16 segments of the laboratory market from that review.
17 Over 50 percent of all laboratory testing is done
18 in hospitals. There's another 7 percent that's done in
19 POLs, maybe 14 percent that's done outside of the
20 independent laboratory sector. All those areas are excluded
21 from competitive bidding. And as part of that review in
22 competitive they're reviewing certain geographic areas.

1 They're saying, we're not going to service cities that have
2 a population over 2 million, we're not going to do it in
3 areas that are under a certain size. Undoubtedly somewhere
4 in this universe you can find a place where a laboratory
5 test would be provided at a lower rate than the fee
6 schedule. But that doesn't mean that that should be the
7 rate that should be set for all laboratory testing in all
8 areas of the country. So that needs very, very careful
9 review in one's examining of the data from any type of
10 competitive bidding project.
11 Finally, I'd like to mention on copays, since it
12 was raised and I think my colleague Jeff Booth articulated
13 some of the concerns that the laboratory industry has in
14 this area. I would just like to reiterate, because it does
15 come up every so often. We think that people understand it
16 now, it just doesn't work in this area. It just doesn't
17 work. The cost of collecting the copayment is gargantuan.
18 It would generate over one billion new bills over the next
19 10 years. Ninety percent of them would go out to senior
20 citizens for under $5. The cost of collecting it is
21 enormous. It's a very inefficient way to collect that
22 revenue and it's unclear that it would produce any

1 offsetting reduction in utilization, if that was its
2 intended purpose.
3 So we can provide the Commission with additional
4 information on all these points and we really appreciate
5 your thoughtful consideration and review of the laboratory
6 spending sector and we're happy to help in any way. Thank
7 you very much.
8 MR. CALMAN: Good morning. My name is Ed Calman.
9 I'm general counsel to the National Association of Long-term
10 Care Hospitals. Our association represents one-third of the
11 discharges of long-term care hospitals in the United States.
12 I would like to briefly respond to some of the questions
13 that were raised earlier in the discussion with the
14 commissioners.
15 First of all, the concentration of beds in the
16 Northeast. I'm from Massachusetts which has the lion's
17 share of those beds. Those beds are in state hospitals.
18 There's three state hospitals. One of them is over 600
19 beds. And their payer mix is not predominantly Medicare.
20 They have a lot of crossover patients. One hospital, the
21 Shattuck Hospital, in order to be admitted to that the chief
22 criterion is to be a prisoner in the state prison system.

1 So that is an explanation.

2 There is also in other states, particularly New
3 York, a large, publicly-owned -- one in particular -- long-
4 term care hospital which I believe is over 700 beds, which
5 has similar issues with very difficult populations that are
6 served.

7 I want to comment on the attractiveness of PPS
8 rates and the quickness of the phase-in. I'm a veteran of
9 that, and if you understand the TEFRA system which preceded
10 this system, we had 90 long-term care hospitals with TEFRA
11 rates that were established in the early 1980s. They were
12 historic. I remember them. They were like for $13,000,
13 $14,000, $17,000 with a requirement for a 25-day hospital
14 level length of stay. And we had the new entrants that
15 could name their TEFRA rate in advance, and I remember those
16 too. They were $30,000, $40,000, and $50,000 per discharge.
17 That was a significant inequity and had significant
18 implications in terms of growth. So you can bet that the 90
19 or so hospitals that had those depressed TEFRA rates would
20 phase in immediately. One of the objectives of the PPS
21 system was to bring some equity to a sector that, as you all
22 know, clearly needs a lot more work.

1 The 25 percent rule, I unfortunately know where
2 the number 25 came from. The preceding rule, which is the
3 so-called hospital-in-hospital rule, had requirements that
4 if hospitals are collocated they must be independent. And
5 if a part of it, just part of it -- there were three
6 alternative requirements. You could meet any one of them.
7 One was to expend no more than 15 percent of operating costs
8 purchasing services from the hospital.
9 And the second was to admit at least 75 percent of
10 the patients from someplace other than the host hospital.
11 It seems me that the government has an issue with the number
12 75. But because of that issue they just called it 25
13 percent and they carved out the outliers. That's the
14 history, and I believe that the preamble to the rule may
15 mentioned that.
16 I have a little more to say about that. We think
17 that rule is very unfair. We've done a study and we know
18 the admission rates from single sources throughout the
19 United States for long-term care hospitals and rehab
20 hospitals and the number varies between 75 to 90 percent.
21 The last thing I would like to say is I want to
22 assure you that our association is committed to research in

1 this area, to the development of criteria that is workable,
2 and we are working in that area, which is something that is
3 known to staff, and to the appropriate integration of
4 payment systems.
5 Thank you all very much.
6 MS. SMITH: Thank you. My name Elise Smith. I'm
7 with the American Healthcare Association and we represent
8 skilled nursing facilities. I just want to make a very
9 brief and maybe very obvious point, but I think it needs
10 making. The Moran study had showed that the IRFs had 40,000
11 patients less after the implementation of the 75 percent
12 rule. The Moran study also did mention that a great deal of
13 this loss were in categories that had appeared to CMS to be
14 problematic to begin with in terms of the appropriateness of
15 the care for those patients in IRFs.
16 So the question really is, and we've heard this
17 theme over and over and over again today, where did the
18 40,000 patients go? Did they have no care at all, or did
19 they really find care in other, and perhaps, more
20 appropriate settings?
21 A great deal of work has to be done on outcomes --
22 and I echo the comment of one of the colleagues here who has

1 commented before -- and the development of a common
2 assessment instrument and a related, better overall payment
3 system so that patients go where they will get the best
4 care, the very best care, and appropriate care.
5 Thank you.
6 MR. HACKBARTH: Okay, thank you very much and
7 we're adjourned.
8 [Whereupon, at 11:47 a.m., the meeting was
9 adjourned.]