

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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10:20 a.m.

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	2
AGENDA	PAGE
Further discussion of issues related to the congressionally mandated report -- Dana Kelley, Scott Harrison	3
Measuring physician resource use -- Niall Brennan	79
Public Comment	116
21st century beneficiary work plan -- Dan Zabinski	120
Congressionally mandated rural hospital report -- Jeff Stensland, Dan Zabinski	143
IME and DSH -- Jack Ashby, Craig Lisk	191
Wage index analysis -- David Glass, Jeff Stensland	243
Part D: Trends in enrollment and payment issues -- Rachel Schmidt	268
Public comment	298
Friday, October 6, 2006	
Panel on physician groups -- Cristina Boccuti	303
-- Lawrence Casalino, MD, PhD, University of Chicago	304
-- Lawton Robert Burns, PhD, MBA, University of Pennsylvania	316
-- Katherine Schneider, MD, M.Phil. Middlesex Health Systems	326
Congressionally mandated study on impact of changes in Medicare payments for Part B drugs -- Joan Sokolovsky, Carol Carter	393
Public Comment	437

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

2 MR. HACKBARTH: Let's begin. This morning we have
3 two sessions related to physician payment, in fact both
4 related to our report on alternatives to the SGR.

5 So Scott or Dana, who's going first here? Dana.

6 MS. KELLEY: Good morning. The Deficit Reduction
7 Act requires that the Commission report to the Congress on
8 mechanisms that could be used to replace the sustainable
9 growth rate that's used to update the physician fee
10 schedule. The report must discuss disaggregating the
11 current national target into multiple pools using five
12 alternatives: group practice, hospital medical staff, type
13 of service, geographic area, and physician outliers.

14 The mandated report also provides an opportunity
15 for the Commission to comment on other reforms that would
16 improve the value of the physician services Medicare buys
17 for its beneficiaries.

18 So today we're going to step away from the five
19 alternatives that we're mandated to consider. First, I'm
20 going to present a summary drawn from Commission discussions
21 and recommendations that forms a vision for the future of
22 Medicare's physician payment system. Then Scott will

1 discuss potential modifications to the current SGR.

2 As you know, Medicare expenditures for physician
3 services are growing rapidly. In 2005 spending on physician
4 services increased 8.5 percent. It's not clear what's
5 behind this growth in spending. Some argue that volume
6 growth is spurred by consumer demand, which may be fed by
7 direct-to-consumer advertising, the Internet, and lifestyle
8 changes that have resulted in rising obesity, diabetes, and
9 other chronic illnesses. The need to practice defensive
10 medicine is also blamed.

11 But research has not found these factors to be
12 driving forces. Some researchers have found no underlying
13 explanation for the growth in the volume of physician
14 services, pointing out that volume varies significantly
15 across geographic areas and that variation is primarily due
16 to greater use of discretionary services that are sensitive
17 to the supply of physician and hospital resources. And care
18 is often no better in areas with high volume.

19 What does seem clear is that the system itself
20 fails to provide the right kind of incentives. Ideally,
21 payment systems are designed so as to encourage providers to
22 furnish better quality of care and to coordinate care, as

1 well as to use resources judiciously. At the same time,
2 beneficiaries would have the information they need to
3 maintain a healthy lifestyle and to choose the highest
4 quality care at lowest cost. Providers would have the
5 information they need to provide better care and reduce or
6 limit growth in resource use. Medicare administrators and
7 policymakers would have sufficient information to give to
8 beneficiaries and providers in usable form and to formulate
9 better policies.

10 Medicare's physician payment system is far from
11 these ideals. Improving the value of the services Medicare
12 pays for will require a shift in the incentives inherent in
13 the physician payment system. It will also require the
14 collection and dissemination of information to help
15 physicians improve their performance and greater attention
16 to program integrity and provider standards.

17 MedPAC has recognized the desire for some control
18 over rapid increases in the volume of physician services,
19 but wise stewardship of the program goes beyond controlling
20 its cost. The Commission's overarching goal is to
21 recommend policies that will improve the efficiency of
22 health care delivery without lowering access or quality.

1 I'm going to take us through 11 different ideas
2 drawn from your discussions and from previous MedPAC
3 recommendations that together will create more rational
4 incentives for providers and beneficiaries and will improve
5 the structure of care delivery.

6 First, we'll talk about changing the payment
7 incentives. Medicare has a responsibility to ensure access
8 to high quality care for its beneficiaries, but
9 beneficiaries receive care in a system that's known to have
10 quality problems. While care is improving in many settings,
11 significant gaps remain between is known to be good care and
12 the care that is delivered.

13 Medicare pays all of its health care providers
14 without differentiation based on quality. Providers who
15 improve quality are not rewarded for their efforts. In
16 fact, Medicare often pays more when poor care results in
17 unnecessary complications.

18 In a series of reports, MedPAC has recommended has
19 recommended that Medicare change the incentives of the
20 system by basing a portion of provider payment on
21 performance. The Commission has found that two types of
22 measures for physicians are ready to be collected and used

1 in a P4P design. The starter set of measures for physicians
2 reflects the needs to balance two priorities: building
3 capacity and minimizing burden.

4 First, MedPAC recommended using structural
5 measures associated with information technology, such as
6 whether a physician office tracks its patients use of follow
7 up care. These types of structural measures apply to all
8 types of physicians.

9 Further, as physicians adopt IT in response, the
10 capacity to move toward more sophisticated and complete
11 measure sets will grow. The idea is to transition to
12 process measures by a specified date. This will create
13 incentives for the physician community to collaborate on the
14 development of measures.

15 The Commission recommended that P4P be budget
16 neutral. It would be funded by setting aside initially a
17 small portion of payments. All payments set aside would be
18 distributed to providers achieving the quality criteria.

19 MedPAC recommended that the Secretary establish a
20 formal process composed of private and public sector
21 participants to streamline, update and improve measure sets.
22 Some of these functions could be performed by CMS or under

1 contract with CMS. Others could be separate from CMS but
2 coordinated with the program. This process should help
3 decrease the burden on physicians of quality reporting by
4 coordinating Medicare's efforts with other payers seeking
5 similar information.

6 Another systemic problem is that many
7 beneficiaries with chronic conditions do not receive
8 recommended care and may have hospitalizations that could
9 have been avoided with better primary care. Researchers
10 attribute this problem to poor monitoring of treatment,
11 especially between visits, and the lack of good
12 communication among providers. Medicare fee-for-service
13 provides little incentive for care planning, management and
14 monitoring over time and across settings.

15 Physicians have limited time and training for care
16 coordination. Few practices have invested in the necessary
17 tools, namely IT systems and care manager staff. And
18 beneficiaries may not know what they should be doing to
19 monitor and improve their own conditions.

20 Care coordination services are described as the
21 glue that holds beneficiaries' care together. Providing
22 this glue may improve quality and reduce costs.

1 In the June 2006 Report to the Congress, MedPAC
2 outlined two illustrative care coordination models for
3 complex patients in the fee for service program. Medicare
4 could contract with providers in large or small groups that
5 are capable of integrating the IT and care manager
6 infrastructure into patient clinical care. CMS could also
7 contract with stand-alone care management organizations that
8 would work with individual physicians. In the second
9 instance, the care management organization would have the IT
10 and the care manager capacity.

11 In either model, patients would volunteer to see a
12 specific physician for their care related to the complex
13 condition that qualifies them to receive care coordination.
14 The physician, or in the case of a provider-based program
15 the group on behalf of the practitioner, would receive the
16 monthly fee when the beneficiary enrolls in the care
17 management program. This designated physician would serve
18 as the central resource, a sort of a medical home.

19 Yet another payment concern is the unit of
20 payment. Compared to most other Medicare payment systems,
21 the unit of payment in the physician fee schedule is very
22 disaggregated, generally representing the discrete services

1 that physician furnish. Such a small unit of payment gives
2 physicians a financial incentive to increase the volume of
3 services they provide, since providing more services usually
4 results in more payment.

5 A larger unit of payment puts physicians at
6 greater financial risk for the services provided and thus
7 gives them an incentive to provide and order services
8 judiciously. Medicare already bundles pre-operative and
9 follow up physician visits into global payments for surgical
10 services. Candidates for further bundling might include
11 services typically provided during the same episode of care.

12 Questions remain, however, about the extent to
13 which an expanded bundling policy is appropriate. Although
14 bundled payments could lead to fewer unnecessary services,
15 they can also lead to stinting and to unbundling. Medicare
16 should explore options for increasing the size of the unit
17 of payment to include bundles of services that physicians
18 often furnish together or during the same episode of care.

19 The volume inducing effects of the physician fee
20 for service payment system may be exacerbated by mispricing.
21 Misvalued services can distort the price signals for
22 physician services as well as for other health care services

1 that physicians order. Some overvalued services may be
2 over-provided because they're more profitable than other
3 services. At the same time, undervalued services may prompt
4 providers to increase volume in order to maintain their
5 overall level of payment. And conversely, some providers
6 may opt not to furnish undervalued services, which can
7 threaten access to care.

8 In addition, if certain types of services become
9 undervalued relative to other types of services, the
10 specialities that perform those services may become less
11 financially attractive. Over time, that can affect the
12 supply of physicians by influencing physician decisions
13 about whether and how to specialize.

14 Although CMS, with the assistance of the RUC,
15 reviews the relative values assigned to physician services
16 every five years, the Commission has found evidence that
17 some physician services continue to be misvalued. Given the
18 importance of accurate payment, the Commission recommended
19 changes to CMS's process for reviewing the relative values
20 for physician services. MedPAC recognized the valuable
21 contribution made by the RUC, but concluded that CMS relies
22 too heavily on physician specialty societies that tend to

1 identify undervalued services without identifying overvalued
2 ones. MedPAC also found that CMS relies too heavily on the
3 specialties to provide supporting evidence.

4 To maintain the integrity of the physician fee
5 schedule, we recommended that CMS play a lead role in
6 identifying overvalued services so that they are not ignored
7 in the process of revising the fee schedules' relative
8 weights and that CMS establish its own group of experts,
9 separate from the RUC to help the Agency conduct these and
10 other activities. This recommendation was not intended to
11 supplant the RUC, but rather to augment it.

12 Research has shown that areas with higher volume
13 and more specialists, as I mentioned before, do not have
14 better access, higher quality, or greater patient
15 satisfaction and in fact, may be worse on these measures.
16 Increasing the use of primary care services and reducing
17 reliance on specialty care can improve the efficiency of
18 health care delivery without compromising quality.

19 But Medicare's payment system provides few
20 incentives for physicians to furnish preventive and primary
21 care services. In addition, Medicare's cost sharing
22 requirements provide little encouragement for beneficiaries

1 to seek services where appropriate from primary care
2 practitioners instead of specialists. Even if Medicare's
3 payment policies and cost sharing structure were aligned to
4 encourage the use of primary care, questions about the
5 number of U.S. medical students choosing careers in primary
6 care raise concerns about the availability of these
7 physicians in the future.

8 MedPAC's pay for performance and care coordination
9 recommendations should help encourage the use of primary
10 care. Changing Medicare's cost sharing requirements to
11 provide incentives for beneficiaries to seek primary care
12 may also help.

13 Going further, some commissioners have argued that
14 the relative value units of the physician fee schedule could
15 be set, at least in part, on the value of a service and not
16 solely on the time, effort, and skill needed to perform it.

17 As I mentioned, physicians lack the time to
18 provide all evidence-based preventive and chronic care
19 services. Multi-specialty group practices offer the
20 potential for better care coordination and efficient
21 resource use. For example, physicians can team up with non-
22 physician colleagues to perform routine preventive care

1 functions and manage less chronic care. In addition,
2 because of economies of scale and greater access to capital,
3 group practices may have greater potential to invest in the
4 IT that can improve physicians' ability to provide quality
5 care and coordinate care appropriately.

6 However, research comparing the quality and
7 efficiency of group practices to other physician practices
8 is very limited. We'll hear more about this issue tomorrow
9 during the panel discussion we have scheduled.

10 Improving Medicare's payment incentives also calls
11 for rethinking the program's cost sharing structure.
12 Ideally, cost sharing would encourage beneficiaries to
13 evaluate the need for discretionary care but not discourage
14 necessary care. Cost sharing should be higher for services
15 that may be discretionary and could potentially be overused
16 and lower for services that are necessary or desirable, such
17 as emergency and preventive services. Cost sharing can even
18 be designed to steer patients to lower cost or more
19 effective treatment options.

20 Medicare's fee-for-service cost sharing structure
21 deviates substantially from this idea. For example,
22 Medicare imposes a relatively high deductible for hospital

1 admissions, which are rarely optional. In contrast,
2 Medicare requires no cost-sharing for home health care
3 services, even though wide geographic disparities in the use
4 of the services have raised concerns about their potential
5 discretionary nature.

6 Unlike in many plans, Medicare's cost sharing
7 requirements for visits to specialists are the same as for
8 visits to primary care practitioners. And further,
9 Medicare's fee-for-service benefit does not provide
10 protection against catastrophic levels of out-of-pocket
11 spending.

12 About 90 percent of Medicare beneficiaries have
13 supplemental coverage that provides some protection against
14 out-of-pocket spending, but that coverage also reduces
15 beneficiaries' sensitivities to the cost of care, thereby
16 undermining the role of cost sharing in health insurance.
17 The Medicare benefit could be significantly improved by
18 combining increases in Medicare's cost sharing requirements
19 with implementation of a catastrophic cap on out-of-pocket
20 spending, which would limit the financial burden on
21 beneficiaries who need the most care.

22 Cost sharing should not be raised

1 indiscriminately, however, since doing so can impose
2 financial barriers to essential care and can cause hardship.
3 Rather, cost sharing requirements should be designed so as
4 to encourage the use of cost-effective and necessary care
5 while prompting beneficiaries to carefully consider the use
6 of discretionary services. Since supplemental coverage
7 would temper any savings from a policy that raised cost
8 sharing, policymakers might want to simultaneously introduce
9 measures that would restrict first dollar coverage.
10 Restricting such coverage would lead to sizeable savings for
11 the Medicare program, large enough to finance some
12 catastrophic protection.

13 Now let's turn to the need for more information.
14 As we all know, across the U.S. there's a wide variation in
15 practice patterns and use of services. But beneficiaries
16 living in regions of the country where practitioners deliver
17 many more health care services do not experience better care
18 or outcomes, nor do they report better satisfaction with
19 care. This suggests that the nation could spend less on
20 health care without sacrificing quality of physicians whose
21 practice styles are more resource intensive reduced the
22 intensity of their practice, if they provided fewer

1 diagnostic services, used fewer subspecialists, use
2 hospitals and ICUs less frequently as a site of care, and
3 did fewer minor procedures.

4 The Commission has recommended that Medicare
5 measure physicians' resource use over time and feed back the
6 results to physicians. Physicians would then be able to
7 assess their practice styles, evaluate whether they tend to
8 use more resources than either their peers or what available
9 evidence-based research recommends and revise their practice
10 styles as appropriate.

11 This process is critical to precipitating
12 reductions in inappropriate resource use. Moreover, when
13 physicians are able to use this information in tandem with
14 information on their quality of care, it will provide a
15 foundation for improving the value of care received by
16 beneficiaries.

17 Confidential feedback alone may be sufficient to
18 induce some change. Eventually, we envision Medicare using
19 the results in payment, for example, as a component of a P4P
20 program that rewards both quality and efficiency or to
21 enable beneficiaries to identify physicians with high
22 quality care and more conservative practice styles. Later

1 this morning, Niall will be presenting information from our
2 analysis of how episode groupers measure physician resource
3 use.

4 We also need more information about the costs and
5 health outcomes of services. Until more is known about the
6 clinical and cost effectiveness of new and existing health
7 care treatments and technologies, patients, providers and
8 the program will have difficulty determining what
9 constitutes good quality care and effective use of
10 resources.

11 Clinical and cost effectiveness information could
12 help Medicare use its resources more efficiently and improve
13 the quality of care delivered to beneficiaries. Medicare
14 could use clinical and cost effectiveness information to
15 inform providers and patients about the value of services,
16 since there's some evidence that both might consider cost
17 effectiveness information when weighing treatment options.

18 Medicare might also use the information to
19 prioritize pay for performance measures, target screening
20 programs, or prioritize disease management initiatives. In
21 addition, Medicare could use cost effectiveness information
22 in its rate setting process.

1 Given the potential utility of cost effectiveness
2 information to the Medicare program, and increased role for
3 the federal government in sponsoring the research may be
4 warranted. There have been concerns raised about the
5 variability and lack of transparency in methods and the
6 potential bias of researchers conducting clinical and cost
7 effectiveness research. It's been shown, for example, that
8 industry-sponsored studies are significantly more likely
9 than non-industry sponsored studies to reach conclusions
10 that are favorable to the sponsor.

11 The federal government could help set priorities
12 for clinical and cost effectiveness review and research.
13 Services could be selected based on disease prevalence, high
14 per unit cost, high total expenditures, or other factors.

15 Forming a public-private partnership could address
16 concerns raised by stakeholders about the use of cost
17 effectiveness analysis. Private payers alone have little
18 incentive to undertake these analyses and may fear that
19 using such information may lead to criticism that they're
20 more concerned about profits than they are about patients'
21 health. A public-private partnership would also send a
22 clear and effective signal to researchers to improve their

1 methods and develop valid and transparent cost effectiveness
2 analyses.

3 It's worth nothing, of course, that cost
4 effectiveness analysis might not save Medicare money. Wider
5 use of cost effective, under utilized services might result
6 in increased Medicare spending, which might not be offset
7 with savings elsewhere. On the other hand, over the long
8 run, cost effectiveness could save the Medicare program
9 money if it encourages manufacturers to develop services
10 that are more cost effective than current ones or helps
11 inform providers and influences their patterns of care.

12 Now we turn to provider standards and overall
13 program integrity. Increasing the value of the Medicare
14 program to beneficiaries and taxpayers requires concerted
15 efforts to identify and prevent Medicare misuse, fraud and
16 abuse. This includes supporting quality through the use of
17 standards as well as ensuring that services are provided by
18 qualified providers to eligible recipients and verifying
19 that services are appropriate and rendered as billed, and
20 that payments for those services are correct.

21 CMS has set standards to ensure minimum
22 qualifications for various types of providers, such as

1 hospitals and skilled nursing facilities, but there are very
2 few examples of federal standards that apply to physician
3 officers. Traditionally, Medicare has paid for all
4 medically services provided by physicians operating within
5 the scope of practice for the state in which they are
6 licensed. But the lack of standards may undermine efforts
7 to improve quality of care and, in some instances, may
8 encourage volume growth.

9 Such is the case with imaging studies provided in
10 physicians' offices, where we've seen that the lack of
11 comprehensive standards for this setting has resulted in
12 evidence of quality problems and significant growth in
13 volume.

14 Where appropriate then, CMS should consider
15 imposing quality standards as a condition of payment. The
16 Commission recommended, in the March 2005 Report to the
17 Congress, that such standards be implemented for physicians
18 who perform and interpret imaging studies. CMS would
19 require statutory authority to implement this change, but
20 there is a precedent. In 1992, the Congress gave the FDA
21 the authority to set standards for physicians who read
22 mammograms. In the future, other types of services may be

1 candidates for such standards, as well.

2 An important element of program integrity is
3 contractor reform. The MMA requires CMS to use competitive
4 procedures to select Medicare administrative contractors and
5 to follow the Federal Acquisitions Regulations. These are
6 substantial departures from previous rules. By July 2009,
7 CMS plans to substantially reduce the number of contractors
8 responsible for paying Medicare claims and to make
9 contractors responsible for both A and B claims. CMS also
10 plans to institute performance incentives in the new
11 contracts, which will be based on a number of different
12 factors, including Medicare error rates.

13 At the same time, Medicare is consolidating its 14
14 data centers that conduct claims processing functions into
15 two data centers. The changes will improve Medicare's
16 ability to implement many of the ideas we've outlined today.
17 CMS should capitalize on its new flexibility to assemble the
18 needed datasets and disseminate information to providers and
19 beneficiaries. For example, CMS will not be able to more
20 effectively track beneficiaries' use of services across
21 providers during episodes of care, which could help the
22 program determine whether beneficiaries receive appropriate

1 care and ultimately could help to improve quality of care
2 and longitudinal efficiency.

3 The changes will also improve program integrity by
4 making it easier to determine if beneficiaries are eligible
5 for services and to connect the dots, so to speak, between
6 health care providers and questionable claims or to spot
7 spikes in particular types of services across localities.
8 Since research has shown that there is significant fraud and
9 abuse in the Medicare program, this is an important step in
10 reducing improper payments.

11 In summary, Medicare's physician payment system
12 encourages volume growth, it discourages quality of care and
13 judicious services and coordination of care.

14 Increasing the value of physician services
15 Medicare pays for will require a shift in the incentives
16 inherent in the payment system, the collection and
17 dissemination of information to help physicians improve
18 their performance, and greater attention to program
19 integrity.

20 The ideas I've outlined will not, in and of
21 themselves, address the volume growth program and on their
22 own some might actually contribute to cost growth, and

1 certainly not every problem can be solved by these ideas.
2 But the expectation is that the collective impact of these
3 ideas will have the effect of improving the structure of
4 care delivery and the incentives providers and beneficiaries
5 face, thereby improving value to Medicare.

6 These improvements will increase demands on an
7 already overburdened CMS. The Commission has called
8 repeatedly for Congress to increase the Agency's funding.
9 Implementation of our ideas will require Medicare to measure
10 the care delivered by a very large number of physicians,
11 collect and analyze a significant amount of new data, and
12 continue research and assessment. As the improvements are
13 intended to achieve better value for Medicare spending, the
14 Congress will need to provide CMS with the financial
15 resources and the administrative flexibility necessary to
16 undertake them.

17 Now I'll turn it over to Scott.

18 DR. HARRISON: Last month you saw a discussion of
19 geographic and type of service options for subnational SGR
20 targets. And next month you will see some other options
21 based on subnational groups of providers. To be complete,
22 this month we wanted to briefly show you how some options

1 that work off the current national SGR target system might
2 affect updates in spending.

3 We will give these options a rather mechanical
4 treatment today as we discussed target setting methods last
5 month and we expect to look at them in more depth when we
6 discuss cross-cutting issues that pertain to national and
7 subnational targets in a future meeting.

8 Before I walk you through some options, let me
9 remind you how the current system works. The current system
10 uses the SGR as a target which allows volume to grow at the
11 same rate as the country's gross domestic product, or GDP.
12 The SGR also incorporates growth in Medicare fee-for-service
13 enrollment and the underlying price of services.

14 The physician fee schedule is updated each year by
15 the MEI, adjusted by a comparison of spending against the
16 target. The system is cumulative, meaning that the
17 expenditure growth in the previous year as compared with a
18 target and the total cumulative spending since the beginning
19 of the system is compared with growth in the SGR target over
20 that time period.

21 In any year the reward or penalty resulting from
22 target comparisons is limited plus 3 percent on the upside

1 and minus 7 percent on the downside. So the update will be
2 between MEI plus 3 and MEI minus 7.

3 We have created an illustrative base case with
4 which to compare other options. Simply put, the base case
5 is how the current system would have worked under current
6 law if there had been no misestimates of GDP enrollment or
7 expenditure growth and if Congress had not intervened by
8 providing higher updates. We used the actual SGR volume and
9 MEI data from 2001 through 2005 and assumed that there had
10 been non misestimates of that data when the targets were
11 set. And we assumed that Congress allowed the resulting fee
12 reductions to take place.

13 The updates in spending produced by this base case
14 will look different from what really happened during our
15 simulation period because there had been significant
16 misestimations during the early part of the period that
17 helped cause the system to widely miss the target, resulting
18 in negative updates in each year starting in 2002.

19 However, in every year after 2002, congressional
20 and administrative actions resulted in positive updates.

21 I want to note that even though the base case no
22 longer results in missed targets due to estimation errors,

1 targets are still missed because the volume growth is
2 significantly above GDP growth in every year during this
3 time period.

4 There has been some dissatisfaction with the
5 current SGR system because it has resulted in negative
6 updates for the past few years and projected negative
7 updates for the foreseeable future. Therefore, we have
8 modeled three alternative options that are softer or less
9 aggressive than the base case so that you might see the
10 tradeoffs of higher updates for higher Medicare costs.

11 We have constructed three options to the base
12 case. Each case uses the GDP-based current SGR as the
13 annual target for expenditure growth. We model each option
14 using the same GDP, enrollment and volume growth data from
15 the 2001 to 2005 period that we used to model the base case.

16 All three options are non-cumulative, meaning that
17 only the previous year's spending performance is compared to
18 the target, only that is used to adjust the update. The old
19 VPS system that preceded the SGR operated like these non-
20 cumulative options.

21 The first option has no limits on how much the
22 update can differ from MEI. Remember that the base case

1 keeps the update between MEI plus 3 and MEI minus 7.
2 Compared with the cumulative base case, this option will
3 result in higher in spending if volume remains above the
4 target.

5 The second option is a corridor allowance. Under
6 a corridor allowance the update is MEI unless expenditures
7 fall outside the corridor. We chose to model a corridor of
8 plus or minus 2 percent. Thus, if spending was above or
9 below the target by more than 2 percent, then a penalty or
10 reward would be applied to bring the expected spending back
11 to the corridor, however not all the way back to the target.
12 If volume remained above the target, this option would
13 forgive excess volume growth of up to 2 percent a year.

14 The third option keeps the update within a limited
15 range between zero and the MEI. If expenditures are at or
16 below the target, then the update would be the MEI.
17 Spending above the target would reduce the update, but never
18 below zero.

19 Here we get a quick comparison of how the three
20 non-cumulative options compare to the illustrative base
21 case. The base case produces negative updates across the
22 entire time period and would continue to do so after the

1 period. The three illustrative options are displayed in
2 order of increasing cost. The non-cumulative option with no
3 limits generally has higher updates than the cumulative base
4 case because the volume was way above GDP in 2001 and that
5 year's performance only affects the update in 2002 in the
6 non-cumulative options but continues to depress updates for
7 the cumulative base case.

8 The corridor allowance compresses the updates for
9 that option. The 2 percent corridor raised the largest
10 negative by two percent and there was a year when the option
11 resulted in a full MEI update of 3 percent.

12 The limited range compressed the updates further
13 and indeed the updates ranged from zero up to the MEI. You
14 can see in the last column that as the update adjustments
15 are more tightly constrained, the cost relative to the
16 illustrative base case increases. We are trading off higher
17 updates for higher spending. The figures in the last column
18 represent the average spending over the illustrative four
19 year period. Those percentages represent large extra
20 expenditures as the actual physician spending in 2005 was
21 around \$80 billion and it is likely that budget scores would
22 be calculated over a 10-year period.

1 Now Dana and I are happy to listen to your
2 discussion and answer any questions on anything you've seen.

3 DR. REISCHAUER: Scott, just a clarifying
4 question.

5 When you vary the updates in your simulation, do
6 you have a feedback on volume effect?

7 DR. HARRISON: We use what the actuaries use for
8 volume, which is it offsets 30 percent of the decrease below
9 MEI.

10 MR. HACKBARTH: Good job.

11 Let me just say a word about this summary slide
12 here. It should have draft stamped prominently on it. This
13 is very much a discussion. We, at the end of the process,
14 may add to the list or delete items from this list.

15 As Dana said at the outset, what we've tried to do
16 is capture ideas that the Commission has discussed in the
17 past, some at great length like pay for performance, and
18 we've made quite specific recommendations. But there are
19 other items on this list that have been discussed very
20 little. Individual commissioners or small groups of
21 commissioners have said this is something that I think ought
22 to be considered. So all of it is fair game.

1 Now in particular, I want to emphasize that for
2 our public audience. People should not infer that this is a
3 MedPAC endorsed list at this point.

4 To me the significance of this list is that I
5 think there is agreement, although I could be corrected on
6 this as well. But I think that there is agreement within
7 the Commission that improving the efficiency and quality of
8 the services provided to Medicare beneficiaries is not as
9 simple as coming up with a new SGR mechanism. There's work
10 to be done on many different fronts if we want to improve
11 efficiency and quality. That's why we're talking about this
12 list. It puts in context whatever we decide to recommend
13 specifically about changes in the SGR. So that's the
14 purpose of this.

15 DR. WOLTER: I thought this was a very well done
16 chapter, I will say, on a complicated topic. As I look at
17 it, I guess the way I'm framing this in my mind, I'd like to
18 start by saying that MedPAC is on record as saying that the
19 SGR has not served its original purpose, and that we should
20 move away from it. I think that's worth reiterating.

21 I think that, when I look at this list, the way I
22 think we should say this is that volume control or

1 appropriate resource utilization is a program goal. It's
2 not limited to Part B and to physician services. We might
3 want to be very explicit about that. I think it might make
4 physicians feel better about this conversation because we do
5 need physician involvement in tackling the issue. And I
6 think this list then becomes a list not just of services
7 physicians are involved in but a list that tackles resource
8 utilization in a way that crosses silos.

9 I think, in that regard, if we're going to take
10 this patient-centered philosophy to heart, one of the
11 problems we have right now is we're trying to solve a lot of
12 problems by putting new mechanisms of payment or whatever
13 into current silos. And we are not looking at ways to
14 integrate and coordinate approaches that might be more
15 successful.

16 This is a great list. One of the things I would
17 really like us to start emphasizing more is that in the
18 early years of tackling more appropriate resource
19 utilization in pay for performance, there would be
20 tremendous merit to creating some focus. If you were to say
21 what are the six or seven areas of incredibly high volume
22 and high cost in the program, what would that list be? And

1 what would the tactics be to go after it?

2 I don't hear anybody saying that. What I hear is
3 we need a measure for every specialty or we need a payment
4 tactic for every silo. I think we're at great risk of being
5 tremendously unsuccessful with resource management and with
6 pay for performance if we don't create tactics that really
7 go after where the cost is.

8 Some of the things on this list will do that and
9 they will start creating things that bring the silos
10 together. But I think it would be a great contribution on
11 the part of MedPAC to be more explicit about some of these
12 things and really make it clear that we're looking at
13 resource utilization. I keep thinking about some of the
14 Dartmouth work on how the growth of capacity drives
15 increased volume and increased utilization. I think that
16 would be an add to the list.

17 In that regard, I think that the issues related
18 to self-referral, physician ownership, MRIs in every doctor
19 office. But the issues are not limited to physicians. We
20 have hospitals that have tremendous strategies built around
21 expansion and growth and they hire physicians explicitly
22 with the goal that volumes will increase. DRGs maybe help

1 you with the episode of admission, but there are many
2 strategies around hospital resource use that we really could
3 add to this list that I think would really help us.

4 Lastly, this is more of a very specific comment, I
5 also think we would do a great service by making clear that
6 the structural measures related to IT, as Ralph said
7 earlier, really are about systems and processes of care that
8 are supported by IT but aren't really going to be solved by
9 IT unless those systems and processes of care are really
10 tackled. And that really is very hard work. I think that
11 would be a contribution.

12 DR. CROSSON: I like the approach also. It's a
13 bit more expansive than I think we have been framing this
14 issue around solving the SGR or fixing the SGR. And I think
15 it's appropriate because it's going to end up with a better
16 project. So I understand we have a mandated report that we
17 have to do on alternatives to the SGR but I would assume
18 that there's range there that we could decide around how to
19 answer that. I think this begins to suggest something.

20 I wanted to suggest that maybe this is actually --
21 it is a list of things we've talked about. But we may be
22 able to think about it in a way that maybe frames the issue

1 differently. So if you start with what question do we think
2 we're trying to answer here, we could simply say we want to
3 discuss alternatives to the SGR because we need to have an
4 effective mechanism to control volume or to manage volume,
5 appropriate volume, reward appropriate volume or whatever
6 you want to call it.

7 Or maybe we need to propose alternatives to the
8 SGR because we need to do the volume thing, but we also want
9 to avoid or find a way to avoid unreasonable and inequitable
10 cost payments to physicians. I think both of those are
11 goals we've talked about and both of those things have been
12 part of previous MedPAC documents.

13 But this takes it a little further, I think,
14 because it essentially, to me, is saying we would like to
15 find an alternative to the SGR or, putting it another way,
16 we would like to take advantage of the opportunity created
17 by the problem that we have with the SGR in order to do
18 something perhaps grander or more important. And that would
19 be something like to restructure physician payment,
20 including the update portion of physician payment to try to
21 improve the Medicare program more broadly.

22 And as you look at this list, it really says what

1 we're after here is to use the physician payment mechanism
2 to improve quality, there's some doubts about quality; to
3 try to approach the coming problem in physician manpower,
4 particularly the lack of primary care physician supply; to
5 perhaps make some changes in benefit design, which would
6 have perhaps a long-term result in improving quality and
7 cost; to perhaps incent the development of more effective
8 delivery system structure; or to alter payment to the
9 delivery systems to get the kind of aggregation that Nick
10 was talking about. And in the end, to create sustainability
11 by, in effect, dealing with the volume concern.

12 So I guess as I looked at this, rather than a list
13 we might, in fact, be more explicit that what we're after
14 here is to restructure physician payment to deal with the
15 volume problem, to make sure we do not have inappropriate
16 and inequitable cuts in physician payment, but also to do it
17 in a way that improves the Medicare program along those
18 lines that I described.

19 DR. CASTELLANOS: I have a lot of comments.

20 Nick, I couldn't agree with you more. We need to
21 get the physician involved. The physician is the core to
22 the Medicare system. And a lot of these issues that we

1 discussed today was not physician involvement. And we need
2 to do that.

3 You know, it's interesting, the physicians are the
4 only payers in Medicare that are held to the standards that
5 you're making us. Nancy, you made that point a number of
6 times. Everybody else gets paid a certain percentage of
7 increased cost of living, et cetera, but the physician
8 community doesn't. If you look at the five-year reviews
9 that just came out, 45 percent of the doctors are going to
10 take more cuts.

11 I don't understand the equity there. I understand
12 that's the law and that's what we need to really follow.

13 But to use my payments, and I'm a practicing
14 physician, contingent upon a lot of the problems that we've
15 been dealing with for 20 years, it doesn't make sense.

16 The SGR, we need to move away from it. The volume
17 control isn't there. There's no incentive for the physician
18 to do volume.

19 I'd like to go back on that for a few minutes.
20 There are a lot of good points. The RUC report about where
21 you want to have an expert panel is absolutely correct.
22 There's no doctor that's going to raise his hand and say I

1 make too much money. There's no businessman that's going to
2 do that. And I think the expert panel is excellent. I
3 think that's good to pick up the overpriced things, and I
4 think that's good.

5 I have a technical problem. You continue to talk
6 about volume control and the variations in the different
7 areas. You quote the Wennberg report or the Dartmouth
8 report.

9 On your page 10, or what we have, you implied
10 that there's no difference between access to care or quality
11 or patient satisfaction, which is true. But you also
12 implied that it may be worse. I have the Wennberg report
13 right in front of me. I've heard that four or five times.
14 I've gone back to the report. I have the editor's notes,
15 and I'll be glad to show you that. There's nothing in that
16 report that says it may be worse. I'd really like to talk
17 to you individually about that because that bothers me, it
18 kind of irritates me.

19 One of the things that, and I look back at my
20 practice and I say what can we do? How can I, as a
21 physician, and what am I doing in my practice that tries to
22 control volume? There is one thing that we do do. One is

1 cost sharing or putting the patient at risk or tiering. We
2 see that in the Medicare Prescription Drug Program. A lot
3 of times my patients will say to me doctor, I can't afford
4 that medicine. And I'm on the patient's side so I'll say to
5 him, you're right, let's see what we can work out.

6 But when I try that on diagnostic studies or x-ray
7 studies, their first comment is listen, I have insurance, it
8 pays anything. I don't want any cut cost. I want you to do
9 the right thing. I have a cancer and I want to be taken
10 care of and I have a right because I have insurance.

11 But I think if we put the patient more at risk in
12 a cost-sharing basis, I think that's something that may be
13 of benefit. I've really thought that out from a practical
14 viewpoint.

15 Coordination of care I think is excellent. There
16 are a number of CPT codes for it, very few of them are
17 funded. So here again, you want the physician to
18 participate in coordination of care and you have CPT codes
19 available, but CMS hasn't funded them. Again, you're
20 putting the burden on the physician and I have a real
21 serious problem about that.

22 Volume, let's just talk a little bit about volume.

1 Mark and myself have had a lot of discussions on that.
2 There's some good volume changes and there's some bad volume
3 changes. What we really need to do is get down to the core
4 values of what is good volume and what's bad volume. Just
5 to say that we can't go above GDP, which is no relationship
6 between GDP and quality of care or volume, doesn't make
7 sense.

8 There are a lot of other comments I could make,
9 but I think other people want to talk, too.

10 DR. MILLER: If I could address one factual point,
11 particularly since you were irritated by it. I'm just
12 trying to navigate this carefully.

13 We did actually pay attention to that slide and
14 actually talk through what words to put on that slide very
15 precisely, on the quality could potentially -- is worse in
16 some instances. The studies that we're referring to are the
17 series of the Annals of Internal Medicine that Eliot Fisher
18 did. I thought that Dana phrased it pretty carefully. She
19 said on some of the measures quality was worse. And that
20 was the point that we were making there.

21

22 DR. CASTELLANOS: I'd like to show you the report

1 and the editor's note. There's no comment on that on the
2 editor's note, and I'll be glad to show this to you.

3 MR. HACKBARTH: We'll actually have Eliot Fisher
4 here next month, so we can discuss it personally with Eliot.

5 DR. REISCHAUER: We'll swear him in.

6 MS. BEHROOZI: I'm going to venture into an area I
7 know very little about and I'm sitting next to Ron so I'll
8 be careful. But I do want to endorse the notion of adding
9 value of a service to how rates are set in terms of
10 physician payment. What little I understand of RVUs is that
11 it's really from the physician perspective, I guess, what
12 the physician thinks they're putting into it.

13 And if we're talking about a more patient-centered
14 model that we want physicians to move to and we're talking
15 about the interests of Medicare, I think we absolutely
16 should become value-based purchasers like everybody who's
17 minding their pennies is supposed to do.

18 So now I'm going to talk about something I do know
19 a little bit more about, and I'm going to be swimming
20 against the tide of the common wisdom, I'm sure, but I want
21 to express some caution about the recommendation or the
22 potential recommendation on the draft list to revisit

1 Medicare's benefit design and impose additional cost-sharing
2 on Medicare beneficiaries. Ron touched on it a little bit.

3 It is the common wisdom that when you charge
4 people something for a commodity that they will be more
5 careful in purchasing it. But health care is different than
6 consumer goods. It's not that kind of a commodity. So when
7 people make decisions based on what they can afford, it
8 really shouldn't be the same exercise that they're going
9 through with respect to health care as if they're buying a
10 car or whatever. You have options of different kinds of
11 cars and different kinds of optional features you can load
12 onto the car. But when you need health care, you need
13 health care.

14 But there are ways, of course, that we think -- or
15 people would have different opinions of that. But in terms,
16 going back to the value notion, there are things that we
17 think are better ways for people to access care or certain
18 types of care that are more valuable, right?

19 So if we want to talk about imposing cost sharing,
20 we need to do it in a way that talks about changing people's
21 behavior, as opposed to setting it up as a barrier to
22 access. To charge everyone the same copayment, particularly

1 Medicare beneficiaries, many of whom are on fixed incomes --
2 and when we talk later about the profile of the future
3 Medicare beneficiary, we're going to talk about people who
4 are losing employer coverage, who have already lost employer
5 coverage before they become retired, pensions plans that are
6 being decimated. When we talk about that, we'll talk about
7 looking at the growing gap in wealth and income among
8 Medicare beneficiaries.

9 It's not the same to charge people a flat
10 copayment. They're not going to make the same decision.
11 The person who can afford the \$20 copayment is going to say
12 give me every test, give me every drug, send me to every
13 specialist. The person who can't afford the \$20 copayment
14 because they're making a choice between that and picking up
15 their prescription drugs or purchasing transportation,
16 buying their Metro card or whatever, and they have to do
17 that, they're going to say okay, I'll live with this cough a
18 little longer. I'm not going to go to the doctor.

19 So I think we have to be very careful about
20 imposing copayments or other kinds of cost-sharing in a way
21 that incents the behavior that we want from the
22 beneficiaries like going to a primary care provider first

1 and receiving a referral. There should be no penalty.
2 There should be no burden on doing it right.

3 And actually, at some other point I'll talk more -
4 - not now -- I'll talk more about how we do it in our
5 benefit fund that I run, where we cover a lot of low-wage
6 workers and we don't want to impose barriers to access. And
7 we have first dollar coverage. But there are other ways to
8 incent appropriate behaviors.

9 MS. BURKE: Glenn, could I just follow up just a
10 brief note on the point Mitra has raised, which I absolutely
11 agree with? And that is we have another discussion that is
12 scheduled that relates to this sort of changing demographics
13 of the program and issues that we might confront.

14 I have the same concerns about the nature of the
15 Medicare beneficiary and what, in fact, we're facing. But I
16 think in the course of that conversation the question of who
17 the patient is going to be, who the client is going to be
18 going forward, the changing racial makeup of the population,
19 the changing age of the population, the absence of employer-
20 sponsored insurance. I think this might well be a
21 conversation that could also play into that and might help
22 us think broadly about -- in the broader context, not

1 specific to this -- what, in fact, should we be thinking
2 about? Who, in fact, will the Medicare beneficiary be 10
3 years from now? And I think it does have a direct
4 relationship to this question of can we assume they are what
5 they are? How does that play into how we look at the
6 benefit design, as well as encouraging certain kinds of
7 behavior?

8 So I'd like, just as a side note, to say we should
9 come back to that point when we have that further
10 conversation.

11 DR. HOLTZ-EAKIN: I also want to just share my
12 congratulations on the chapter. It was a great read.

13 I'm a new person, so I'm catching up on the
14 vision. So there are a couple of points I didn't understand
15 on the details.

16 One is really a question for the group. Is there
17 an interest in promoting physician groups, per se? Or are
18 they a means to an end in which there is better coordination
19 of care, the infrastructure for IT platforms, best
20 practices, things like that? It just struck me it sort of
21 stood out that they're just picking this way to do business.
22 That was one question on details.

1 A second was on this notion that you could set
2 these resource value units in a way that was not a
3 measurement of cost but somehow God's correct price for
4 different activities. I'd like to know how you're going to
5 do that?

6 And then some of the broader issues that it
7 raises, I think, is really the point that was made earlier
8 about needing to focus. This is a tremendous list, very
9 impressive. But what are you going to do? And back to the
10 point made earlier today, in what order are you going to do
11 them? The sort of focus and sequencing.

12 Measuring resource use, for example, is at the
13 heart of trying to get all of these efficiency measures
14 right, doing that up front, making sure the doctors explain
15 how they do business I think would be absolutely an
16 imperative and ought to be up front and we ought to think
17 about that.

18 And it also, I think, would help in some of the
19 discussions. If you're taking care of efficiency and
20 quality through other means, the cost sharing is less scary.
21 It's a sensible thing to do. A lot of this is about costs.
22 It gets scary if you think somehow you're stinting on

1 something or you don't know what you're cutting out. And so
2 making that point would, I think, make a more sensible
3 discussion of things like cost-sharing.

4 Finally, I want to close with at least my view
5 that I would be very disappointed if this group somehow said
6 well, we're going to go do this list and let's just pitch
7 the SGR. The SGR is a highly inelegant offense to anyone
8 who looks at health care. It is, however, a very clear
9 recognition of the fact that we're scared about how much it
10 costs and how much we're spending in the federal budget and
11 in the economy as a whole. And I think to discard that
12 casually would be a big mistake, especially if this is going
13 to be done sequentially. There will be pieces that are or
14 aren't covered by these new incentives. And especially if
15 we're not really sure if these incentives are implemented
16 the way they're envisioned at this table and effective in
17 the way that the research suggests.

18 And so I, at least, would like to keep some
19 overall pressure on the spending that we're doing before we
20 discard it entirely in favor of what we hope would be a much
21 better system.

22 I want to make clear, that's not a criticism of

1 this list. It's just a recognition that it is still a
2 consideration.

3 MR. HACKBARTH: I'd like to take a crack, Doug, at
4 your first question about how groups fits into this.

5 To me, the goal is not to promote groups but
6 rather to promote better care, higher quality care, as
7 efficient care as we can possibly get for beneficiaries. So
8 it would not be my view that we ought to just say groups,
9 per se. Indeed, groups come in all sorts of different sizes
10 and shapes and flavors and some may have more potential than
11 others to provide high quality, integrated, well coordinated
12 care.

13 And so I'm a believer in multispecialty group
14 practice. I think everybody knows that. But I wouldn't say
15 that Medicare ought to simply pursue a policy of rewarding
16 groups, promoting groups. I think that's a very different
17 proposition.

18 What I would say is that the current Medicare
19 payment systems are not well designed to support the efforts
20 of people who are in some types of groups, who are eager to
21 provide that high quality, efficient, well coordinated care.
22 The fragmented fee-for-service model is not conducive to

1 supporting groups that may want to do things differently.

2 So I think of it not so much as promoting groups
3 but creating more avenues in the Medicare payment system
4 that can support group practice for the people who want to
5 do that. But if there are other physicians who don' want to
6 do that, I don't think they should be herded into groups. I
7 think we should evaluate their performance and pay them well
8 if they perform well and pay them poorly if they don't.

9 DR. WOLTER: I think that's exactly right. The
10 issue is can we create an accountable network of care
11 providers that can respond to the needs to provide higher
12 quality with appropriate resource utilization? Many do
13 believe groups probably have some advantage that way, in
14 terms of infrastructure they can build. But there would be
15 other virtual groups that could possibly play in that arena.

16 I think the add, though, is that we also need to
17 provide some incentive for physician groups, whatever that
18 means, and hospitals to cooperate and coordinate. Because
19 again, back to what should our focus be in these early
20 years, where is all the cost? And it tends to be at that
21 intersection where physicians are caring for patients in
22 hospital. There's so much cost there, there's so much

1 opportunity there. And yet we really aren't creating an
2 approach in P4P or with incentives unless we can move along
3 with bundling or gainsharing or some of these other
4 opportunities, to really incent that cooperation.

5 DR. MILLER: Just to give you a quick response on
6 the price, and I think it's much more complicated than I'm
7 going to say. And I think invoking God is probably an
8 appropriate point.

9 I can think of it in three ways, and obviously I'd
10 be looking at my guys to see if I'm off point.

11 There's some technical things that I think we can
12 look at. When we did the work on the RUC and the valuing of
13 the work, which Ron referred to, there were points in the
14 process where we could point to and say look, there's a bias
15 here that could be corrected.

16 And there's some technical stuff on the practice
17 expense side that you're going to see shortly. There's that
18 kind of work, getting really down in the weeds and fixing
19 some stuff.

20 Another way to think about price, and again this
21 is not technical and I don't think there's a clear empirical
22 standard. If people -- and this has been expressed by some

1 commissioners -- think we're not doing enough for primary
2 care. Maybe we should be amping up what we have in the fee
3 schedule related to primary care. Accuracy is a funny word
4 there. That's more going for some outcome that you want in
5 that particular instance.

6 Exactly, it's not a technical and empirical.

7 And then there is one last thought, and it's a big
8 thought and it's way down the road. And I think this is in
9 part how the cost effectiveness and clinical effectiveness
10 work comes into play. If you had clinical effectiveness
11 information and you knew for certain services that one was
12 superior to the other, that might go in -- to Mitra's point
13 -- into setting a price for one thing versus another.

14 I think that's another thought on the pricing
15 front.

16 MR. BERTKO: I also have a list. I'll try to be
17 brief.

18 First of all, I'll agree with many of the earlier
19 comments. But in focusing on the one that Nick made first,
20 the SGR doesn't seem to be doing what maybe it was hoped to
21 be done. And recognizing Scott's numbers there that they
22 are just a couple of illustrations. But the point to be

1 made, if you multiplied those by the baseline, they come out
2 to be very big numbers.

3 If we're going to agree that that's necessary, we
4 ought to be getting better value across the board from this.

5 The next comment is I'll compliment you guys on
6 doing a great job of discussing all these draft elements.
7 But to be more explicit and follow up Doug's comment here,
8 in my mind, at least, it might be useful to have a broad
9 timeline or chart. Many of these things are connected to
10 each other. And yet they are sequential.

11 So P4P, there may need things that need to be done
12 immediately, the feedback perhaps followed by the payment
13 mechanism. And having some illustration that we could all
14 see together and hopefully gain some consensus would be
15 important.

16 In particular, on that side, as we've just talked
17 about the primary care manpower thing, strikes me, from what
18 limited I know about it, it's a very long term change. So
19 to get doctors incented to become primary care physicians is
20 perhaps a five, seven, 10-year mechanism, in order to have
21 enough. And I believe the manpower is such that a large
22 number of them will be retiring over the next 10 years. And

1 that has implications on access first, of course. From at
2 least our data it has cost implications.

3 Primary care doctors generally do a very good and
4 very cost effective job, compared to having send the same
5 person with the same condition to specialists and the use of
6 appropriate care there.

7 I forgot to say, I'm going to agree with Doug that
8 some version of a target or otherwise constraint needs to be
9 recognized in whatever we do.

10 DR. KANE: I think John was looking at my notes,
11 but I agree that there is a need to -- maybe we should think
12 about bundling our proposals because I noticed, for
13 instance, with the severity adjustment that we thought
14 should go with a cost-based update for the DRG system, that
15 we were fearful that that could get unbundled and pretty
16 much undo what we were hoping to accomplish with those
17 adjustments to the DRG system.

18 So I think we need to be very explicit about what
19 needs to go together. And not only do I think the pay for
20 performance needs to go with payment, but I agree with
21 Nick's point that the physician piece and the hospital piece
22 need to go together. In fact, if you would incentivize

1 physicians to reduce volume, the hospitals will start
2 complaining and doing odd things that will offset that.

3 So I think we really do need to think about how
4 these things work in concert and not try these one by one
5 unless it's very misleading to think that these things
6 aren't totally related to each other.

7 My last point, the only thing I would add -- I
8 hate to do this to a list that long. But I would add that
9 we should start thinking about what incentives or
10 encouragements can we give to the medical education system?
11 Because I still see, I train a lot of physicians and young
12 physicians who come out -- really, they're still sometimes
13 third year medical school. And I say what are you thinking
14 of for a specialty? And they say dermatology or
15 anesthesiology or pathology. And I say what about primary
16 care? They say we get told day one to stay away from that.

17 So obviously the training system is not helping us
18 with our problem. And I don't know whether it would be good
19 to pay higher for primary care residencies or reward medical
20 schools that actually produce people who choose primary care
21 specialties. It's a deeply ingrained culture, anti-primary
22 care culture in many medical schools. But we need to think

1 about how can we start to offset that. Otherwise, I think
2 it's going to be longer than 10 years to get people to be
3 coming into the primary care side. And it really starts
4 right there at the medical school.

5 MR. HACKBARTH: I saw a lot of heads nodding in
6 response to John's and Nancy's comments about how to
7 organize that, to try to think of this in terms of links
8 among proposals and steps that might be pursued in sequence
9 over a longer period of time. That's attractive to people,
10 I sense?

11 Now I think it's easier to say in the abstract
12 than it is to do in practice. But we can devote some effort
13 to trying to accomplish that if people want to go that
14 direction.

15 DR. WOLTER: This is on Nancy's comments really,
16 and other comments on primary care, which I'm a very big
17 supporter on the primary care issue. I'm very worried about
18 the supply over the next 10 or 15 years.

19 It's a complicated issue, though, and I think that
20 there are other specialities where we're going to see
21 significant shortages. I'm very worried about general
22 surgery. There are also lots of opportunities on quality

1 and cost management that will involve the appropriate
2 numbers and involvement of other specialists.

3 So it's sort of a complex issue. And it seemed to
4 me in the '90s, when managed care was all the rage,
5 everybody thought primary care was the solution to
6 everything and their predictions were we would move to two-
7 thirds of all physicians being primary care and one-third
8 specialty, which is kind of the reverse of what we had
9 today. That hasn't happened and I don't think it's a likely
10 scenario either in the next 10 or 15 years.

11 So the question I've had is where is the planning
12 around physician manpower and woman power mix going on? I
13 don't know if it's going on anywhere. But it's a fairly
14 complex issue.

15 DR. CROSSON: It just strikes me that perhaps a
16 timetable or a schedule with dates and years, as was
17 mentioned earlier, may be hard. But I do think it would be
18 valuable to frame, as I said earlier, why we are talking
19 about physician payment and what we're trying to achieve by
20 changing the physician structure, and then to identify the
21 critical interdependencies, some of which are temporal and
22 essentially draw the reader to understand that some things

1 have to happen first, and some things have to happen in
2 concert. Otherwise, you don't get the goal that you're
3 looking at.

4 MR. HACKBARTH: On the issue of primary care and
5 the point that Nick raised about the same concerns being
6 relevant for other specialities, I know from past
7 conversations that both Karen and Ron share that concern
8 that in other specialties there may be developing problems,
9 as well. Not just primary care.

10 It's a tough issue in the sense that we can't be
11 the place that starts with a fresh piece of paper and says
12 here's what the manpower or person power ought to look like
13 for the long-term. That's just way beyond our expertise and
14 our capabilities.

15 I'm sort of getting tangled here. What I'd like
16 to do is go back to the people who have been waiting
17 patiently and then if there are some other comments on these
18 issues, we can try to get them at the end, as well.

19 DR. MILSTEIN: One of the levers that we've
20 discussed previously is this notion of, within the limits of
21 what the current statutes permit, better synchronizing
22 Medicare efforts to improve clinical efficiency with what's

1 happening in the private sector. So with that as an
2 introduction, I thought I might share at least my view as to
3 where I see a fair amount of private sector convergence with
4 respect to these issues. We might think about how we might
5 align.

6 First, I think there's an increasing view among
7 private payers, whether they are self-insured employers or
8 insurance companies or union managed Taft-Hartley trusts,
9 that we have, in this country, given uniquely high levels of
10 authority to our physicians in the country to determine
11 resource use and to shape the speed with which quality
12 improves. There are others in the private sector who would
13 add to that comment, as we've also accorded our physicians,
14 on average, a much more favorable income level relative to
15 cost of living as compared to other industrialized countries
16 with which we compete economically.

17 With that greater authority and more favored
18 lifestyle ought to come a greater accountability for driving
19 performance improvement overall in the health care system.

20 So I think a simply stated vision of private
21 sector convergence is that we need to make changes in how we
22 manage our health benefits programs that, in particular,

1 incentivize physicians to lead in efficiency gaining
2 innovations because of this great power and authority we've
3 given them. There's almost no component of the health
4 benefit supply chain that isn't very sensitive and affected
5 by what doctors do.

6 So a simple way of putting it is how do we --
7 given that we're operating in a very complex system, what is
8 the smallest number of changes you can make such that within
9 the not-too-distant future we have physicians in America who
10 wake up in the morning and foremost in their minds are how
11 they might innovate in delivering care that day to improve
12 efficiency, both quality and resource use, by the days end
13 or the weeks end or the years end.

14 As I look at our list, first of all I think it's a
15 terrific list, and the only things that occur to me in terms
16 of refinements would go something like this: number one, I
17 think we remain far too conservative with respect to our
18 recommendation to let resource use only be something in the
19 near term we use for provider feedback.

20 I think almost all of the big national commercial
21 health plans are using measures of physician resource use in
22 ways that have substantial consequences for physicians, such

1 as tiering, tiered networks or narrowed networks. Aetna,
2 Cigna, United, Humana, they're already there.

3 So whatever imperfections there may be in that
4 measurement system, clearly they are not enough to outweigh
5 what are perceived to be the advantages of moving forward.
6 So recommendation one is can we consider notching up that
7 particular recommendation? Maybe we should hold our
8 discussion of that until our next presentation, which is on
9 this issue of feasibility.

10 Second, I just reinforce earlier comments about
11 content of medical education right now. Our medical
12 education dollars are really without strings. I think that,
13 per some of the examples cited, that's not working out very
14 well for us right now. And so I think moving the federal
15 government or, for that fact, private sector payers into the
16 content of medical education or mix of residencies selected
17 is obviously maybe not the first place you would want to go
18 but we're clearly failing, I would say, with respect to this
19 idea, this policy of no strings attached which has been the
20 policy in place since the beginning of Medicare's medical
21 education payments.

22 Third, another thing that would maybe be a

1 possibility for adding to the list is can we think about --
2 what about the idea of doing more to incentivize physicians
3 and everybody else in the delivery system to use their
4 creative powers to come up with innovations that improve
5 both quality and efficiency?

6 One way that could be done that we don't do today
7 would be to essentially say we're going to treat innovations
8 that have a favorable profile with respect to efficiency
9 gain, both resource use and quality, with a faster track for
10 Medicare coverage for that subset of innovations that would
11 require a coverage role. I'm thinking about some of the
12 agony that innovators, for example in remote patient
13 monitoring devices, a subset of which might carry a
14 favorable profile with respect to substantial improvements
15 in efficiency and quality.

16 People who come up with such innovations face very
17 long roads to Medicare coverage decisions, and there's
18 nothing for them more favorable when they've got an
19 innovation that, for example, not only improves quality but
20 also reduces cost, as compared to somebody that has an
21 innovation that improves quality equally but worsens
22 Medicare sustainability because it's cost additive. Could

1 we consider a faster track for that subset of innovations
2 that require coverage decisions and which have an extremely
3 favorable profile with respect to both quality and more
4 conservative resource use or lower cost per unit?

5 Those are my three suggestions.

6 DR. REISCHAUER: I'd like to congratulate the
7 staff on what I think is a very comprehensive and good
8 treatment. But I was thinking, were I staff on the Hill or
9 a member of Congress and we have the SGR, a sledgehammer, it
10 isn't working, and we sent a letter to MedPAC and say give
11 me an alternative and here I have a whole lot of good ideas
12 that are hard to implement and I really don't know what to
13 do with them. They undoubtedly, if they were all
14 implemented, would improve quality. And they may have some
15 modest impact on cost growth. But I would feel that I
16 didn't have something to sink my teeth into.

17 I think Doug raised a very important issue, which
18 is the impetus behind the SGR, of course, was to moderate
19 the growth of expenditures so that it fit within some notion
20 of affordability. We need this because Medicare is an
21 entitlement, which means we have no budget constraint on it
22 at all. We spend what millions of individuals and their

1 providers decide they want to have in the way of medical
2 care during the year. And maybe we should try and structure
3 this in really simplistic ways to help Congress understand
4 why, in a sense, the mission that we've been asked to do is
5 almost impossible, meaning come up with a silver bullet that
6 will substitute for the SGR without causing an outcry from
7 Ron or patients.

8 We could look at this and say you can affect
9 quantity, volume. You can affect price, or you can affect
10 the way resources are put together to produce the health
11 outcome.

12 We, as a society, have decided that we're very
13 reluctant to directly affect quantity or volume. That's
14 called rationing. And while we -- directly, I said. While
15 we put some limits like how mental visits can you have
16 during a year, we aren't willing to go the next step, which
17 would be to go through lots of different diagnoses and say
18 for this you can have two x-rays and one MRI, for that you
19 can have none.

20 Jay, I'll give you equal time afterwards. I see
21 you shaking your head at everything I say -- shaking it the
22 wrong way, right to left.

1 But in that group, as far as we seem to be willing
2 to go is to entertain mechanisms that would eliminate volume
3 of services that seem to have no benefit or very low
4 benefits, and do it through cost effectiveness studies or
5 evaluating the worthiness of various medical interventions
6 about which we do based on faith rather than an evidence
7 base that this works.

8 We can directly affect price, and that's what
9 we've done. That's what the SGR is, and it can have
10 significant impact. It's focused right now on physicians,
11 Ron, you're right. But we have and do change the updates of
12 all of the other providers as well, when we think budgets
13 are running amok.

14 But what we have here is a bunch of rather softer
15 proposals to move forward in that area, like let's set the
16 prices right so they really reflect the cost of producing
17 the service accurately. But the way we do that now, through
18 the RUC and all that, is to dampen down the price here but
19 then throw the money back into the pool. So in effect,
20 we've done nothing to the overall pool. We've made prices
21 better reflective of underlying cost, but we haven't "saved"
22 any money.

1 Mitra wants to set prices based on value, and I'm
2 all for that, too. But I'll be damned if I know how to do
3 it. In the rest of the competitive world we have markets
4 and they determine what the value of a plasma TV set is
5 versus a new tire. But in this area, we really wouldn't
6 have anything except professional judgment. And I'm not
7 sure that's going to get us very far.

8 Third, we can try to improve efficiency, or the
9 way in which we put together resources. That's what a lot
10 of this is. But it's a long haul and it will occur very
11 gradually and have to involve a whole lot of behavioral and
12 structural changes.

13 I think if we go through it like that then you can
14 understand better why it isn't so simple to throw out the
15 SGR and replace it with something else.

16 Just a footnote on cost sharing and where one
17 might go with that. I'm very skeptical that we could ever
18 institute limitations on supplemental policies that said you
19 can't, in a sense, prepay for the cost sharing that Medicare
20 requires. What this really is is who's going to pay for it?
21 Is Medicare going to pay for it? Is the individual going to
22 pay for it through premiums to Medicare? Or is the

1 individual going to pay for it through their Medigap
2 premiums and their former employers? That's really what
3 we're talking about.

4 Think of how hard it would be to say to those with
5 employer sponsored retiree benefits, you have to redefine
6 this, which is set in a contract, so that the first \$500 is
7 a deductible. In theory, it's a great idea to go that
8 direction, but I think we'd be tilting at windmills that it
9 would never occur politically.

10 DR. HOLTZ-EAKIN: I didn't mean to suggest that.

11 DR. REISCHAUER: No, I wasn't looking at you. No.
12 I was looking at you because everybody else has disagreed
13 with everything I've said so far and you were the sole
14 friendly face in this side of the table and I was trying to
15 boost my confidence here.

16 [Laughter.]

17 DR. REISCHAUER: In a desperate attempt to get
18 agreement further around the table, the right way to do this
19 is to have an appropriate catastrophic benefit in Medicare
20 that's defined on the income of the beneficiary so that a
21 person with a \$20,000 income would have a \$500 catastrophic
22 limit and somebody with \$80,000 would have a \$5,000 limit or

1 something like that.

2 MS. BURKE: Of course, you'd have to get agreement
3 on what income was.

4 DR. CROSSON: I just wanted to appropriately
5 respond to my body language indication.

6 I just wanted to make two points. The point I
7 reacted to was I don't really think that volume management
8 is the same as rationing. Because I think the issue of
9 appropriateness or necessity has to come in there. I've
10 never heard the term rationing and Mercedes Benz used in the
11 same sentence.

12 So the issue of, I think, rationing as a term
13 generally comes in when someone is talking about having to
14 limit things that are necessary or appropriate. But
15 everything that we're dealing with in some of the volume
16 issues doesn't fall into that category. That was the only
17 point that I argued.

18 But I would heartily agree, and I don't think I
19 believe that if we do these things or many of these things
20 on the list and walk away from the volume piece, that we've
21 done the job. We have not.

22 I think what I was saying earlier was that I think

1 we ought to just recognize that we have an opportunity here
2 created by the conundrum of the failure of the SGR to more
3 broadly address physician payment and call out explicitly
4 those things that we think need to be improved in the
5 Medicare program that can be impacted by a better physician
6 payment system, among which is appropriateness or excessive
7 volume.

8 And I don't have a Mercedes Benz.

9 MS. BEHROOZI: Just on value, but when you buy
10 something in the market, when you buy tires, don't you look
11 at Consumer Reports or some kind of expert advice? There is
12 evidence about which things provide higher value. And the
13 market isn't always right. The market doesn't always price
14 things according to their value. That's kind of what value
15 is. Can you get more by paying less?

16 So I think that we talk enough in this group, and
17 certainly there's plenty of evidence out there and private
18 payers are using all of that evidence. It seems to me to be
19 really not progress for us to sort of put up a wall and say
20 we'll never be able to figure it out because it's too
21 complex and there's too many political implications and
22 whatever. And I think Dana's point about it's going to take

1 a lot more administrative dollars to be able to make good
2 judgments about value. But some of them just jump out at
3 you. And to say it's going to be too complex and too
4 fraught to come up with a whole value-based system isn't a
5 good reason not to at least start moving on the things that
6 we spend a lot of time looking at and there's plenty of
7 evidence for.

8 And on the cost sharing, I think we have
9 different notions of cost sharing. In terms of a chunk of
10 \$500, yes, that's something that you get insurance for,
11 whether it's a deductible or a back end catastrophic. But
12 in terms of things that incent behavior, like copayments, a
13 few bucks here or there, I don't know that that's the kind
14 of thing that people buy insurance to cover.

15 And not only does that incent beneficiary
16 behavior, but also provider behavior. Whatever is easier
17 for the beneficiary obviously becomes easier for the
18 provider.

19 MR. HACKBARTH: We're running short of time.

20 MR. MULLER: Being this late in the process, a lot
21 of the things have been covered before. But I want to go
22 back and build on a point that Nick made, which is there's a

1 lot of incentives inside the system for everybody to do
2 more. It's not just doctors that are -- the issue at hand
3 is the SGR but providers do, pharma does, device
4 manufacturers do.

5 And as Bob and others and Doug have pointed out,
6 in a system where prices and markets don't work that well,
7 given the way we insure and cover, going back and looking at
8 the professional judgment of the physician as a central
9 player in the system, a point that Ron made earlier, I think
10 is a critical thing that we should be looking at.

11 It's not just that they have more physician
12 services. But they admit people to hospitals, they order
13 imaging, they write medication scrips for their patients, et
14 cetera, and so forth.

15 So I think in terms of some of the issues that we
16 have around the costs of the program, the access for
17 beneficiaries and so forth, looking at ways in which, based
18 on the evidence that we have, one has incentives for the
19 physician to be more a central player in cost control and
20 access I think is a critical part of this. Because we do
21 ultimately have to rely on their professional judgment.
22 There's many ways of abetting their professional judgment

1 through appropriateness criteria, through evidence-based
2 medicine, through investments in IT, et cetera that we
3 ve discussed over the course of the last few years.

4 So I'm not a believer in just saying every
5 physician should just come to this professional revelation
6 on their own. There's an awful lot of what we've learned in
7 the understanding of quality and the appropriateness of care
8 over the last 10 years we should bring to bear.

9 But I would like, as we think about these 10 or 11
10 things on these summary slides, to focus on the role of the
11 physician as the central player in the whole system and not
12 just in the more narrow sense of how we define the SGR and
13 how they affect the whole thing. I think Arnie and others
14 have said that, as well. And that's why I said, some of
15 these may be repeats.

16 But we might say to the Congress or whoever is
17 looking to on this, the central thing we've learned is these
18 players are the ones that can have some shaping of the fact
19 that most of the health system is very asymmetric in its
20 incentives. The incentives are there to do more. There's
21 very few incentives to do less.

22 As Nick and others have said, you don't want to

1 merely start getting into thinking that doing less is
2 stinting. You want to have appropriateness. But I would
3 really focus on therefore how the appropriate behavior and
4 appropriate incentives to physicians can help the whole
5 system. And whether we do that through doing even much more
6 than we have ever done on gainsharing, where I think our
7 efforts are basically a tweak like this compared to what
8 could be done, I think is of critical importance. Because
9 if they don't have those right incentives, then all the
10 things we're worried about is going to keep happening and
11 happening.

12 MS. HANSEN: Many of the comments have been made,
13 but I just would add one more different one relative to the
14 primary care component. I believe there's actually a
15 nascent plan for the IOM to take on whole aspect of the
16 geriatric workforce, which will include primary care and
17 other disciplines, as well. As you said, this is not really
18 the work of our focus, but we probably would benefit from
19 working with that in tandem, including given the fact of
20 chronic care management being a large part of it.

21 I just want to put forth here, even though the
22 funding is not quite there, but the whole aspect of really

1 looking at alternative or complementary providers like nurse
2 practitioners in this. So the physician is still the core
3 of this, but the complementariness of really making sure
4 standardized kinds of issues that will grow in both number
5 and need to be able to look at alternative practitioners.

6 DR. BORMAN: Just a couple of things that will
7 relate to future topics. One, with regard to the
8 encouraging or using clinical and cost effectiveness
9 information, I think that's where we've put IT under that
10 umbrella. We've all said IT can be for good or for bad.

11 I sometimes find myself waiting for the perfect
12 system before I make a decision. I think we regularly fall
13 into that trap.

14 I would say, under this one that, for example,
15 some regularly recurring things like prescription renewals
16 or cross-checking prescriptions relative to side effects,
17 follow-up appointments, annual preventive services, and so
18 forth. I don't think we have to debate the value that IT
19 can help a practitioner with those. And maybe we do need to
20 endorse those things as a good things of IT and kind of move
21 forward and leave the things that we have to figure out the
22 data for, okay, we'll get to those. But let's not just not

1 move with regards to the areas where we know those can be of
2 benefit.

3 Another, with regard to encourage care
4 coordination. I think I'm coming to learn that the word
5 encourage means potentially pay more or potentially pay
6 others less. So in that mode, I would wonder if perhaps
7 staff could -- and you can just get it to me or whatever,
8 but the definition of certain services that are provided and
9 billed now includes care coordination. And it's things like
10 post-service work of evaluation and management visits. It's
11 things like some of the education and preventive visits,
12 some of which the Medicare program chooses not to cover
13 currently, and that's a separate issue. But there have been
14 some values assigned to those.

15 But any rate, I would like to see us take that big
16 column that we show in the comparative graph that's
17 evaluation and management services, and let's find out what
18 percentage of that, at least in theory, already is
19 supposedly representing coordination of care. Before we put
20 more money into coordination of care, let's find out the
21 percentage of that that's already marked to that.

22 MR. HACKBARTH: I think that would be useful to

1 do.

2 Let me go back to your initial comment about
3 encourage means pay more money. In some ways that's true
4 but in some ways it isn't. I think this is actually an
5 example.

6 If you want to "encourage" care coordination, you
7 might move on several fronts. One is, as you pointed out,
8 do we have codes for that? Is it a payable activity?

9 So that's the most basic level. And maybe we do
10 have lots of codes. You know 100 times more about that than
11 I do, and we can document that.

12 The next step though is do we pay sufficiently for
13 that activity to get as much as we might want? And that
14 could be an issue of the unit price that we pay for whatever
15 codes we've got for care coordination.

16 But then the third aspect is one that actually we
17 focused on in our report of last June, which was look, there
18 are spillover benefits to the broader system of this
19 activity of care coordination that we may want to allow the
20 providers who do it to share in those savings. And that's a
21 third way to encourage care coordination.

22 So we need to decide which of the levels we want

1 to work on, where we've done enough, and where we haven't
2 done enough.

3 DR. BORMAN: You gave me a lead-in to my next
4 comment, which was that I would encourage everybody to
5 remember that the scale that we use is purposefully termed
6 relative. And I'm going to suggest to you that as you
7 consider these things here that, before you move things
8 around here a fair amount, you want to know -- on the
9 physician side, we may all say to you we're all underpaid.
10 The issue here is are we appropriately relatively underpaid
11 or whatever adverb or adjective you want to put in there?

12 And let's keep in mind here that we are talking
13 relative. The ephemeral notion of value, I await seeing the
14 criteria in the definition. And maybe it's a sniff test,
15 Supreme Court kind of pornography kind of thing. But I
16 think we have to be a little careful about that because the
17 same value word goes into a lot of nuts and bolts of the
18 physician fee schedule. I think we have to be a little bit
19 careful about translating that how we currently do RVUs
20 corresponds to the notion of value that Mitra brings forth,
21 as best I understand it. And I think we get a little bit
22 confused in that terminology.

1 MR. HACKBARTH: I'm sure that we do. I think it
2 was at the last public meeting, Karen, or maybe this was in
3 our conversation, I thought I heard you second an idea that
4 Bill Scanlon had made, which is that our basic framework now
5 is a resource-based relative value scale. So we tried to
6 assess the resources that go into 7,000 different codes and
7 make sure that on a resource basis the payments are
8 equitable.

9 I thought I heard you say well, that might be a
10 good starting point but it isn't necessarily the ending
11 point. And it may be appropriate to break out of that
12 framework and say for policy reasons that we want to start
13 with the resource-based relative value and then adjust it to
14 achieve other goals.

15 DR. BORMAN: You're absolutely correct, and what
16 I'm supporting, however, is that we maybe move past the
17 sniff test piece to maybe some criteria or better definition
18 or whatever of what it is we're doing here. I mean, as
19 opposed to is this a farm subsidy? Is this a signing bonus?
20 Give me a little better sense of how we build something
21 around that.

22 Just a brief comment about education issue, since

1 I am an academic physician. I guess I have a little bit
2 different view perhaps than Nancy has seen. In state-
3 supported medical schools there has been a huge press to
4 encourage primary care and encourage those students.
5 Frankly, to the detriment of some specialty recruiting at
6 those institutions. So I think it's a bit geographic
7 variable.

8 I would agree with her that the pipeline is long
9 for primary care. It's even longer for certain other
10 things. I think you need to know something about the
11 patterns of what students select and at least why they say
12 they select them.

13 I would tell you that in every survey of students
14 about selection, the first thing is it's something that I
15 can be passionate about or interested, and the other things
16 flow. And in fact, the group that is deserting primary care
17 at the greatest speed are male U.S. medical graduates and
18 they are going to some of the specialties that you
19 mentioned in terms of radiology, dermatology, and so forth.

20 So I think you have to look at the data and see
21 what they tell you. And I'm not sure that exactly what they
22 tell us is that, as it's been presented to you, that people

1 are discouraging them from primary care.

2 I would just close with that comment. Thanks.

3 MR. HACKBARTH: Thank you Dana and Scott.

4 Interesting discussion.

5 We have one more session before we break for
6 lunch, and that's on measuring physician resource use.

7 Whenever you're ready, Niall.

8 MR. BRENNAN: Thank you, Glenn.

9 Good morning, everybody. Today we'll be
10 presenting our latest findings related to our assessment of
11 two commercially episode groupers and how they perform on
12 Medicare claims and their suitability for measuring
13 physician resource use.

14 I'd like to start off by thanking Megan and
15 Jennifer, both of whose work is represented in this
16 presentation.

17 To briefly review the two groupers we're using are
18 Episode Treatment Groups created by Symmetry Data Systems
19 and the MedStat Episode Grouper, created by Thomson Medstat.
20 These groupers are designed to comb through administrative
21 claims to create clinically distinct episodes of care.
22 These episodes can vary in length and a beneficiary can have

1 more than one episode open at any given time. For example,
2 a beneficiary can have concurrent episodes of diabetes and
3 sinusitis.

4 Today we're going to revisit some regional
5 variation issues that arose when we last presented to you on
6 this topic in April. And we'll also present some initial
7 results from our analysis using the groupers on 100 percent
8 of Medicare claims in six selected MSAs, Boston, Greenville,
9 Miami, Minneapolis, Orange County, and Phoenix.

10 Some of you may remember that when we compared
11 episode costs across MSAs back in April, for certain
12 conditions areas that have traditionally been thought of as
13 high resource use, such as Miami, turned out to be low
14 resource use and vice versa. This was most pronounced for
15 coronary artery disease. This table presents additional
16 information on CAD episodes from the ETG grouper. I
17 mentioned the ETG grouper because the data you've seen to
18 date on this issue has been from the MEG grouper. However,
19 these regional differences to occur in both groupers.

20 As you can see, average costs for CAD episodes are
21 roughly \$3,500 in Minneapolis versus \$2,700 in Miami. One
22 of our initial hypothesis was that Miami CAD episodes might

1 be shorter in duration or be comprised of fewer claims than
2 those in Minneapolis. However, the average number of claims
3 per CAD episode is the same in each MSA.

4 However, we did find that a greater proportion of
5 beneficiaries in Miami had a CAD episode, 23 percent versus
6 9 percent, perhaps suggesting that beneficiaries in Miami
7 are more likely to visit a physician in the first place and
8 more likely to be coded as having CAD when they do.

9 Beneficiaries in Miami have more total episodes
10 than those in Minneapolis, six versus four, and this
11 difference rises to 15 versus 10 episodes when we restrict
12 the comparison solely to those beneficiaries with an episode
13 of CAD.

14 Finally, because CAD beneficiaries in Miami have a
15 greater number of episodes, they also see a greater number
16 of doctors over the course of those episodes, 7 versus 4.

17 We then decided to split CAD episodes in each MSA
18 into diagnostic and treatment or intervention categories.
19 We defined treatment CAD episodes as any episode that
20 involved either a major CAD procedure such as CABG or
21 insertion of a pacemaker or a hospitalization. As the
22 second and third rows of the table indicate, there are

1 different rates of diagnostic versus treatment episodes in
2 each MSA, 29 percent of CAD episodes in Minneapolis involve
3 treatment versus 21 percent in Miami.

4 The fourth and fifth rows of the table indicate
5 that, not surprisingly, per episode costs are much higher
6 for treatment episodes than they are for diagnostic
7 episodes. So if Minneapolis has more treatment episodes, it
8 stands to reason that it's overall average costs would be
9 higher.

10 Interestingly, however, for diagnostic episodes,
11 average costs in Miami are almost twice as high as those in
12 Minneapolis, \$822 versus \$448.

13 If average costs for diagnostic episodes in Miami
14 were the same as in Minneapolis, if they were \$448, the
15 difference between the two MSAs will be even greater.
16 Miami's average would be \$2,400 instead of the \$2,700 you
17 see at the top of the table there.

18 Put another way, if Miami had the same rates of
19 diagnostic versus treatment episodes as Minneapolis; i.e., a
20 higher rate of more expensive treatment episodes, its per
21 episode costs will be largely similar to those in
22 Minneapolis, \$3,400 versus \$3,500.

1 This is only part of the story because even when
2 we broke our CAD episodes into diagnosis and treatment
3 episodes, average cost for treatment episodes were still
4 somewhat lower in Miami versus Minneapolis. We were
5 initially concerned that there might have been an error in
6 the way we had standardized hospital payments that was
7 systematically leading to lower costs in Miami. But what we
8 instead found was that there was a different mix of DRGs
9 reported on hospital claims in the two MSA with a higher
10 proportion of hospital admissions for CAD in Minneapolis
11 tending to be for more expensive DRGs, which also has the
12 effect of pushing up their overall average slightly.

13 Finally, the last two rows of this table show the
14 number of claims per diagnostic and treatment episode. As
15 you can see, the higher cost for diagnostic episodes in
16 Miami is reflected in a higher number of claims, 14 versus
17 11, and these additional claims and the dollars associated
18 with them are mainly E&M, evaluation and management, and
19 imaging claims.

20 Another hypothesis we had regarding these regional
21 differences was that perhaps due to a greater concentration
22 of physicians and specialists in Miami, beneficiaries in

1 Miami were being assigned to other heart-related episodes,
2 as opposed to remaining in a single CAD episode, as in
3 Minneapolis. We examined all other types of episodes for
4 beneficiaries with at least one CAD episode in both MSAs,
5 categorizing all ETGs or episodes into one of 22 major
6 practice categories. For example, cardiology, dermatology,
7 gastroenterology, et cetera.

8 This permitted us to see if CAD beneficiaries in
9 Miami had additional cardiology episodes compared with those
10 in Minneapolis. We found that beneficiaries with a CAD
11 episode in Miami had more cardiology episodes than those in
12 Minneapolis, an average of almost three per beneficiary
13 compared to two in Minneapolis.

14 In addition to having higher rates of cardiology
15 episodes, CAD beneficiaries in Miami also had higher rates
16 of episodes in every other type of major practice category
17 with the exception of preventive care. Overall, CAD
18 beneficiaries in Miami had 15 total episodes of care
19 compared to 10 for similar beneficiaries in Minneapolis.

20 So just to summarize, at first blush, Miami does
21 have lower per episode costs for CAD than Minneapolis.
22 However, this is driven by the fact that Miami has a

1 disproportionate number of lower cost diagnostic CAD
2 episodes, even though those diagnostic episodes may, in
3 fact, be provided inefficiently, as evidenced by the \$800 to
4 \$400 comparison on the previous slide.

5 Additionally, Miami CAD beneficiaries are more
6 likely to have other types of episodes and care for Miami
7 CAD beneficiaries is more expensive than Minneapolis when
8 calculated on a per capita basis.

9 All this suggests that more research is needed
10 into the issue of regional variations and how they effect
11 episode-based analyses. It's also possible that perhaps
12 some limited chart-based review might be necessary to
13 especially drill down to the hospital level where we're
14 finding some differences in the types of DRGs even.

15 The next few slides will present some descriptive
16 statistics from our analysis of 100 percent of claims in six
17 MSAs. At the last meeting there was some concern raised
18 about the ability of the groupers to deal with claims from
19 settings where Medicare was the dominant payer, as they were
20 initially developed for use in the commercially insured non-
21 elderly population.

22 We calculated the proportion of claims that were

1 successfully grouped to episodes across all six MSAs and
2 across eight different types of claims: hospital inpatient,
3 physician, hospital outpatient, skilled nursing facility,
4 home health, long-term care hospital, rehabilitation
5 hospital and psychiatric hospital. We found that the ETG
6 grouper does successfully group claims to episodes. The
7 lowest proportion of claims that are grouped in any MSA are
8 94 percent of hospital outpatient department claims in
9 Orange County while PPS hospital claims generally have the
10 highest grouping rates of between 99 and 100 percent in
11 every MSA.

12 Even the 94 percent for Orange County can be
13 viewed as something of a low outlier in a way. Across our
14 six MSAs and our eight different types of claim
15 combinations, more than 70 percent grouped at a rate of 97
16 percent or higher.

17 Looking specifically at settings where Medicare is
18 the dominant payer, such as rehab and long-term care
19 hospitals, grouping rates were all in the high 90s.

20 Of course, there's a difference between grouping
21 to an episode and grouping to a clinically appropriate
22 episode. We looked at episodes to which claims from

1 settings such as rehabilitation and psychiatric hospitals
2 were grouped. Over 90 percent of claims from psychiatric
3 hospitals were grouped to episodes such as schizoaffective
4 disorders, bipolar disorders, alcohol or drug dependence
5 and dementia. Similarly, the majority of rehabilitation
6 hospital claims were grouped to episodes such as hip
7 fracture or replacement, stroke and spinal trauma.

8 The data in this table just confirms that at a
9 highly aggregated level, our findings from the 100 percent
10 analysis are similar to those from our 5 percent analysis.
11 Across our six selected MSAs the average beneficiary had
12 five episodes at an average episode cost of \$942. Per
13 capita costs for those beneficiaries were slightly less than
14 \$5,000.

15 However, at the individual MSA level there was
16 variation in all these statistics. The number of episodes
17 per person ranged from a low of 4 in Minneapolis to a high
18 of 7 in Miami. And the high number of episodes per person
19 in Miami enabled their per episode average cost to be in
20 line with other MSAs but their per capita costs in Miami
21 were significantly higher than other MSAs, \$6,400 compared
22 to as low as \$4,000 in Minneapolis.

1 This last table shows for each MSA in our 100
2 percent analysis a highly aggregated look at the components
3 of cost across all episodes in an MSA. We split those costs
4 into six categories: evaluation and management dollars,
5 procedure dollars, imaging dollars, test or other dollars,
6 hospital dollars, and post-acute care dollars. That's what
7 the PAC stands for.

8 Again, as you can see, there is some variation in
9 the proportion of episode costs accounted for by different
10 service types across MSAs. Boston episodes have a higher
11 than average share of costs attributable to post-acute care
12 while Miami has higher than average shares of E&M and
13 imaging.

14 Echoing some of the CAD results presented at the
15 beginning of the presentation, Minneapolis has the highest
16 share of episode costs attributable to inpatient hospital
17 care, 40 percent of all their episode costs. While Orange
18 County, in contrast, has the lowest proportion of hospital
19 care, 29 percent, but higher than average E&M care on
20 procedures, 24 percent and 24 percent respectively.

21 So in conclusion, we feel that we have some
22 interesting and illuminating results on the regional

1 variation issue, but we're also continuing to examine it and
2 the implications that it has for episode-based analysis.

3 We've looked closely at the ability of the
4 groupers to assign claims to episodes and found that a high
5 proportion of claims are successfully assigned to episodes,
6 even from Medicare dominated settings.

7 Finally, we're working hard on taking this data
8 and looking at it at the provider level and we'll return in
9 November with details on this analysis and how it might
10 inform the outlier portion of the SGR report.

11 I'd be happy to take any questions that you have.

12 MR. HACKBARTH: If you look at the Miami versus
13 Minneapolis analysis, I'm trying to think how this tool can
14 be used to reward and encourage efficiency.

15 We looked at this comparison and we found some
16 surprising results last time, namely that the episode costs
17 were lower in Miami. So what you did was subdivide the CAD
18 episodes by diagnosis versus treatment, and then you looked
19 at the number of episodes per beneficiary with CAD. And you
20 found, at least to my eye, some potential explanations that
21 help us reconcile that initially surprising finding with our
22 other beliefs about the relative efficiency of Minneapolis

1 and Miami. So that's good. I feel better now than I felt
2 before.

3 But this all raises the question in my mind, how
4 would you then apply this tool in a payment policy so that
5 you truly reward efficiency? Are you saying that you'd have
6 to subdivide episodes into treatment versus diagnosis for
7 all the categories and take into account the number of
8 episodes? I know we've got people here who have used these
9 tools so this is a question for everybody. That's where I
10 am in this sequence.

11 Niall can go first, and then --

12 DR. HOLTZ-EAKIN: My question is about these
13 groupers themselves, the software. In their development,
14 what do we know about the testing, for example putting
15 together artificial databases where you know the actual
16 episodes that should be grouped and you look at the success
17 rate in the software in actually putting together the right
18 claims?

19 To the eye, it looks like they've successfully
20 assigned these things to the right places. But did they
21 really group the episodes the way the doctors actually did
22 them?

1 MR. BRENNAN: There are a couple of questions
2 here. I think I'll start with Doug's, because it's slightly
3 easier, I hope.

4 There is an extensive clinical background, going
5 back 10 or 15 years, behind these products. They are
6 private sector products and it's my understanding that
7 they're quite expensive to use and employ. So they have
8 panels of physicians and clinical expert panels that look at
9 the algorithms. And I'm sure they take specific cases and
10 make sure that yes, this beneficiary ended up in this
11 episode and this episode was appropriate.

12 I'm probably not the person to say whether or not
13 they're absolutely perfect or even if absolute perfection is
14 the goal here. Certainly I think, based on our analyses,
15 which have not been very rigorous in terms of a clinical
16 evaluation, things like the types of episodes to which
17 psychiatric -- that is encouraging to a non-clinician like
18 me.

19 Last year, in April, we presented some information
20 on the components, before you got on the commission, on the
21 components of costs for different types of episodes. And
22 again, without it being a rigorous clinical evaluation, you

1 could sort of see that certain episodes were very heavy on
2 inpatient costs and it was kind of well, that make sense,
3 and certain episodes were very heavy on E&M care, and that
4 makes sense, too.

5 We could do a number of things. We could get some
6 of the vendors in here or we could reach out to them to get
7 a more systematic explanation of their clinical logic and
8 any internal testing or validation that they've done.

9 DR. HOLTZ-EAKIN: That was helpful.

10 MR. BERTKO: First, I'll address the easier of the
11 questions, Doug. We've used some of these and we've held
12 them up to physician audiences where we've applied them, and
13 in a relatively friendly fashion explained them using one of
14 the developers to stand there. And they have passed that
15 kind of face test of validity.

16 So not the detail that you perhaps were suggesting
17 here, but were they acceptable? That answer was yes.

18 DR. HOLTZ-EAKIN: Do you pay based on them?

19 MR. BERTKO: We tier based on them, so indirectly,
20 yes.

21 First of all, I want to recognize Niall. When he
22 said he worked hard, he worked really hard with his staff to

1 do this, because these datasets are just gigantic. But
2 what's next?

3 There's lots of ways. This data is very, very
4 dense. Lots of interesting things to find. So the per
5 beneficiary or per beneficiary with disease view of these is
6 more of how does it work?

7 Now how would you apply it? I think, and Niall,
8 I'm going to suggest -- interpreting what you said here is
9 the next step here for next month is to build on the
10 physician case loads, is the way that it's actually applied.
11 Arnie, you can jump in after me.

12 But instead of looking at it on a per beneficiary,
13 you look at it either implicitly or explicitly on what does
14 a physician do across a practice pattern? We used two of
15 them. One of the ones we use actually builds up a specific
16 market basket much like the CPI has done for those kinds of
17 things. The implicit ones like ETGs and the MEGs do it and
18 just say if you've got all of this and you severity adjust
19 it, you've essentially got the basics of a physician
20 practice. And that's where you begin to see efficiency and
21 inefficiency in terms of it.

22 And to that I would say you impute or infer that

1 folks that are way out here at the end of the tail in terms
2 of efficiency probably have inappropriate care. And as
3 we've been forced a couple of times to provide feedback, you
4 find things like imaging is 200 percent of the peer group
5 within the speciality within the market, let alone -- I'm
6 sorry, market-to-market.

7 So Niall, have I correctly imputed, inferred that
8 the next go around we'll be closer to telling how we would
9 use it?

10 MR. BRENNAN: We're certainly going to aggregate
11 episodes to the physician level. We're looking at several
12 different ways of then computing a composite type score, be
13 it a market basket type approach or a more indirect
14 standardization type approach.

15 In partial answer to Glenn's question, I think it
16 does raise a number of interesting issues. I think both
17 makers of the software are interested in this issue and
18 they're amenable to change if they feel that this is
19 something that isn't working.

20 It's also most pronounced at a cross-national
21 regional variation level. And one thing you could possibly
22 envision -- and Mark can cut me off at any time -- is that

1 there are regional variations. But within Miami there's
2 still a distribution of efficient and inefficient providers.
3 So one way would be to possibly combine some kind of a per
4 capita evaluation with then a per episode evaluation in a
5 defined geographic area.

6 This is way, way, way down the road, but do you
7 really want to use these tools to literally compare a
8 physician in Key West to a physician in Anchorage? These
9 are all implementation issues that need to be thought
10 through and discussed.

11 I think what we've discovered is very interesting
12 analytically and, like I say, the makers of the software are
13 interested in working with us or other people to try and
14 either come up with a solution or a work around.

15 DR. REISCHAUER: Niall, I thought this was
16 absolutely fascinating and incredibly discouraging. Having
17 come out of the IOM experience and thinking that if we got
18 good episode measures of resource use this might be used in
19 a P4P system for measuring efficiency, and I come out of
20 this and I'm just mind-boggled by the variation between
21 Miami and Minneapolis on the fraction of the beneficiary
22 population that has CAD episode, 9 versus 23 percent.

1 Now it's conceivable that unhealthy people leave
2 cold climates and all you have left is Norwegian bachelor
3 farmers who are very healthy except when they have
4 horrendous heart problem, and huge numbers of sick people go
5 from New York and New Jersey down to Miami to be treated.

6 But it just strikes me that the variation across
7 regions is not so much -- and I'd like to see this actually,
8 just try to do a calculation -- it's not so much how much
9 resources does the average CAD person get in Miami versus
10 the other, but how many of them are there? And 9 percent
11 versus 23 percent, and then you extended that to other types
12 of conditions and the incidence was high in Miami for
13 everything.

14 It just strikes me as a hugely complicating factor
15 because you have to then, if you're worried about regional
16 differences in per beneficiary aggregate spending, you have
17 to ask yourself, are people being woefully underserved in
18 Minneapolis or horrendously overserved in Miami or are there
19 real variations in the underlying population?

20 And until you answer that question, you can't go
21 to the next step in using this kind of information.

22 MR. BERTKO: Bob, some of that actually is known

1 through the CMS-HCC risk adjuster. And in Miami, for
2 example, because I pay close attention to it, about a third
3 of the variation is explained by I'll call it disease-
4 specific risk adjustment. And the rest of is -- I won't use
5 the word horrendous --

6 DR. REISCHAUER: But the risk adjuster, unless I'm
7 wrong, comes out of your utilization of resources in the
8 previous year. So it's sort of like a self-fulfilling
9 prophecy.

10 MR. BERTKO: No. That's partly true, but mostly
11 you only get one flag per unit of service. And if you have
12 10 units of service, you don't get 10 flags, that is 10
13 points. You get one point.

14 DR. MILLER: One other point on this. I think you
15 could begin to look at some of the disaggregation that Niall
16 was doing here, and start to ask the question of -- you
17 began to see where the differences were accruing. And a lot
18 of this, in this instance, was the diagnostic work which
19 begins to raise questions about okay -- I mean, I think that
20 begins to start to segue into some of the other work that
21 Wennberg has done is these services tend to be more
22 discretionary.

1 I'm not saying that it answers your questions, but
2 it really gives you much more directed focus of what you're
3 looking at. I think you could begin to disaggregate some of
4 this and point more precisely to why is it that there's so
5 much more diagnosis that's going on here, as opposed to
6 treatment in this particular example?

7 DR. REISCHAUER: But if I were interested in the
8 explanation for the differences between aggregate
9 beneficiary spending in Miami versus Minneapolis, how much
10 of it is going to be due to that sort of thing versus the
11 fraction of individuals who are diagnosed with a certain
12 condition? I don't know.

13 From just looking at the numbers, my guess is it's
14 going to be 60 percent from the difference in the percentage
15 of individuals who have CAD and --

16 MR. BERTKO: It's the other way around.

17 DR. REISCHAUER: Well, 40 percent is still a big
18 number.

19 MR. BRENNAN: Can I just clarify a little the 23
20 versus 9 percent? I may have been a little imprecise in my
21 language. It's not a true prevalence from a pool of all
22 Medicare eligibles. The pool was anybody who had a claim.

1 There's still obviously a difference there, and Miami was
2 higher.

3 DR. REISCHAUER: I'll bet you lunch that the
4 fraction of people in Miami who have one claim is higher
5 than it is in Minneapolis.

6 MR. BRENNAN: It is. We don't have to bet that.
7 I just wanted to clarify.

8 DR. MILLER: Don't bet him, because we're paying
9 for his lunch.

10 [Laughter.]

11 MS. BURKE: I really want to continue in the vein
12 that Bob was going in. If Bob had looked on this side of
13 the table, he would have seen affirmation of his comments in
14 this context.

15 DR. REISCHAUER: I did.

16 MS. BURKE: Thank you.

17 But I, too, am confused and am not certain that I
18 fully understand what it is we now know.

19 DR. REISCHAUER: Less than we thought before.

20 MS. BURKE: And how this informs us, to Bob's
21 point, is what do we now know? And how might we apply this
22 as a routine matter, in terms of a method going forward?

1 But I, for example, was particularly struck with
2 the number of physicians, for example, that were seen by the
3 patients in Miami as compared to the number of physicians
4 that were seen in Minneapolis, where there was a far greater
5 rate of referral in Miami. So the presumption is they're
6 less efficient. So I'm trying to understand what we know
7 and why we know that from that referral pattern, that the
8 presumption is they are less efficient because they see more
9 people.

10 And also by the rates of hospitalization in
11 Minneapolis, which were far greater, and whether we assume
12 that is because the patient is more acutely ill and
13 therefore they would use more hospital services as a routine
14 matter because they are seen later because they are these
15 stalwart Norwegians who only wait until they are in acute
16 distress.

17 I'm trying to understand, what are the message? I
18 know we've got wonderful information now and I'm trying to
19 understand how to understand the data and what the data
20 tells us. What do we presume to be inefficient in this
21 case? We're looking at both a per episode, but we're also
22 looking at per capita. And we get different messages,

1 depending on what that combination is.

2 In the course of this, Niall, what you've said is
3 perhaps we look at some combination of those two things.
4 But I'm trying to understand how going forward we get to the
5 point of understanding what is efficient and what isn't?
6 How one determines that? There's a presumption here, for
7 example, about the number of referrals that we might or
8 might not use.

9 And I'm trying to understand, how do we know what
10 is, in fact, the appropriate -- is four better than seven?
11 Or is seven better than four?

12 So I'm trying to understand how using this it
13 really informs us going forward in terms of its application
14 in a broad range of cases? How much information do we need
15 to gather to be able to apply this and adjust appropriately?
16 At what point is it a risk adjuster? At what point do we
17 have some certainty that the tools are, in fact -- I mean, I
18 felt better knowing that, in fact, the episode, the
19 gathering of information around an episode, seems to be
20 relatively good. Beyond that, I'm not sure what I know with
21 any certainty and how I interpret it without presuming to
22 have interpreted something that may not be right.

1 DR. MILLER: Just to take a crack at this, and
2 other people can offer their opinions.

3 I think what we're doing here in this exercise is
4 really two things. And I think you've summarized this well
5 in the sense that you're getting different signals,
6 depending on which measures you look at. And in some ways
7 that just drives you to saying we've got to think of these
8 things together. And I think, to Niall's point earlier,
9 there's a question of within what universe do you want to
10 start looking at this?

11 But I think in the end, at a very conceptual
12 level, we're only doing two things here. One is the
13 standard will always be a standard that's relative to some
14 metric. You will always be within -- I don't know whether
15 Miami, or whether it's the country in this particular
16 instance. You would say why four, why seven? And look at
17 the people who are out at the tails and say I'm going to
18 focus my efforts there to find out why so much more imaging
19 or so many more visits or so many more physicians.

20 So there will never be a standard that says seven
21 is correct and four is incorrect. It will be why is
22 somebody way outside of the range?

1 MS. BURKE: To your point, which I think is
2 exactly, right, is that the measure we even look at? Do we
3 care what the referral pattern is? If we're looking at the
4 per cost episode, or are we looking at the per capita?
5 Because in the case of the episode, irrespective of the
6 number of referrals, they were less expensive. But in the
7 case of the per capita, they were more.

8 So the question is do I care how many referrals
9 there are?

10 MR. BERTKO: Yes.

11 MS. BURKE: Yes, if you're looking at per capita.
12 If you're looking at per episode, it didn't matter.

13 MR. BERTKO: No, it does.

14 MS. BURKE: But it didn't, in terms of the cost.

15 My only point is how do I know which of these
16 indicators it the right one to care about, to your point?
17 It is a question of what you mix and match, and it is a
18 question of where the outliers are. And the question is
19 which outliers do I care about? Do I care about the
20 outliers that relate to referrals? Do I care about the
21 outliers that relate to per episode costs? Do I care about
22 the outliers that relate to per capita? At what point do I

1 decide for a payment purpose how many of these outliers I
2 care about and which of these I track? Or do I care about
3 all of them? And then you sort of combine them all together
4 and figure out where it matters?

5 That's really what I'm trying to understand. I'm
6 presuming I do care about the referral pattern, but to what
7 end? Because it costs more? Because I think it's
8 inefficient? Because I don't like who they're referring?
9 Because I don't think cardiologists ought to be dealing with
10 -- I mean, which of those do I care about? And why do I
11 care about them?

12 MR. BERTKO: I've got to jump in here. Niall and
13 his crew are about halfway through the book. Sheila, you
14 asked a good question. But until you get to the part which
15 is next month's, you don't know what the answer is.

16 The beauty of episodes, in general, is that they
17 collect everything together. And when you do it then you
18 have a couple of different things.

19 Think of the way a physician practices as a bell-
20 shaped curve that looks a little odd. And so you've got
21 several things that go on. The first thing to do, and this
22 is kind of Niall's comparison, is you're looking where the

1 means are. And the means do move around but that's not
2 necessarily the important part. It's the distribution of
3 the tail, particularly the right side of the tail.

4 Our evidence shows that in some places, and South
5 Florida is one of them, the potential for improved
6 efficiency, that is reducing inappropriate outcomes, is
7 really high, well above 10 percent and maybe as much as 20
8 percent.

9 I don't have Minnesota, we don't have a market
10 there. But in Wisconsin, the potential is really low. And
11 the grouping, the density around the mean, is quite tight.
12 So the Garrison Keillor kind of things about the doctors
13 behave well in Wisconsin and probably Minneapolis is right.
14 They all behave about the same way and so there's not much
15 tail to be fixed there.

16 But the episodes in general, when you look at it
17 using that kind of a viewpoint, tell you something
18 immediately. And then it's up to people like Jay and Ron
19 and Arnie, who are docs, to say okay, what's the cutoff
20 there? What is inappropriate care.

21 MS. BURKE: But let me, if I could, just follow
22 that up. And I'm more than happy to wait for chapter two to

1 be told the answer. But if I understand your logic, if I
2 could follow it for a moment, if the episode matters --
3 which I would agree it does matter -- then arguably they're
4 doing better in Miami, based on this information.

5 MR. BERTKO: Yes, and I didn't mean to say that.
6 It's actually the practice of the specialty, which includes
7 numerous kinds of episodes, all severity adjusted, for the
8 people who take care -- the ones who take care of very, very
9 sick patients get a divisor that reduces their score. The
10 ones who take care of only the easiest patients have a
11 divisor which increases their score. And then it's compared
12 across a market basket.

13 You can ask Ron. A given specialist, you probably
14 do 10 or 15 procedures which are the bulk of your practice.
15 Once you grab those for a urologist, I think you could say
16 that you know what the urologist is doing. And each of the
17 specialties has that kind of a package, whether it's a
18 market basket or otherwise.

19 MS. BURKE: Again, just to take it one step
20 further, and I don't want to prolong this, if we're going to
21 have this further conversation, we'll come back to it. But I
22 just want to understand the logic.

1 In that case, it is the episode by physician
2 within the episode, not the episode.

3 MR. BERTKO: No, it's the physician practice in a
4 grouping of episodes.

5 MS. BURKE: But again, to that point, in Miami
6 this information suggests to me that Miami is doing a more
7 efficient job than Minneapolis.

8 MR. BERTKO: No.

9 MR. HACKBARTH: We've got a number of people in
10 the queue. I'd like to get to them because we're behind.

11 MR. BRENNAN: Could I just respond to both Sheila
12 and John? You're both correct.

13 MS. BURKE: That's a perfectly perfect answer in
14 every way.

15 MR. BRENNAN: But it's a fairly complicated
16 undertaking we're doing here and we never said that this
17 would be the magic bullet to figure out things. I've always
18 likened this to like kicking the wheels on a car.

19 But we had a potentially confounding result for
20 CAD, which is an individual episode in two MSAs. Our
21 initial instinct was let's find out why that's happened.
22 We've tried to find out why it's happened.

1 John is right. Now we're going to move away from
2 looking at individual episodes and we're going to count all
3 of the episodes a physician has, not just CAD.

4 But I would also caution that when we come back in
5 November, it will probably raise just as many questions as
6 it has raised today. This is an ongoing process and
7 certainly, at least in the Medicare world, I know in the
8 private sector world, people are significantly more
9 comfortable with these tools. But we're still taking baby
10 steps, so to speak.

11 DR. HOLTZ-EAKIN: I'm trying to interpret this
12 dialogue, and I think there are really two very different
13 ways even Medicare could go using these. And you're talking
14 about different exercises.

15 One exercise would be to use these kinds of tools
16 to find the appropriate payment for an episode, all the
17 things that went on in that episode and bundled together,
18 and really hit the gold standard that we aim for.

19 And when that gets raised using this grouper, Bob
20 worries about the kind of people coming in. You worry about
21 whether it's appropriate care and all those issues. That's
22 not ready for prime time.

1 There's a different suggestion this group has made
2 even today that says suppose we inform doctors about the way
3 they look compared to everyone else? There the focus is not
4 episodes but doctors. And if you organized by doctors and
5 just sent this to them and said look, you are the imaging
6 king of Coshocton, Ohio. Did you know that? It might
7 affect behavior in a beneficial way.

8 And so those are two different exercises and they
9 shouldn't be confused.

10 MR. HACKBARTH: And incidentally that was the
11 initial recommendation for how this should be used.

12 DR. MILSTEIN: First, we have to remember that our
13 frame of reference is what we have today when we do nothing
14 to draw attention or incentivize efficient resource use.
15 And so in some ways our competition is even worse than what
16 we're seeing here.

17 Second is if you reflect back on last month's
18 presentation, what we saw was when we used total
19 longitudinal spending for various illnesses, that we had no
20 counterintuitive findings for most categories of illness.
21 There were two categories of illness for which we had
22 counterintuitive findings, and that's what we're drilling

1 into now.

2 So in terms of rendering a judgment about whether
3 episodes might be a useful basis for a variety of potential
4 policy changes, I think what this tells us not that we throw
5 this out. For example, this works great and there were no
6 counterintuitive findings for hip fracture. But we have two
7 chronic illnesses in which there's a lot of coding and
8 diagnostic discretion where we realize we have a problem.

9 And hopefully, in the next session, we will
10 explore a variety of solutions, one of which is what John
11 outlined but I think with more preparation time will be more
12 comprehensible maybe to everybody.

13 Another approach, and I'll defer to Eliot Fisher
14 in his next presentation, might be for these small number of
15 chronic diseases where we're getting counterintuitive
16 results is to think about fashioning an index that not only
17 took into account cost per episode but number of episodes
18 per year within a chronic illness. That's where I'm going
19 to predict someone like Eliot might land.

20 And so I think that we have to have the right
21 frame of reference. Where we're drilling into the two
22 diagnoses among all that we looked at were the only ones

1 that had some counterintuitive findings. And I think we
2 ought to reserve judgment until our next meeting as to
3 whether or not we have some solutions that at least
4 represent progress in judging and rewarding physicians
5 relative to what we have today, which I thin is indefensible
6 and not working.

7 DR. CASTELLANOS: Unlike Bob, I find this very,
8 very fascinating and very, very encouraging. You're
9 discouraged but I'm encouraged.

10 Niall, your group did a great job. This is a
11 tremendous amount of work. This is the first time I saw
12 data on a longitudinal viewpoint.

13 It goes to show two things. You need to look at
14 the data more carefully, not just breeze through it. You've
15 got to look at the data more carefully.

16 But more importantly, as I see it, you need to get
17 the physician involved right away. You need to let the
18 doctor know about these things. And don't be afraid to tell
19 physicians. We've all been very competitive. We compete to
20 get into medical school. We compete to get into residency
21 programs. And when the data is available to utilization
22 review and practice patterns, it's going to make a

1 difference.

2 So I'm excited about this, and I think it may be
3 something that we can identify the outliers and maybe
4 identify why we're having a lot of excess volume.

5 DR. CROSSON: On this one, I'm joining the Bob
6 Reischauer fan club -- you're nervous now -- because when I
7 finished it I had the same degree of skepticism, I think.
8 So I asked myself what was the lesson of this? Is it simply
9 that looking at the cost per episode is a limited but useful
10 tool? Or is it that it's so limited that without the
11 information about how many episodes and what kind of
12 episodes you really can't draw any firm conclusions? And
13 that in order to get to better conclusions you have to have
14 all that information?

15 But then I matched that up with what we initially
16 said was the original idea here, which was we're not going
17 to chop the tail off, which is I think where it has been
18 used successfully commercially. But what we're going to try
19 to do is provide information to physicians to help them
20 understand how they're doing compared with their peers.

21 My concern is if it's this arcane, and I realize
22 we just biopsied the most obviously odd one. But I would

1 imagine that that issue is buried in other diagnosis
2 groupers, and that is that there isn't necessarily a one-to-
3 one relationship between the cost of an individual episode
4 and/or the number of episodes and/or the kind of episodes.

5 And so my concern, and we'll see more later, is
6 that when we end up with this are we going to have something
7 that is understandable and actionable enough to meet the
8 need that we said we were after in the first place?

9 DR. WOLTER: It seems to me at least one of the
10 questions this raises, I think Bob that's what you were
11 trying to say. But in my simple way of thinking about it,
12 utilization is the driver of cost. And is that a big factor
13 in what's going on in these two comparisons? And when John
14 says two-thirds of these things tend to not be related to
15 underlying disease incidence, if I heard you right, then
16 that tells me we have a big issue there that is going to
17 need attention if we're going to tackle these things well.

18 And of course, this isn't a surprise really
19 because all the Wennberg work over the years has shown that
20 the number of back surgeries in Montana per 1,000
21 beneficiaries way exceeds that number in Maine. And there
22 are many other examples in other disease states. The

1 question is why is that?

2 I was worried that this data was the reason that
3 Dave Durenberger didn't make it today, but I would say that
4 again, when I hear John talking about Wisconsin, there's
5 been a lot of work done in Minneapolis amongst the different
6 medical groups around clinical protocols, the ICSI group, et
7 cetera, et cetera. And one of the things I think that's in
8 our future is how do we create some kind of protocols around
9 decisions as to when things are needed? We can't do that
10 for everything in medicine, but we can do it for some
11 things. That's one of the lessons here.

12 Sheila, I don't think the number of
13 hospitalizations is necessarily more in Minneapolis because
14 the number of episodes is so many fewer, that if we looked
15 at hospitalizations per 1,000 beneficiaries we might find
16 that's still equivalent or maybe even lower in Minneapolis.

17 I don't know if you know offhand?

18 MR. BRENNAN: The absolute rate of
19 hospitalizations among people with a CAD episode is higher.
20 If you abstract back to a population-based Medicare
21 eligible, it probably is lower because they're less likely
22 to have a CAD episode.

1 DR. WOLTER: The rate within the episode analysis
2 is obviously higher in Minneapolis, but there are so many
3 fewer episodes.

4 MR. BRENNAN: Right.

5 DR. WOLTER: I think that skews your thinking
6 about this.

7 The other thing that this really strikes me is
8 that, relative to our earlier conversation, although the
9 physician is so much the driver of the decision about
10 whether or not some of these things are done, when you look
11 at the total cost involved, much of that is dependent on
12 other factors that the physician has no control over. And
13 that would be hospital costs or post-acute care costs or
14 imaging costs.

15 That's why ultimately we need to be thinking about
16 bigger units than the physician alone, in terms of
17 accountability. I'm much less optimistic than Arnie that by
18 focusing on the physician alone as the unit of
19 accountability we can make as much progress as if we create
20 some other set of accountable providers.

21 Arnie said an interesting thing, and that is
22 cutting off the tail. That is a strategy. Find the

1 outliers and deal with them. But to really deal with the
2 issues in the Medicare program, we're going to have to find
3 a way to move the middle of the pack of the bell curve
4 forward to best practices. So we sort of have to move
5 beyond that way of thinking about the utility of this
6 information.

7 DR. MILSTEIN: For the record, that was not my
8 description or suggestion.

9 DR. WOLTER: I'm glad to hear that.

10 MR. HACKBARTH: Thank you Niall. We look forward
11 to the next chapter.

12 We'll have a brief public comment period. Just a
13 reminder on the ground rules. Brief means no more than two
14 minutes per person.

15 MS. McILRATH: I liked it better when you talked
16 about hospitals and I didn't have to get up here every
17 month.

18 I'll be brief. I just want to focus on two
19 things. One is to sort of expand on the scenario on what
20 physicians are facing right now. Dr. Castellanos mentioned
21 the 45 percent. That's 45 percent of physicians that, if
22 Congress does not act, are going to be facing on January 1

1 cuts that are greater than 5 percent because there are a
2 number of other things going on. That would be partly
3 budgetary neutrality factor on the five year review. It's
4 partly the imaging adjustments. It's partly that the floor
5 on the work GPCI is going away. There are 5 percent of
6 physicians that are facing cuts in the neighborhood of 16
7 percent, 13 that are facing cuts of greater than 10 percent.

8 So when you think about how you are going to do
9 some of these things, and if you continue to have an SGR,
10 that they are really working against each other. So when
11 you think of is this -- the things you have talked about
12 today, are they in addition to or are they instead of an
13 SGR?

14 Think about all the ways that the SGR is
15 incompatible with all the other things that you want to do.
16 How can you have pay for performance and ask people to
17 investing in IT when they are today being paid at the same
18 rate that they were in 2001? You're not asking that of any
19 other provider group. And then to expect them to come in
20 and make the investments that they need to make if you want
21 them to do this. And then, when they are still facing cuts
22 of nearly 40 percent over the next nine years. And what

1 they might get back if you had a 2 percent bonus. And if
2 they were in the specialty that has the highest Medicare mix
3 is about \$5,000 a year. Then it just doesn't seem feasible
4 to a lot of physicians.

5 Add to that that about a third of them are over
6 55, and that's on average. In some specialties, it's much
7 higher than that. And you can start to think about that
8 there might be a lot of these guys that will simply say I'm
9 out of here.

10 So the other thing about the incompatibility is if
11 what you're trying to do is focus on the chronic conditions
12 and actually hit on just the things where it's going to have
13 more impact with Medicare, when you tie it to the payment
14 and you tie it to an SGR-type system where the only way
15 people can avoid being penalized is to have a measure,
16 that's what drives -- we've developed, in the physician
17 consortium, 170 measures. That's still not going to cover
18 every single physician.

19 So you end up having the way you've tied these two
20 things together driving what measures you develop more than
21 what would actually make a difference.

22 Also, you're going to have an increase on the

1 physician side of the equation because what you're trying to
2 do is get those people in to see the physician more often so
3 that you can keep them out of the hospital. Under the SGR,
4 they will be penalized for doing that.

5 So I just think those are things to think about
6 when you're thinking about the big picture here.

7 MR. HACKBARTH: Okay, we will reconvene at about
8 1:35.

9 [Whereupon, at 12:52 p.m., the meeting was
10 recessed, to reconvene at 1:35 p.m., this same day.]

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1 first, a decline in the proportion of beneficiaries who have
2 employer-sponsored insurance to supplement their Medicare
3 coverage. This ESI coverage is relatively generous so its
4 decline in prevalence could increase beneficiaries' exposure
5 to financial liability and could affect beneficiaries'
6 retirement decisions.

7 There also could be a change in the prevalence of
8 some chronic diseases and conditions. For example, obesity
9 is becoming much more common among Medicare beneficiaries.
10 Obesity is a rather unusual chronic condition because, first
11 of all, like most chronic conditions, it does increase the
12 annual cost of beneficiaries to the Medicare program. But
13 different from most other chronic conditions, it does not
14 reduce longevity amongst the elderly. Therefore, these
15 beneficiaries tend to have very high lifetime cost to the
16 Medicare program.

17 Another change may be in the racial and ethnic mix
18 of Medicare beneficiaries, especially an increase in the
19 number of Hispanic and Latino beneficiaries. One thing I
20 want to emphasize though is that Medicare would be affected
21 only if Hispanics and Latinos are different from the average
22 beneficiary in terms of their use preference and sources of

1 health care.

2 There also may be a change in beneficiaries'
3 income and wealth. One thing that we do know is that
4 adjusting for inflation the elderly have had increasing
5 incomes. But the rate of increase in this real income has
6 been slow, slightly higher than 1 percent per year over the
7 last 10 to 15 years. If supplemental and Part D premiums
8 continue to increase at much higher rates than
9 beneficiaries' real incomes, beneficiaries may have
10 increasing difficulties obtaining coverage to supplement
11 Medicare or to cover their Part B services.

12 There also may be a change in the proportion of
13 beneficiaries who are very old. This proportion is expected
14 to fluctuate in the coming decades. First, it is expected
15 to increase through 2010. Then, as the baby boom generation
16 enters the program, it is expected to decrease through 2030.
17 Then after that it is expected to increase quickly as the
18 baby boom generation ages. And the very old are a very
19 important population because we find that they are about 40
20 percent more expensive than the average beneficiary.

21 Finally, future beneficiaries are likely to have
22 more formal education. More educated beneficiaries may

1 present a lot of interesting issues. One thing is they may
2 take a greater role in their clinic decisions. For example,
3 they may ask more questions of their providers or might
4 research alternative methods of treatment for any particular
5 condition.

6 A changing beneficiary profile can have the
7 following important effects. Number one, it could influence
8 program spending, for example, increases in the prevalence
9 of obesity or the number of very old beneficiaries would
10 increase program spending. Also, it could influence
11 beneficiaries' needs and preferences for health care.
12 Third, it could also influence beneficiary sources of care.
13 For example, a beneficiaries' characteristics could be a
14 strong indicator of whether a beneficiary primarily gets
15 their care from a doctor's office or through the emergency
16 room. And finally, it could influence beneficiaries'
17 financial exposure. In particular, fewer beneficiaries with
18 employer-sponsored insurance may indicate an increase in
19 their exposure to program cost sharing or the cost of non-
20 covered services.

21 Now I'd like to discuss what will be at the heart
22 of our study. The core of the study will be four questions.

1 First, what are the most important changes to the
2 beneficiary profile in the coming decades? And second, why
3 are these changes occurring? Knowing the causes of the
4 changes can help determine whether Medicare can help prevent
5 any undesirable impact of the changes. Third, what might be
6 the impact of these changes on Medicare in terms of overall
7 resource use and types of services that beneficiaries' use?
8 And then finally, what are likely to be the appropriate
9 responses to the changes so that Medicare can better serve
10 and protect beneficiaries?

11 To answer these questions, we have developed the
12 following work plan. We'd like to start by consulting with
13 experts to get their views on which of the changes in the
14 beneficiary profile are the most important? What could be
15 the impact of these changes on the program? And finally,
16 how could Medicare be modified in response to these changes?

17 We'd also like to do a thorough review of the
18 literature to get a complete view of the issues facing the
19 Medicare program and help us be more engaged in our
20 discussions with the experts. We'd also like to analyze
21 databases such as the MCBS or MEPS to give us a better
22 understanding of the current state of the Medicare program

1 and to provide a sense of the potential impacts of any
2 changes in beneficiary characteristics. And then finally,
3 we'd like to do a simulation of the effects of the changes
4 to the beneficiary profile and any modifications to the
5 Medicare program we might want to look at. These results
6 would likely be obtained from a computer-based simulation
7 model. We emphasize, though, that this part of the work
8 plan is likely to be a longer term project with results
9 probably in the 2008 production cycle.

10 Now that concludes my discussion and I'll turn it
11 over to the Commission for their discussion. I'm
12 particularly interested in hearing about any changes in the
13 profile I might have overlooked, and also your overall view
14 of the proposed analysis.

15 MR. BERTKO: Dan, a question on the statement that
16 you have in there about the greater folks with obesity will
17 have the same average lifetime. Is that based on solid
18 data? Is it based on expert opinion?

19 I just checked into something, trying to find body
20 mass index among our seniors and it's very difficult. I was
21 wondering if it's a mortality study or another kind?

22 DR. ZABINSKI: What I'm citing there is a study

1 from RAND. The idea there is that say somebody becomes
2 obese at a young age. They're likely to die younger than
3 your average person. But the point is if they are able to
4 make it to age 65, their expected longevity at that point
5 isn't any different than somebody who's not obese.

6 MR. BERTKO: But is that a true mortality study?
7 Because the difficulty to me would be looking and saying
8 this group of people were obese, versus their actual future
9 livelihood at that point.

10 DR. ZABINSKI: My recollection is that yes, it is
11 a mortality study.

12 MR. BERTKO: Can you send that to me?

13 DR. ZABINSKI: Sure.

14 MR. BERTKO: It sounds contradictory.

15 DR. ZABINSKI: That's one of those things, I had
16 to read the sentence twice to believe what I was reading.

17 MS. HANSEN: I'm really glad that we are doing
18 this study on out and I know that it's pretty difficult to
19 get one's arms around it.

20 In responding to a few of the bullet comments
21 here, one is the difference of chronic conditions. But
22 also, with the whole aspect of race and ethnicity. I wonder

1 if, in addition to the Latino/Hispanic population, we could
2 probably look at work from the Office of Minority Health
3 relative to health conditions, prevalence of different
4 conditions in different racial groups, as to what that also
5 will do.

6 Back to the one on chronic conditions, I just
7 wonder if there's any way to -- whether maybe this will come
8 out in the simulation in the future, but looking at diabetes
9 as an example, and maybe obesity and other cardiac diseases
10 with the impact on the ESRD program, in particular, as that
11 changes over time.

12 And then the whole area of income, wealth and
13 distribution. I wonder along the way here, as health care
14 becomes more expensive for beneficiaries, whether or not
15 there will be proportionally more people who will fall in
16 the dual eligible category over time, just because of the
17 sheer cost of care?

18 And the amount of savings that baby boomers have.
19 I think one study, ERI, said I believe, that about 50
20 percent of boomers have only about \$25,000 net saved beyond
21 their mortgage of their house.

22 And then finally, the proportion of old-old will

1 fluctuate. And once we do have a large group, the fact that
2 some of the medical costs start to spill over into social
3 costs, and whether or not the whole aspect of social care
4 can be looked at here. Let me give you an example of old-
5 old in California has really used this whole method of
6 paying for caregivers to keep people in the home instead of
7 going into nursing homes. And that actually is a movement
8 afoot where the concept of money follows the person. Some
9 of the findings are that people are more stabilized and
10 don't end up having to go into acute hospital care as a
11 result of that.

12 So there are some confounding kinds of things, but
13 it is about what impact it will have on Medicare cost in the
14 future.

15 MS. BURKE: Dan, like Jennie, I think this is a
16 terrific opportunity for us to sort of look ahead and think
17 about some of the implications of changes in the population
18 and what that means for the program.

19 Two, I want to go back to the point I began to
20 raise in the earlier discussion about income. Jennie sort
21 of mentioned this, but the whole question of disposable
22 income, the question of what the capacity will be of these

1 individuals to finance care, what we might imagine the
2 breakdown of the nuclear family, the fact that historically
3 -- and I suspect this will be true going forward -- that
4 there is a far greater preponderance of single women rather
5 than men in the population, and what that means in terms the
6 nature of the services that they need and their locations.
7 Certainly, race as well as gender make a big difference.

8 You've noted, in particular, the Hispanic
9 beneficiaries. One of the sort of unique things that I know
10 we've seen, for example, is they tend not to use hospice
11 services. They use a greater preponderance of nursing home
12 services. And what does that mean about the structure of
13 the benefits and how one might anticipate that? And the
14 service and where they are located and how we might service
15 this population. What does it mean about the need for
16 language-related kinds of materials, whether that becomes
17 even more dominant in the out-years, I think are things that
18 we clearly need to consider and look at.

19 I wonder what the relationship between the change
20 in the race of the population and the level of education
21 issues, as well. Those seem a little at odds, but perhaps
22 not. But I think that that is something that we want to

1 take a look at as we go forward.

2 But the income issue, in particular, that again I
3 want to make sure that we pay close attention to is one that
4 continues to confound us and how you incentivize people's
5 behavior and what it is that they respond to. I don't think
6 we should assume necessarily that the easy answer is that
7 you create a catastrophic environment and do away with first
8 dollar coverage. I don't think it's as simple as that with
9 this population. I think that is something that we need to
10 look at very carefully. We began to see some changes in the
11 creation of Part D. But again, I think that structuring the
12 benefit, whether it's around the home care benefit, whether
13 it's around the things that we have traditionally not
14 required copays on, getting rid of the hospital copay
15 because it's less discretionary. Again, I think they are
16 not simple questions, nor will they be simple answers.

17 So I think an understanding of that will be
18 important to us going forward. I think you've raised some
19 terrific questions. I think it will be a good process to
20 follow.

21 DR. REISCHAUER: Dan, I think we're headed down a
22 very interesting track here. There are two very different

1 perspectives or approaches one can take. Or we could do
2 both.

3 One is what I think a lot of this is, which is
4 take Medicare as a constant program and look at the change
5 that is likely to occur in a demography, economic, social
6 attributes of the participants in the program. Where will
7 this constant program not fit? Will its cost go up or down
8 because of all of these changes? That's all very
9 interesting.

10 Another way to look at it is to say let's look at
11 these dramatic changes that are going to take place in the
12 population. What kind of opportunities does it open up for
13 changing Medicare into a different kind of program?

14 One of the things that I thought of immediately,
15 reading this was 30 years from now virtually everybody is
16 going to be computer savvy in ways that they aren't now,
17 which means that information can go directly from CMS to
18 things you can put, probably stuff like the Dartmouth
19 prostate cancer, a little movie and interactive thing, on
20 the Net. And so you could access this stuff from home.

21 People will be comfortable with different kinds of
22 delivery systems because they've spent their whole life in

1 network systems or systems that are managing their care and
2 we'll have an elderly population with much larger
3 disparities in distribution of income, which will allow for
4 different kinds of income-related premium charges and all of
5 that.

6 And so to look at it from both angles in a sense,
7 both as an opportunity and as a need to respond I think
8 would be valuable.

9 DR. HOLTZ-EAKIN: Bob has made the major points
10 that I was going to make. When I first read this, and the
11 question that was dictated says should we continue to work
12 on this issue? I wrote no.

13 Because if you take the first few, fixed program,
14 I think there is not a comparative advantage in this group
15 to doing that work.

16 I'm sure you're familiar with the Congressional
17 Budget Office. I don't know if you've talked to them about
18 the long-term simulation model they've got. But it is
19 exactly the first exercise that Bob described. It takes a
20 representative cross-section of the U.S. population at a
21 point in time. It statistically replicates its marriage,
22 fertility, divorce, morbidity, mortality, immigration

1 patterns. It matches the cross-sectional distribution of
2 income, the longitudinal distribution of income. And so
3 there are people out there, outside of this group, who can
4 characterize how this existing Medicare program will age
5 along with the population and how much it will cost and
6 things like that.

7 I don't see a great advantage to us replicating
8 that. Certainly, consulting them becomes an issue.

9 It's also true that you run into a real problem
10 with the small cell sizes there, when you start trying to
11 identify people who are of a particular racial background,
12 at a certain age, with education, income, wealth. So I
13 don't think there's big returns there.

14 On the other hand, if we built a flexible,
15 patient-centered, efficient Medicare program that produced
16 appropriate care, the whole point would be you'd do that
17 regardless of who walked in the door. And the people who
18 walk in the door will be different in the future than in the
19 past. And I think the focus should be on the program. I
20 think Bob has made that point very well. I'd go that
21 direction.

22 MS. BEHROOZI: I wonder if those comments go more

1 toward where the data could be gleaned from. Among the
2 recommendations is to review the literature. But I think it
3 is important to maintain a focus here at MedPAC that's
4 specific to the work that we do and the questions that we
5 have to answer, because there are so many assumptions that
6 we either share or that we don't hold in common, but they're
7 assumptions.

8 Like the obesity/mortality issue. That's really
9 important for us to have the data on. So good if it can
10 come from someplace else, rather than having to reinvent the
11 wheel.

12 And I do think that there are some areas that are
13 particularly important, given the kinds of questions we're
14 asked to answer, as Sheila referred back to the earlier
15 discussion when we were talking about benefit design change.
16 I think it matters a lot whether -- well, it's important to
17 look at income distribution.

18 I think it's quite irrelevant that overall, on
19 average, Medicare beneficiaries' incomes may stay a little
20 ahead of inflation, because that doesn't give you a picture
21 of a Medicare beneficiary. That's most likely -- and again,
22 this is an assumption -- most likely driven by very few

1 people at the top. Because we know, for the most part,
2 people are on fixed incomes.

3 But I really also think that, for our purposes, a
4 couple of other factors that are specific to retirement --
5 not just general demographic characteristics, but employer-
6 based coverage and the decline of defined benefit pension
7 plans and retirement income security in general, hasn't hit
8 yet. You're not going to see it in the data now. It's not
9 going to be in these -- I wouldn't think it would be in
10 these longitudinal studies based on current -- what people
11 are earning currently or what kinds of plans they have now,
12 but rather projecting forward in a workforce whose
13 expectations of what they can rely on in retirement are
14 changing. I think we need to stay ahead of that curve, or
15 at least keep up with that curve. Because that's huge and
16 that's been fairly recent that those changes have been
17 really taking on some momentum.

18 DR. SCANLON: One thought about a dimension to
19 include and then a caution. The dimension to include is to
20 think about not how much Medicaid will absorb some of the
21 effects of the changing demographics, but to think about how
22 Medicaid changes may impact on those people. Because

1 Medicaid is a very different kind of entitlement program.
2 It's not nearly as fixed as Medicare. The states make
3 dramatic changes both gradually and sometimes very quickly.

4 Over the past 25 years the number of people in
5 nursing homes has declined as a share of the population by
6 about 30-some percent. I think we probably don't appreciate
7 that but it's largely a Medicaid phenomenon. States have
8 said we're not going to have any more beds periods and have
9 had moratoriums in a number of states.

10 At the same time, there are almost 1 million
11 people getting home care, which was not true 25 years ago.
12 So these are pretty big changes that may have some impact on
13 Medicare. For a while, when Medicare home health was almost
14 a long-term care program, we had states that had laws that
15 said we're going to maximize Medicare. That option is not
16 available anymore, but I think we need to think about it
17 just as much as we're talking about how changes in employer-
18 based insurance is going to impact upon Medicare in the
19 future.

20 The caution would be about modeling, and it's in
21 the context of what I've been talking about here in terms of
22 some dramatic changes. I'm not familiar with the details of

1 the CBO model, but some of the longer term projection
2 models, in some respects, start with a cross-sectional
3 static point and say if we take things like demography and
4 we trend them forward, what's going to happen?

5 We have to also, I think, be very sensitive to
6 the fact that we can have huge changes to the world, like
7 we're not going to have another million nursing home beds,
8 the way that projection would imply. Some of these things
9 are going to be influenced strongly by some other decisions
10 that are going to change the world that we operate in. And
11 how good are our estimates, given that that may be
12 occurring?

13 That would be another part of thinking about this
14 and maybe that fits well with Bob's suggestion of don't
15 think about Medicare as a static program, but think about as
16 what it could in the future.

17 DR. KANE: I'm going to try to briefly reiterate
18 some of the things that came to my mind that some people
19 have already touched on.

20 One is that I think that the under-65 population,
21 the employed population has, for a very long time, been in
22 managed care networks and HMOs and more strictly restricted

1 networks. We're pretty much, as a generation, much more
2 willing than my parents' generation to accept restriction.
3 I'm probably going to just keep on going with my HMO if they
4 don't turn into a private fee-for-service plan.

5 So I think that opens a great opportunity up for
6 encouraging that and trying to find ways to make sure that
7 managed care stays a part of it, and not just a network of
8 discounted fees.

9 Another thing, and it touches on some of the
10 things that people were saying, but I'm on a board of a
11 group of doctors who deal with chronic frail elders now.
12 They're no longer in nursing homes. Actually, that's a good
13 thing. Where they are now is in congregate housing and
14 assisted living facilities.

15 We have a special program that we fund through
16 foundations and gifts called House Calls, and nurse
17 practitioners, as well as physicians, provide the care.
18 Through that, we're able to avoid all kinds of
19 hospitalizations and unfortunate accidents.

20 I think that whole where are elderly going to be
21 living in the future and what does that mean for the types
22 of services they're going to be needing and the type of

1 payment environments you're going to have be creating is
2 another one.

3 The third thing that came to mind as we were
4 talking is the possibility of a little bit more global
5 influence on our health care. We were talking a little bit
6 about people going to Mexico and India and Thailand, but
7 also the whole where is the manpower going to come from?
8 Because a lot of our physicians workforce and our nurse
9 workforce comes from overseas. And how might that all
10 change in the next 15 or 20 years as well?

11 So it's not just looking at the population, but
12 some of the housing structure, labor structure that's likely
13 to be coming about, as well.

14 DR. CASTELLANOS: I did appreciate this and I know
15 that you mentioned that Hispanic is the largest percentage
16 of ethnic minorities now. Being very sensitive, because I
17 am a Hispanic-American, the Hispanic-Americans definitely
18 have different risks. They have different rates of cancer.
19 And if you're going to look at that as an ethnic group,
20 you're going to have to think of different strategies for
21 control and prevention strategies. They have a higher
22 incidence of obesity. Interestingly, they have less

1 incidence of adult smoking. The cancers are diagnosed a lot
2 less or at a much later stage and their prognosis on
3 treatment is not as well.

4 But the cancers that are very common in the
5 Spanish American or the Hispanic American are stomach,
6 liver, cervix, gall bladder, lymphomas and leukemias.

7 DR. MILSTEIN: This is, I think, really a further
8 amplification on Bob's idea.

9 One of the things that I've been doing outside of
10 Medicare is beginning to use consumer surveys to test with
11 consumers their openness to various innovations, either with
12 respect to health benefits plans innovations or health care
13 delivery innovations.

14 It occurs to me that one way of further applying
15 Bob's suggestion would be to think about taking some or all
16 of the options that we've put together on our sustainability
17 of Medicare program list and think about how to translate
18 each of those into something that a civilian could easily
19 understand -- and I think it would be doable -- and then
20 take whatever survey activity we're planning to implement,
21 and think about laying out those options for Medicare's
22 long-term sustainability, both to current Medicare

1 beneficiaries and to, I guess Medicare's farm team, the
2 pipeline of Medicare beneficiaries, so that you have a sense
3 of where the big deltas are with respect to the potential
4 greater acceptability of some of these options with the
5 incoming class than with the current class.

6 DR. CROSSON: The assumption underlying this is
7 that over this period of time the eligibility for the
8 Medicare program is not going to change.

9 DR. REISCHAUER: On the second part of my
10 perspective, that would be open. People are getting
11 healthier, there's more ability to work longer. That
12 creates an opportunity. That's why I was saying look at the
13 population and ask what kind of opportunities it opens up
14 for the future.

15 DR. CROSSON: So the eligibility, you could argue,
16 might end up at some point going in either direction. We
17 could end up with a Medicare program that was predominantly
18 for older individuals. More recently, I think, some have
19 suggested, as a path to universal coverage, applying the
20 Medicare program to a younger cohort of individuals. So is
21 that in scope or out of scope?

22 DR. REISCHAUER: It strikes me that that's out of

1 scope because it's addressing a different problem, which is
2 the uninsured.

3 DR. KANE: But if the age of eligibility goes up,
4 you're walking right into it. I mean, 68-year-olds -- right
5 now 55-to-64 year olds are among the most vulnerable. Now
6 you're going to make it 55-to-70 year olds? You can't
7 ignore the employment trend and the employer-based insurance
8 meltdown if you're thinking about age of eligibility.

9 DR. MILLER: In a way, I conceive of this work,
10 and particularly at this stage of this work, as I don't know
11 what is in and out of scope. I think part of the exercise
12 here was let's understand what these trends are and what
13 kind of directions they would begin to start to push, where
14 you'd see the tension points, whether it's eligibility or a
15 specific kind of services or income or whatever the case may
16 be that might say well, should we do something about this?
17 And then I think you address the in or out of scope
18 question. There may be disagreement at that point.

19 We see this really as just trying to cast ahead
20 and starting to see where the tension points that will fall
21 out of the data.

22 MR. HACKBARTH: Okay, thank you very much, Dan.

1 Next up is the congressionally mandated rural
2 hospital report.

3 DR. STENSLAND: I think as you can remember from
4 last time, Congress has mandated that we conduct a study of
5 certain rural provisions of the MMA. Our report is due this
6 December.

7 Today we're going to start out by answering some
8 questions you raised at the last meeting. Then we'll
9 discuss economies of scale problems at small rural hospitals
10 and explain why a low-volume adjustment is a more targeted
11 solution than current policy. Then we'll discuss the two
12 draft recommendations we brought up last time and hope to
13 hear some feedback from you regarding those recommendations.

14 Last time one commissioner asked us a question
15 regarding the distribution of total profit margins at CAHs
16 and a second commissioner asked us about the percentage of
17 CAHs that are for-profit. With respect to profit margins,
18 the mean total profit margin for CAHs was 1 percent, the
19 mean for PPS hospitals was 3 percent. And as you can see
20 from this slide there's a wide distribution of profit
21 margins at CAHs. On average, the distribution for CAHs is
22 slightly lower than the distribution for PPS hospitals.

1 With respect to for-profit status, about 4 percent
2 of CAHs are for-profit hospitals. These for-profit CAHs
3 have roughly the same distribution of total profit margin as
4 non-profit CAHs.

5 As you know, Medicare margins are set at 1 percent
6 for both for-profit and non-profit CAHs. What you see here
7 are the total profit margins.

8 We will now shift from CAHs to PPS hospitals so
9 Dan can discuss the low volume proposal for PPS hospitals.

10 DR. ZABINSKI: Last month we discussed two
11 provisions from the MMA that augment outpatient PPS payments
12 for rural hospitals. One of these is that MMA required CMS
13 to do an analysis that resulted in rural sole community
14 hospitals receiving a 7.1 percent add on to their standard
15 outpatient PPS payments. In addition, the AMA, together
16 with the Deficit Reduction Act extended what are called hold
17 harmless payments for several years. The idea of the hold
18 harmless payments is that hospitals that qualified received
19 the greater of their payments from the outpatient PPS or the
20 cost-based system that preceded it. The hold harmless
21 payments are intended to be transitional and are scheduled
22 to sunset at the end of 2008.

1 Because they are scheduled to sunset, we are
2 looking to alternatives to the hold harmless payments as
3 well as to the add on for the rural SCHs. Our motivation
4 for considering alternatives to the two current policies is
5 that neither policy efficiently targets hospitals that are
6 in need or are important to beneficiaries' access to care.
7 In addition, both policies tie higher payments to higher
8 hospital costs without asking why hospital costs are high in
9 the first place. In particular, the hold harmless policy,
10 by its design, can produce higher payments for a hospital if
11 a hospital simply lets its costs drift higher.

12 However, we're also very aware about rural
13 hospitals having, on average, relatively poor financial
14 performance without any supplements to its standard
15 outpatient PPS payments. Therefore, we set out to develop a
16 method of augmenting the outpatient PPS payments that would
17 better target hospitals that are in need or important to
18 beneficiaries' access to care.

19 We started by analyzing data on hospital's
20 outpatient costs and outpatient service volume and we found
21 that hospitals exhibit economies of scale in their
22 outpatient departments. In particular, outpatient costs per

1 service tend to decline as outpatient service volume
2 increases. Also, we have a regression model that predicts
3 that costs per service steadily declines as outpatient
4 volume rises and falls below the mean at about 100,000
5 outpatient services. Therefore, for our discussion, we'll
6 define a low volume hospital as one that has fewer than
7 100,000 outpatient services.

8 We also found that rural hospitals tend to have
9 lower service volumes than their urban counterparts, and we
10 believe this low volume among the rural hospitals
11 contributes to their relatively poor performance in the
12 outpatient PPS.

13 The purpose of this slide is to show that the SCH
14 add on policy does not efficiently target low volume
15 hospitals. Specifically, 25 percent of the hospitals that
16 receive the SCH add on provide more than 100,000 outpatient
17 services, which is our cutoff for defining a low volume
18 hospital. Because of the empirical finding we have
19 discussed on the last two slides, when the hold harmless
20 payments sunset at the end of 2008, we are considering an
21 approach that would give low volume hospitals a percentage
22 increase over their standard outpatient PPS payments instead

1 of the hold harmless payments in the SCH add on.

2 A low-volume adjustment would be more efficient
3 than a hold harmless payment or a SCH add on because it can
4 more efficiently target hospitals that are important to
5 beneficiaries' access to care. Also, it can directly target
6 a factor that affects hospital financial performance and is
7 typically beyond the control of an isolated hospital, that
8 being whether the hospital is low volume or high volume.

9 On the next three slides, we show the effects of
10 moving from the current policies to a proposed low-volume
11 adjustment. Under current policies, the SCH add on is a
12 budget neutral policy that transfers about \$90 million
13 primarily from urban hospitals to rural hospitals. But this
14 policy does not increase overall spending in the outpatient
15 PPS. In addition, there's the hold harmless payments that
16 add \$70 million to the outpatient PPS payments for small
17 rural hospitals. But these payments go down to zero when
18 this policy sunsets at the end of 2008.

19 Our proposal is to replace the current policies
20 with a low-volume adjustment beginning January 2009, after
21 the sunset of the hold harmless payments. In your briefing
22 materials, there's an example of a low-volume adjustment

1 that has a distance requirement that hospitals must be at
2 least 15 miles from the nearest hospital and uses
3 empirically based adjustment rates that are highest among
4 the lowest volume hospitals and decline as hospital volume
5 increases. We estimate that this policy would add about \$40
6 million to the payments to rural hospitals.

7 We understand though that some may be concerned
8 about the magnitude of the assistance provided by this low-
9 volume adjustment, so we want to be clear that spending
10 under the low-volume adjustment can be increased by changing
11 the policy's parameters such as the distance requirement.

12 I also want to be clear that critical access
13 hospitals would not be affected by a low-volume adjustment
14 and would maintain their current cost-based payments.

15 On this table, I want to draw your attention to
16 the first column of numbers which shows outpatient margins
17 under current law that would exist in 2009. Under this
18 scenario, rural hospitals get the SCH add on but there's no
19 hold harmless payments because those expire at the end of
20 2008, nor would there be any low-volume adjustments.
21 Hospitals that would be eligible for a low-volume
22 adjustment, if it existed, would have an outpatient margin

1 of minus 20.3 percent under current law in 2009. Larger
2 hospitals that would not be eligible for a low-volume
3 adjustment would have an outpatient margin of minus 12.7
4 percent. So this is nearly an 8 percentage point difference
5 between these two groups.

6 Now I'd like to draw your attention to the third
7 column, which shows outpatient margins under our proposed
8 policy, which means hospitals would receive low-volume
9 adjustments but there would be no SCH add on or hold
10 harmless payments.

11 The difference between the two categories in this
12 column is much smaller than what we saw in column one.
13 Hospitals that are eligible for the low-volume adjustment
14 would have an outpatient margin of minus 18 percent and the
15 larger hospitals that are not eligible for a low-volume
16 adjustment would have an outpatient margin of minus 16.1
17 percent. So there's only a 2 percentage point difference
18 between the groups in this column, as opposed to an 8
19 percentage point difference in column one. So the takeaway
20 point is that outpatient margins among rural hospitals would
21 be more even under our proposed low-volume adjustment than
22 under current law.

1 We developed this draft recommendation that
2 beginning January 2009, the Congress should enact a
3 graduated low-volume adjustment to the rates used in the
4 outpatient PPS. This adjustment should apply only to
5 hospitals with fewer than 100,000 outpatient services and
6 that are more than 15 road miles from another hospital
7 offering outpatient services.

8 The spending implications would be modest in that
9 it would add less than \$50 million to total budgetary
10 spending. And the implication for beneficiaries is that it
11 would help assure their access to care.

12 Now I turn it over to Jeff again and he's going to
13 continue the presentation on critical access hospitals.

14 DR. STENSLAND: As you remember, we also had a
15 draft recommendation to provide CAHs with more flexibility
16 to merge. The draft recommendation now read the Secretary
17 shall allow CAHs to merge and retain their CAH status if one
18 or both of the two closes and the new CAH serves both
19 communities. The new CAH should be allowed to staff enough
20 beds to meet the combined 2006 peak acute census of the two
21 closed hospitals. The new CAH cannot be significantly
22 closer to any PPS hospital than the closest CAH.

1 As I stated last time, we should not expect to see
2 a large number of mergers. Many small town residents often
3 want their hospital in their town. But in some agricultural
4 areas, farms continue to consolidate and populations
5 continue to decline. We may want to give those communities
6 that are changing the option of changing their structure of
7 the local health care delivery system, especially if a new
8 structure is seen as a more efficient way to provide their
9 communities with high quality health care.

10 You'll note that this recommendation is a little
11 different from last time. It's been refined to make it
12 clear that the merged CAHs cannot be significantly closer to
13 any PPS hospitals than the closest CAH. We're trying to do
14 that to not allow the new CAH to have a significant
15 competitive advantage over any local competitors.

16 We've talked to several rural stakeholders about
17 our recommendations. With respect to the first
18 recommendation, some rural advocates would like to see the
19 current hold harmless payments extended, rather than have a
20 low volume adjustment. Hold harmless payments are provided
21 to all high cost providers, resulting in larger transfer of
22 dollars to rural communities. Our alternative targets

1 hospitals that have high cost due to having a low volume of
2 outpatient services.

3 With respect to implementing a low-volume
4 adjustment, many rural stakeholders are sympathetic to the
5 idea but they have concerns about how CMS would implement a
6 low-volume adjustment. They point to the case of the
7 inpatient low-volume adjustment where CMS implemented a much
8 more conservative adjustment than MedPAC had recommended.

9 In response to this concern, the draft
10 recommendation now specifically states that the adjustment
11 would go to all rural hospitals with fewer than 100,000
12 outpatient visits, trying to clarify where the cutoff would
13 be.

14 With respect to the draft recommendation on CAHs,
15 I think most rural stakeholders agreed with the concept, in
16 that we don't want to discourage integration of rural
17 facilities, but they felt very few communities would be
18 willing to close their hospital and merge with a neighbor.
19 So I thought we should maybe discuss briefly how many
20 hospitals may be affected by this recommendation.

21 Back in 2005, when we look at the distance between
22 providers, we noticed there was about 200 CAHs that were

1 within 20 miles of another CAH. So you have roughly 100
2 pairs, or used to have roughly 100 pairs that you consider
3 could be candidates for mergers. There's been some growth
4 in the CAH program since then, so we should have more than
5 100 candidates.

6 Of course, when they discuss merger, there's going
7 to be conflicting sides. On the one side, there will be the
8 benefits of economies of scale. On the other side there
9 will be concerns about travel time and the local political
10 desire just to have our own hospital in our own town. These
11 two things will be fighting it out. But I think it's
12 important to note that this is not a static kind of a fight.

13 And that the benefits of economies of scale may
14 change over time. For example, as the population changes,
15 it may be more important to merge. Even over the last five
16 years, talking to rural hospital administrators, they seem
17 to be more concerned about having a pharmacist onsite. They
18 maybe want a pharmacist at the hospital to check for
19 interactions, to check if the dosing is right. Not all CAHs
20 have a full-time pharmacist. By merging they may be able to
21 have more pharmacy coverage.

22 Technology costs may change. There may be P4P

1 reporting requirements. The difficulty of recruiting
2 physicians to practice in a three or four person group
3 rather than a six or eight person group may change over
4 time.

5 So the idea is that despite the benefits of
6 economies of scale and the local political desire to have
7 our own hospital in our own town, the dynamics of that fight
8 may change over time and this recommendation would provide
9 the communities a little more flexibility to make a change
10 in their decision over time with respect to whether they
11 want to merge.

12 There is one possible answer, rather than actually
13 taking up this adjustment, would say let's just do some
14 watchful waiting and see how many hospitals come up to us
15 and say we want a change in the law. I think the only
16 concern there would be I think a lot of these small
17 hospitals, when they see the law they say well, that's the
18 law and I'll set my policy and set my strategic plan based
19 on the law. They don't think I'll give Washington a call
20 and change the law.

21 So there might be some concern that hospitals may
22 be building two facilities nearby to each other rather than

1 merge because in a few cases they're afraid of losing their
2 CAH status. I did talk to one of the pairs. We have 100
3 pairs that we think may be candidates for mergers. I talked
4 to one of them. They said they had agreed between the
5 administrators that it would be a good idea to merge, from a
6 clinical standpoint, from a financial standpoint. But the
7 communities basically couldn't agree on whose town gets the
8 hospital. And that's probably going to be the case in 95
9 out of 100 cases. But this would provide those few other
10 cases a little flexibility.

11 We'll now open it up to your comments on the
12 chapter in general and these two recommendations.

13 DR. WOLTER: I guess I worry when I look at the
14 margins under both current law and proposed policy, and I
15 don't know if equalizing margins that are that negative is
16 what I would consider good strategy. So that's one comment.

17 Then I worry that the provision that we would
18 merge two CAHs into bed numbers in one institution larger
19 than 25 really would create the rationale -- particularly
20 when you look at some of these margins on page 11 -- that
21 there are a number of other institutions that are currently
22 on PPS in the bed range of 25 to 50 that might have good

1 arguments that they should also go to cost-based
2 reimbursement. And they might have good arguments for that
3 when you look at these numbers.

4 So I think there's a larger discussion and
5 analysis here about where cost-based reimbursement fits.
6 And we could either open it by allowing two CAHs to merge,
7 and then the discussion will unfold. Or we could face it up
8 front before we make a recommendation like this. So I'm
9 kind of reluctant on that second recommendation, just
10 because I think there's a bigger picture discussion that
11 hasn't occurred.

12 And then on the issue of the low-volume adjuster,
13 I think in concept that makes a lot more sense than ongoing
14 year after year of hold harmless, because at what point does
15 that stop? But would a compromise be that the hold harmless
16 is put in place in a budget neutral way for say two years,
17 so that we can study what's the right way to do the low-
18 volume analysis to make sure that it kind of is distributed
19 in the right way? Because we're taking a fair amount of
20 money out with the proposal as its currently on the table.
21 So that would be one possible adjustment to the
22 recommendation that might move us to low volume but keep

1 things budget neutral for a couple of years to really make
2 sure we got it right.

3 MR. HACKBARTH: When you say study how to do it
4 right, just say more about what you mean.

5 DR. WOLTER: We're talking about going from \$70
6 million -- and it's more than that if you include the sole
7 community hospital piece -- down to \$40 million with the way
8 the low-volume adjuster is currently being proposed.
9 There's a little analysis here of how that might change
10 margins on page 11. But I think there's a desire on the
11 part of those who are in the middle of all of this to
12 understand better how are they going to be positioned to
13 deliver care? And in fact, you mentioned in one of the
14 slides, there could be other ways to set the formulas that
15 could put more or less money in.

16 MR. HACKBARTH: So like the mileage limit and some
17 of the other variables that you could --

18 DR. WOLTER: Even the amount of money that flows
19 through the low-volume adjustment system. I think it might
20 give people some better sense of security if we had a period
21 of time where we weren't taking quite so much money out.

22 That's obviously an off-the-cuff thought.

1 DR. MILLER: You would keep it hold harmless to
2 the money that's currently in, as opposed to hold harmless
3 when it sunsets? That's your point? You said keep it
4 budget neutral for two years.

5 DR. WOLTER: I was thinking of keeping it budget
6 neutral to current law, including the hold harmless.

7 MR. HACKBARTH: So you're saying keep the hold
8 harmless for two more years while we study how to properly
9 do low volume?

10 DR. WOLTER: No, what I was suggesting, go to low-
11 volume adjustment --

12 DR. REISCHAUER: You want to do the \$160 million
13 for the next two years?

14 DR. WOLTER: You could come up with a rationale
15 that would either keep the entire amount in, including the
16 sole community hospital, or you could at least keep the \$70
17 million. But go ahead and implement the low-volume
18 adjustment but adjust it so that all of that money is part
19 of the distribution. That's kind of what I was thinking, as
20 a compromise.

21 MR. HACKBARTH: Increase the conversion factor.

22 DR. WOLTER: Move away the hold harmless but give

1 people some --

2 MR. HACKBARTH: Give people more losing low
3 volume.

4 DR. WOLTER: Yes, some sense that we're -- because
5 we're not talking about large dollars here in the big
6 picture, but that might allow us to fine tune this a little
7 more effectively.

8 DR. SCANLON: This is along the lines of where
9 Nick ended up, because I was concerned that this table, in
10 some respects, is allocating the \$40 million. And that in
11 some ways we'll focus on these numbers and evaluate the
12 wisdom of the low-volume adjustment as opposed to thinking
13 of the wisdom of the low-volume adjustment more generally,
14 and thinking if we funded it at \$70 million or \$80 million,
15 what would be the impact. And there's still the issue of
16 those that are not going to be eligible and how they're
17 going to be affected.

18 But for me, the low-volume adjustment is something
19 where we're doing exactly what you've proposed, which is to
20 target the money by some characteristic of the hospital that
21 they don't control that is influencing their costs, which is
22 one of the basic principles behind the PPS. And I think

1 that's a very positive thing.

2 The other thing I'd like to bring up is the whole
3 issue of -- and this relates to the overall margins, is that
4 the Commission has been, in the past, an advocate of or
5 recommended a low-volume adjustment on the inpatient side.
6 But we're not seeing much of an impact of that because of
7 the way it's been implemented. Congress did accept it, it
8 went into statute, but very few hospitals are being affected
9 and you can see that here in the hospitals that are being
10 affected.

11 If it was implemented the way the Commission had
12 said, there may have been a much different overall margin
13 for the low-volume hospitals.

14 On the merger proposal, on the one hand, there are
15 all the positive benefits of the mergers. The negatives one
16 can potentially discount a bit by the fact that we don't
17 expect this to happen very often. But it does open the
18 door. It opens the door to this consideration of is there a
19 class of hospitals that has characteristics that are very
20 similar to the merged hospitals and should they now be
21 treated differently? It also opens the door to the future.
22 There are, I presume, some areas of the country where

1 eventually suburban growth is going to take over enough land
2 that we're going to have new hospitals coming into areas and
3 they're going to be competing with one of these merged
4 hospitals.

5 I would think at a minimum, if we want to create a
6 carrot for mergers, that it be a transitional carrot and not
7 a permanent carrot.

8 MR. HACKBARTH: Say more about that, Bill. When
9 people are making capital investment and long-term
10 decisions, how do you --

11 DR. SCANLON: The idea would be that you give them
12 an incentive where they can retain some of the cost-based
13 reimbursement over a period of time. Maybe it's five years.
14 Maybe it's 10. Over that period of time you phase out costs
15 and you move into a PPS base. Something along those lines.

16 DR. KANE: I'm just taking a longer term view,
17 looking at both the results of the PPS rural hospitals
18 negative overall margins, whether they're low volume or not.
19 And then the negative margins of about half of the critical
20 access hospitals' total margins. I'm just kind of wondering
21 if there's not some kind of propping up here of institutions
22 that are just not financially viable overall. I don't know

1 whether allowing either one class or the other, propping
2 either class up, is helping the other class survive.

3 It's a little unclear to me what we're really
4 trying to accomplish by having -- first of all, two
5 different classes of hospitals, one set on 101 percent of
6 cost and the other one on PPS, neither one of whom looks
7 viable for at least half of them.

8 It's a broader of question of when you look at
9 this, you go geez, there's an awful lot of hospitals here
10 that don't look very viable.

11 And to the extent that having a CAH neighbor
12 exacerbates the PPS hospitals' financial situation, but then
13 you're freezing the CAH and its size class because if it
14 moves up it has to into that -- I'm just wondering if
15 overall the whole way we've segmented the rural payment to
16 hospitals isn't freezing both sets of hospitals into really
17 financially disadvantaged arrangements. It just doesn't
18 look very viable without special little prop ups.

19 DR. REISCHAUER: What's the alternative? No
20 hospital?

21 DR. KANE: One really might be arguing the same
22 thing about why do you want consolidation. Maybe we have

1 too many low-volume hospitals out there. I don't know. But
2 I know how hard it is to close a hospital. I agree.

3 But is there are ways to think about -- I know
4 Maine's hospitals pretty well. And I have seen rural
5 hospitals there do quite well when their relationship is
6 with a central hospital that does provide a 24-hour
7 pharmacist and shares services. And that model looked like
8 it worked. But these models don't look like they work.

9 I guess that's what I'm trying to get at, are
10 there ways that we can create incentives for the rural
11 hospitals to thrive, rather than kind of barely hang on?
12 Does it require regional affiliations instead of staying by
13 yourself in a 25-bed hospital? But are we freezing them
14 instead into that model, rather than saying why don't you
15 find a big partner who expands your scope of services
16 without adding the overhead by either telemedicine or
17 visiting specialists?

18 It just seems like this payment method of CAHs up
19 to a certain size at 101 percent of costs and then PPS right
20 over that, a whole bunch of hospitals into financial
21 distress and frozen into models that don't seem to be viable
22 the way the payment system works right now.

1 MR. HACKBARTH: These issues, as Sheila and other
2 people in the room can attest, have been around since the
3 very beginning of the PPS system. And these various
4 adjustments and special payment methods and levels have been
5 added over the years. And the short version is that they
6 reflect Congress' unwillingness to go the consolidation
7 route and have people travel longer distances, even in many
8 cases recognizing that there's increased expenditures, a
9 loss of operational efficiency, and perhaps even some
10 compromise on technical quality available.

11 DR. KANE: And you're freezing them into a
12 strategic mindset they can't get out of. That's what I
13 guess I'm trying to get at.

14 MR. HACKBARTH: I very much agree with your point
15 of view and whenever we've discussed these issues I've
16 expressed concern about freezing the system and what's the
17 impact on nearby small PPS hospitals. We create this
18 ongoing momentum to ever expand the exceptions and special
19 payment rules because every time you do it there's a new
20 group of people just on the border, just outside the rules,
21 and now they want in.

22 I don't know what the solution is, but that

1 dynamic has been in place for quite some time now.

2 DR. KANE: Is there a way to say, instead of
3 saying let's do a low-volume adjustment, to say instead why
4 don't we try to reward critical access hospitals who find
5 partners who help them expand their -- or some viable model?
6 There are rural hospitals that aren't losing tons of money,
7 and there are models of rural health delivery that aren't
8 losers. Is there ways to try to push -- just as we're
9 trying to push physicians, encourage physicians to do more
10 group-based virtual group, couldn't we do the same thing for
11 rural health systems rather than freeze them into this lone
12 cowboy out there in the sagebrush? As an incentive instead
13 of talking about these little fixes. It's already clearly a
14 financially dead system.

15 MR. HACKBARTH: We've got a number of people, I
16 think, who want to explore that further. I suspect Sheila
17 is among them.

18 MS. BURKE: Nancy, I think you raise a number of
19 good questions. As Glenn pointed out, this is a
20 conversation that began in the 80s and hasn't changed
21 dramatically except for this tortuous adjustment to unique
22 sets of circumstances. For example, if you look at the

1 Section 406, it deals with five hospitals. That is the
2 nature and history of this attempt to try and figure out
3 what to do with facilities that are located in areas that
4 are sparsely populated.

5 There is a unique history of this issue in the
6 Senate Finance Committee, and given its current leadership,
7 that I don't anticipate changing, with Montana and Iowa
8 considerable players in this issue.

9 But the question you raise, which is is there a
10 better way to do this, there's no question there are unique
11 sets of circumstances in every one of these hospitals and
12 every one of these states. In some cases the partnerships
13 with regional hospitals have been quite effective. In other
14 cases, less so.

15 There are issues around ownership of some of these
16 hospitals that either encourage or discourage those kinds of
17 relationships.

18 I think it's a question we should certainly
19 engage. But as Glenn suggested, it is enormously
20 complicated, and the politics of this. In many cases, these
21 are the largest employers in those communities. In many
22 cases, they are the only reason that they have kept a

1 physician or any kind of a health care system within many
2 miles of other activities. People that don't live in these
3 areas are sort of immune to the fact that while we think 25
4 miles is not a big deal, except if you live in Butte,
5 Montana and it's winter. And then 25 miles is a long, long
6 way.

7 I feel like Mary is sitting right here on my
8 shoulder, listening to every word that I would say. And she
9 would say it much better than I can.

10 But I think the question is a good question. It's
11 one that we ought to engage. I don't think there's a simple
12 solution. I don't think you can force these institutions to
13 essentially come together if there aren't ways to do that or
14 reasons to do that.

15 It's certainly worth talking with the folks on the
16 Hill as to whether there is a way around this. But each of
17 these is a unique set of circumstances. In some cases they
18 have swing beds. In some cases, they have freestanding
19 psych units or rehab units. In many cases, they are the
20 only long-term care facility availability in a large area
21 and people want to stay closer to home so they've adjusted
22 to those circumstances.

1 I think we ought to look at it. I think we ought
2 to look at moving them off of being stuck in one place
3 because of these sort of strange circumstances. But they
4 came about because of strange circumstances and unique
5 concerns on the part of Finance and Ways and Means that have
6 adjusted to -- just as we did in some urban areas. I
7 remember only too well moving people across state lines
8 depending on the definition of how they were going to be
9 incorporated.

10 So I think we ought to ask the question. But
11 again, I don't think this is a simple -- any more than
12 anything else is. It's not a simple solution and each of
13 them are sort of unique. Ralph has certainly talked with
14 and seen a lot of these guys. There is an opportunity for
15 some collaboration.

16 And frankly, as Arnie was suggesting, things are
17 different now than they were then. We can do things now in
18 terms of capacity with computers and a variety of other --
19 telemedicine that is relatively new, given the history of
20 the program, that might lend itself to things that we
21 couldn't have done 25 or 30 years ago that might lend
22 themselves to solutions today that we might want to think

1 about or incentivize in some way.

2 So I think it's a perfectly reasonable question to
3 ask, but it won't be a simple answer and it's fraught with
4 politics.

5 DR. STENSLAND: Maybe I could make a little
6 clarification on this slide. I don't know if it's clear,
7 but when we're saying all PPS hospitals, this is urban and
8 rural. So the PPS hospitals in general, their margins
9 aren't that much lower than CAH margins. And the CAH
10 margins aren't just stuck there. There's some movement back
11 and forth between categories from one year to the next.

12 Like a couple of those in the minus 20 category I
13 called and found out what was going on, why were you minus
14 20. They had some rationales, their billing system was out
15 of whack or whatever. And now they're in the black.

16 So there is some movement back and forth. And I
17 think if we look at the other slide here, these negative
18 margins you see overall for these small rural hospitals,
19 negative overall Medicare margins, I don't know if they're
20 really any worse than you would find for urban PPS hospitals
21 who aren't getting IME or DSH payments.

22 So just trying to clarify that these aren't

1 dramatically worse than --

2 DR. REISCHAUER: We can put them out of business,
3 too, right Nancy? And solve the Medicare program at large.

4 DR. KANE: I'm not saying let's put them out of
5 business. I'm saying let's not, through the payment system,
6 freeze them into a mode where they can't do better by virtue
7 of affiliation, consolidation, virtual networks.

8 MR. HACKBARTH: What's very much the spirit of the
9 merger proposal. Here's an incremental step we can take so
10 that we don't freeze things in place in an unproductive
11 manner.

12 MS. BURKE: Can I just add one comment on that,
13 just following up on Bill's point. That is, as you suggest
14 the merger, you don't want to discourage the kinds of
15 behaviors that Nancy has pointed out might well make great
16 sense.

17 But you also don't want to create another set of
18 challenges with a population of hospitals that are just this
19 side of that and suddenly want to move in where you suddenly
20 expand dramatically a group of people that are caught in
21 this set of reimbursement rules.

22 So I worry about that as well. And one of the

1 questions I would have is how frequent has this been an
2 issue? How frequently have these sort of rules prevented or
3 discouraged what otherwise might have occurred in terms of a
4 merger? And is it a problem that is substantial and one
5 that needs to be addressed? Or is it one that we think
6 might be an issue? I just don't want to create an
7 circumstance where the unexpected consequences are far worse
8 than the problem we're facing today.

9 MR. HACKBARTH: And I think that's a good framing
10 of the issue. There's a potential benefit and also some
11 risk. You only want to go after the benefit if the
12 risk/reward is appropriate. What I heard Jeff say is that
13 at least at this point there's not a long line of people
14 clamoring for this merger opportunity. So we're trying to
15 anticipate, as opposed to react to a heavy demand. Is that
16 right, Jeff?

17 DR. STENSLAND: I think there's a large number of
18 rural hospitals and about 100 pairs I talked about, maybe a
19 little over 100, that might be candidates for this. And a
20 lot of these are old Hill-Burton hospitals and they're both
21 thinking should we build a new hospital? They may decide
22 maybe it makes more sense to build one hospital with one

1 covered ER, with one CT. So those would be the questions.

2 I only heard of a couple places. I talked to
3 people in the different states offices of rural health and
4 that kind of thing and they think well, I may have one in my
5 state that might be interested in. We have two hospitals in
6 the county and they might want to do this kind of thing.

7 So there's just a little bit of interest out
8 there, but it's probably not the kind of thing where the
9 small hospitals are coming up and thinking of this on their
10 own. It's more they're taking the law as given, and then
11 thinking how am I going to work within the law.

12 MR. HACKBARTH: Under those circumstances, one
13 potential avenue for us would be to stop short of a bold-
14 faced recommendation and just discuss the issue in the text
15 and then reach out and try see if this is a developing
16 problem. But not try to fix something that's not yet risen
17 to that level and incur some adverse consequences as a
18 result of our fix.

19 MS. BURKE: And also, if it's a couple of very
20 specific instances where it might arise, look at those
21 instances and find out whether, in fact, it would create an
22 issue. Is there another hospital in proximity? Could it be

1 a competitor?

2 If we have the opportunity where it's a limited
3 number of circumstances, let's look at what the reality is.
4 Because that's really the question, is do they then
5 essentially compete with someone who's in relative close
6 proximity? Or are they, in fact, simply consolidating,
7 improving the services, doing a better job, reducing one
8 hospital that isn't needed and still servicing that
9 community?

10 That's really the question, is does it create the
11 problem we're worrying about, which is that you're going to
12 have another group of hospitals that are right there, just
13 over the bed size or just over the line who will suddenly
14 want to move to cost-based reimbursement?

15 So I think if we've got the chance, let's look at
16 the circumstances.

17 DR. HOLTZ-EAKIN: I agree those are the right
18 issues but I guess what I thought I heard Bill Scanlon say
19 struck me as exactly the right solution with the transition
20 to PPS. Is there -- if that's really wrong, I'd like to
21 hear why. It seems like a sensible way to go and I would
22 endorse it.

1 Bill just said look, let them merge. But don't
 2 freeze them in this status forever. Make a transition to
 3 PPS over an appropriate horizon. That strikes me as exactly
 4 the right solution. It allows for the planning and all the
 5 issues you're worried out. You know what the future it, but
 6 it doesn't create another inequity as a result of this.

7 DR. STENSLAND: I have talked to a few hundred
 8 hospitals out there, and I think they would be reluctant to
 9 do that. Because they are going to have some long-term debt
 10 here. If they build a new hospital they're going to have a
 11 30-year mortgage.

12 And I'm afraid they're not going to have faith in
 13 what PPS rates will be 10 years down the line. They're kind
 14 of making a bet that Congress is going to have reasonable
 15 PPS rates for small rural hospitals 10 years down the line
 16 and I'm afraid they might be fearful of that.

17 DR. HOLTZ-EAKIN: That's true in the whole system
 18 at some level. And on the low volume, that strikes me as a
 19 very sensible way to go. What you like to have people do is
 20 deliver services efficiently and also take advantage of
 21 economies of scale. And if, as a policy matter, you want to
 22 preclude their ability to take advantage of the economies of

1 scale, then you're going to have to pay them for the
2 difference.

3 But you want to make sure you get the efficiency
4 first and compensate for lack of economies of scale. This
5 is a good way to do it. It doesn't solve all of the
6 problems but it strikes me as a step in the right direction.

7 DR. WOLTER: I think the history of this had good
8 motives. It was pioneered in Montana. And at that time
9 these were called medical assistance facilities and there
10 really was the intention that there be a reasonably
11 significant number of miles between facilities and there was
12 some kind of limits on what services could be offered.

13 I think what's really confounding the situation
14 now is that, as we move the bed size up and the mileage
15 requirements down, there's great concern that is that really
16 an appropriate place for a program like this?

17 That was discussed, I think, in some depth by us
18 the last time we did a rural report, which by the way I
19 thought was really well done. My sense of where we are on
20 this is I think over this next year or two we should do a
21 fairly good analysis of what is happening to the annual
22 increase in costs in critical access hospitals? How much

1 new capital investment is there? And are we going to get to
2 a point where we really do need to reconsider is it
3 appropriate to have critical access hospitals 15 miles from
4 one another? How many of them? Do we need to revisit state
5 standards versus national standards? Although the ability
6 to use state standards now is gone.

7 So I think there is some future analysis here that
8 will be very, very important.

9 The other thing I'm remembering is that in the
10 analysis done when the program was expanded to critical
11 access hospital, the real issue was outpatient payment. As
12 I'm recalling, that's where the losses really were in these
13 small facilities. Most of them on the inpatient PPS side
14 actually did sort of okay.

15 And so I think that's another good reason to
16 consider an outpatient low volume adjuster. Because if you
17 do feel there is a place in America where rural health care
18 is important, and you can't create the same economies of
19 scale or have enough volume for a PPS system to create the
20 right averaging, a low-volume adjustment is probably a nice
21 policy. And maybe that's a stepping stone to reexamining
22 what's the future of the program? And is there a place to

1 bring PPS back in on the inpatient side.

2 So I don't think this is a definitive final
3 decision for us, certainly. But we're kind of where we are
4 and it's still a relatively new program for many of these
5 facilities. The issues Sheila pointed out, it's not just
6 about Medicare and health care. This has got so many
7 political and economic and other aspects for these
8 communities.

9 So I think a low-volume adjuster, if we keep the
10 money in the pipeline for a couple of years to really
11 understand what we're doing might make sense. I'm really
12 reluctant on the merger piece because it just raises so many
13 other, bigger questions.

14 DR. SCANLON: Just quickly, because Nick covered
15 what I wanted to say.

16 I want to emphasize, we shouldn't think of this as
17 a low-volume adjustment alone. We think of a low-volume
18 adjustment for isolated hospitals that we want to keep. And
19 we've got a parameter in this which is the distance, and
20 maybe not the best parameter in terms of identifying the
21 hospitals that we want to keep. But that's what we need to
22 care about because there are hospitals that are going to be

1 in a very precarious position financially. Probably even if
2 they were to affiliate, they couldn't necessarily get all of
3 the economies that are going to put them into a positive
4 margin. And yet we want them there because of the point
5 Sheila was making, 15 miles or 20 miles in Montana in the
6 middle of winter is very different than it is around here.

7 So think of it in those terms. If we can target
8 it even further than just low volume, we'd be better off.

9 DR. BORMAN: I think the notion of the transition
10 that's been proposed is a good one. I am in a state that
11 has a couple of clusters of population and lots of places
12 that potentially come into these very sorts of categories.

13 I think, frankly, what needs to apply here, and I
14 think maybe this is part of Nick's idea of the going forward
15 analysis, as we're looking at other aspects of the program
16 in terms of quality, we need to ask are there some quality
17 items here that apply to this group of hospitals to which we
18 can start to tie some of these considerations? Because for
19 example, what I see at the big cluster population is that
20 lots of things are getting done at these kinds of places
21 that end up being repeated at my place because they've not
22 been done in a quality way. And all that is translated to

1 is a delay in patient care.

2 I think on the provider side there are some
3 significant issues in that there are some data that would
4 suggest that recertification, that board recertification at
5 the second or third interval, 20 years or 30 years out, is
6 clearly a higher failure rate for individuals in rural
7 practices, on the specialty side, at least. And so I think
8 there are some potential quality issues out here.

9 That has to be balanced, of course, against the
10 issue of access of care. And of course, that starts to
11 certainly feed into the politics of it. But I think access
12 to what kind of care? That starts to feed in a bit to the
13 coordination, the issue of quality, who many of certain
14 kinds of things do you have to do to do it in a quality way?
15 And the notion that every little place can retain a
16 specialist in everything, or even three primary care
17 physicians, may not be a viable position going forward,
18 particularly if we apply technology, as Arnie has suggested.

19 So I would like to maybe see this go forward with
20 the idea if there is additional study that it start to look
21 at some of these quality and practice kinds of things as an
22 idea of how do we better shape this in the future?

1 MR. HACKBARTH: I want to take a couple of minutes
2 to just try to nail down where we are because this is a
3 mandated report that's due in December, December 8th. So
4 we'll need to take our votes on any recommendations next
5 month. So I want to try to make sure that we have the right
6 draft recommendations when we come back next month.

7 Let me just start with a general comment. I
8 always find these rural issues difficult to deal with
9 personally. In some respects, to me, they're sort of like
10 IME and DSH. The scale is very different, the locations are
11 very different. But in terms of the policy context, there
12 are some similarities.

13 I sort of think like Nancy. I'm inclined to say
14 let's pretend we could start with a clean piece of paper.
15 How would we want to design the payment systems to reward
16 the development of a high quality, efficient system. But
17 that's not how the political process is working on this
18 issue or this group of issues, or on IME and DSH issue.

19 In each case, Congress has repeatedly expressed a
20 preference for a different approach, which wouldn't be the
21 one I would take. But it's there.

22 So what's MedPAC's role in that circumstance? I

1 don't think our role in either IME and DSH or in these rural
2 hospital issues is to simply throw in the towel and say
3 well, Congress wants to do it its way and therefore we won't
4 say anything at all.

5 I do think though that we need to recognize the
6 political realities and try to suggest ways to better target
7 resources that are being put into the program and get
8 improvements at the margin if we can't start with a fresh
9 piece of paper and redesign the whole system.

10 I think that the sort of recommendations that Jeff
11 and Dan brought are in that spirit. Can we target the
12 resources a little bit better on the institutions that we
13 most want to keep. So I think we're in the ballpark.

14 Now I've heard different options laid out on each
15 of the two issues. Let me start with critical access
16 hospitals. I've heard three basic options be put on the
17 table. One is the current recommendation that was presented
18 by -- would you put up the critical access recommendation?
19 This is one of the options.

20 The second option is to say well, this whole thing
21 isn't quite ripe yet. We don't have a lot of CAHs asking to
22 be able to merge and maybe we ought to just let it sit for a

1 while and monitor the situation and see whether we should do
2 something when there's more evident demand for a change in
3 policy.

4 And then the third possibility is the one that
5 Bill Scanlon first proposed, which would be to say yes, you
6 can merge and keep critical access status for a period of
7 time, but then you convert over to PPS.

8 I think those are the three options that I've
9 heard. Any others that I missed?

10 Hearing none, what I'd like to do is get a sense -
11 - these are not final votes. I'm just trying to get a sense
12 of where people are. How many of us would like to see the
13 recommendation that's on the screen be the one that we
14 consider at the next meeting?

15 How many would like to see us not make a
16 recommendation at all and continue to study and monitor the
17 situation?

18 How many would like to go with the temporary CAH
19 status coupled with conversion? You're going to make this
20 difficult, aren't you?

21 DR. KANE: Could we add coupled with conversion to
22 PPS for inpatient? Didn't we hear that the problem is on

1 the outpatient side?

2 MR. HACKBARTH: So convert to PPS after some
3 period for inpatient but allow them to keep cost
4 reimbursement indefinitely for outpatient would be another
5 iteration. Does that change any perspectives?

6 I think we had a slightly larger number in favor
7 of let's just hold off for now.

8 DR. REISCHAUER: Does hold off mean not even
9 discuss the issue at all?

10 MR. HACKBARTH: No, discuss it in the text but
11 stop short of a bold-faced recommendation.

12 DR. REISCHAUER: I would assume that the
13 discussion would lay out some markers, such as if we went in
14 this direction it would be important to have it a gradual
15 transition, a marker.

16 MR. HACKBARTH: Yes.

17 DR. MILLER: I also think the notion of if we're
18 removing barriers, let's talk about barriers broadly, the
19 notion of moving into groups versus just consolidating a
20 couple of hospitals.

21 I also think there was Nick's point early on about
22 what are the implications for cost reimbursement generally?

1 We could have a discussion about this without making a
2 recommendation and sort of cover all of those points.

3 MR. HACKBARTH: Rather than put ourselves in a
4 position where we've got some significantly divided vote,
5 I'd rather take that approach, of discuss in the text and,
6 as Bob says, lay out some markers, discuss some options but
7 stop short of a bold-faced recommendation if people feel
8 comfortable..

9 MS. BURKE: One of the things that's not clear to
10 me, it wasn't clear in the context of this recommendation or
11 even in the context of let's transition them to PPS. It's
12 not clear to me what we're assuming. Are we assuming that
13 the end result needs to be literally the combining of the
14 two so they're now a big? Or is it that they combine the
15 two but they stay small?

16 I mean, it sounded like the presumption was if
17 they merged they would simply -- you know, one and one is
18 two, and that's the new one.

19 DR. KANE: It says combined 2006 peak --

20 MS. BURKE: My point is what do we think the new
21 thing would be? Would it necessarily be simply a doubling
22 of what exists in each of the independent places now, by

1 literally the combining because it addresses their peak
2 periods? Or is it that we would imagine they combine, but
3 they combine smarter, they do better systems, they
4 collaborate with somebody?

5 I mean, one of my concerns about this was it
6 presumed what the end was. And it's not clear to me -- I
7 mean, whether they go to PPS or not, in part, depends on
8 what it is they become. It's hard to know --

9 DR. SCANLON: I assume that the assumption was
10 that they were going to be big enough after they merged not
11 to qualify as critical access anymore.

12 MS. BURKE: That's the question.

13 DR. SCANLON: There's certainly no barrier now to
14 merging and still qualifying.

15 MS. BURKE: But to Nancy's point, what is it we
16 want to encourage? Is there a way, if we're going to look
17 at this going forward, what do we want to encourage them to
18 do? Is it simply to become big enough that they're now out
19 of critical access? Or is it to remain smallish but to be
20 smarter to collaborate with somebody?

21 What I'm trying to suggest is that we ought to
22 think about what we want them to become, how we create those

1 kinds of incentives, whether or not they end up being
2 appropriately treated in PPS or whether they have to stay in
3 a CAH because they're small enough. I don't know what we're
4 presuming we want the answer to be. But that's presumably
5 what we want to encourage is that kind of a consideration.

6 MR. HACKBARTH: But in terms of what we consider
7 at the next meeting, what you're adding is sort of another
8 dimension of complexity to this, which I think argues in
9 favor of no bold-faced recommendation at this point.

10 MS. BURKE: I agree.

11 DR. CROSSON: Another part of the option that we
12 might want to consider would be to recommend -- we heard
13 that there's not that many hospitals that want to do this.
14 We've also heard that we really can't figure out how they
15 would end up. So another possibility would be to encourage
16 a very small pilot or a sunset thing where you could say to
17 CMS why don't you do a pilot of up to five or 10 of these
18 things, and then study them over a period of a few years,
19 and then we could learn more about the dynamic.

20 MR. HACKBARTH: If I may, I'd like to move on to
21 the low-volume adjustment and recommendation. Would you put
22 that up?

1 Here I hear two options having been put on the
2 table. One is the draft on the screen. The alternative was
3 the one that Nick offered, which is to say to go with the
4 low-volume adjustment as a way to better target Medicare's
5 investment in these institutions. A low volume, as Bill
6 puts it, plus distance requirement. Low volume for isolated
7 institutions. But ease the transition by temporarily
8 keeping all or part of the additional payment in the system.
9 So it's a middle ground, if you will, between endless hold
10 harmless and immediately to the PPS with low volume.

11 Who would prefer to see us stick with the
12 recommendation on the screen?

13 DR. HOLTZ-EAKIN: I'm not clear what Nick's
14 proposal is?

15 MR. HACKBARTH: It's basically put more money in.
16 Keep at least some of the difference --

17 DR. HOLTZ-EAKIN: To people who don't quality --

18 DR. REISCHAUER: Forever?

19 MR. HACKBARTH: No, they'd only get it if --

20 DR. HOLTZ-EAKIN: It only goes to the low-volume.

21 MR. HACKBARTH: Right.

22 DR. HOLTZ-EAKIN: Who's in transition [inaudible].

1 MR. HACKBARTH: I don't want to put words in your
2 mouth, Nick.

3 DR. WOLTER: We currently have what, \$70 million
4 that's going related to the hold harmless and how much
5 related to the sole community hospital?

6 DR. ZABINSKI: \$90 million, but that's budget
7 neutral. It's a shift of money primarily from urban to
8 rural.

9 DR. WOLTER: My thought was part of what might
10 create a little confidence that trying to use the concept of
11 low-volume adjustment, as opposed to endless renewals of
12 hold harmless might be if we tried to keep this budget
13 neutral. Instead of going from \$70 million to \$40 million,
14 we would try to put more money into what's returned in the
15 low-volume adjustment but recommend going to low volume.

16 DR. HOLTZ-EAKIN: But some of that \$70 million is
17 going to hospitals that won't get anything, that are high
18 volume. So you're more than budget neutral for the people
19 who are making the transition. You're throwing a lot of
20 money at them and then taking it away later. I don't see
21 why we want to do that.

22 DR. WOLTER: One reason I'd like to do it is I'm

1 looking at the negative margins that they're facing.

2 MS. BURKE: The winners or the losers.

3 DR. HOLTZ-EAKIN: These are the winners.

4 MS. BURKE: I understand but the question is are
5 you worried about the [inaudible]?

6 DR. HOLTZ-EAKIN: I'm utterly heartless and I'm
7 not in this. I just want to understand it.

8 MR. HACKBARTH: So Doug's point is that if you go
9 to a low-volume adjustment, only some of the hospitals
10 currently benefitting from the hold harmless are going to
11 quality. If you take the full pot of money and put it into
12 hold harmless, you're actually elevating the payments
13 further to the institutions who quality for the low-volume
14 adjustment and then the others get zero.

15 DR. REISCHAUER: You could just phase this in and
16 the first year do a third, the second year two-thirds of
17 both of those pools.

18 DR. WOLTER: There would be a lot of ways to do
19 it. The other way you could do it is increase the number of
20 procedures that can be done relative to the payment for low
21 volume, and then that would affect more institutions. I
22 mean, there would be a lot of different ways to try to keep

1 some of this money in the system.

2 MR. HACKBARTH: Rather than trying to invent those
3 on the spot, let us think about those options. Before the
4 next meeting I'll be talking to you folks on the phone and
5 we'll try to craft something that will work for the next
6 meeting.

7 DR. KANE: I just want to be sure I understood,
8 that the sole community hospital \$90 million isn't in this
9 transfer to the low-volume hospitals? Or is it?

10 DR. MILLER: It was in the proposed
11 recommendation.

12 DR. KANE: You were taking \$160 million, lowering
13 it to \$40 million?

14 DR. MILLER: Remember, \$70 million of it sunsets.

15 DR. KANE: But you were going from \$160 million
16 down to \$40 million?

17 DR. MILLER: That's correct.

18 DR. KANE: I thought it was \$70 million down to
19 \$40 million. Now I understand, it's \$160 million down to
20 \$40 million.

21 DR. MILLER: That's correct.

22 DR. KANE: Is what the recommendation is. So the

1 rest goes back to the urbans.

2 MR. HACKBARTH: We will come back to this next
3 month, for the last time in this cycle anyhow. Thank you
4 very much, Jeff and Dan.

5 Now we have another presentation which will be
6 equally easy, IME and DSH.

7 MR. ASHBY: I'd like to start today by presenting
8 a couple of supplements to the data that we presented at the
9 last meeting, items that commissioners have asked about.

10 Then, also relating back to the last meeting, our
11 discussion brought out a wide range of perspectives on the
12 current levels of the IME and DSH and we thought we would
13 summarize some of those key issues for you today.

14 And then finally, we will present the results of
15 two analyses we've done relating to two of the issues that
16 have been raised. That would be the relationship of
17 teaching and low-income patient care to hospitals' cost and
18 the relationship of IME and DSH payments to hospitals'
19 uncompensated care.

20 And we'll return to others of the issues that you
21 have raised at later meetings.

22 Our presentation last time included the

1 distribution of combined add ons for those hospitals
2 receiving both IME and DSH, and that would be the last line
3 on this chart that we have here. But the question came up
4 about how the add on split between IME and DSH for those
5 that received both payments. Over all hospitals, and that
6 would be the top half of the chart, DSH payments dominated
7 over much of the distribution. For example, the 75th
8 percentile of DSH payments among all hospitals is 10
9 percent, while the 75th percentile of IME is 1 percent.

10 This mostly reflects the fact that about three-
11 quarters of all hospitals receive a DSH payment while only
12 30 percent receive an IME payment.

13 MR. HACKBARTH: Could you say that again? It's 10
14 percent of what and 1 percent of what in the example you
15 just gave?

16 MR. ASHBY: Among all hospitals, among all 3,500
17 hospitals, if you array them from low to high on their DSH
18 adjustment, the 75th percentile would be a 10 percent add
19 on.

20 If you did the same for IME, if you arrayed them
21 all, many of which are zero. But if you arrayed them all
22 from low to high, the 75th percentile hospital gets only a 1

1 percent.

2 MR. HACKBARTH: We're still talking add ons to
3 base payments in this table?

4 MR. ASHBY: Right, but in the second half of the
5 chart, we're looking solely at the hospitals that get both
6 IME and DSH. And we see, though, that DSH still accounts
7 for more of the add on payments than does IME.

8 So again, looking at the 75th percentile, you'll
9 see that the 75th percentile adjustment, just among those
10 getting both, is 21 percent and the 75th percentile is 15
11 percent for IME. At all of the points that we see here, the
12 hospitals are getting more from DSH than they are from IME.
13 But you'll notice that as we move towards the higher end of
14 add ons, the IME begins to play more of a role.

15 Another question that came up is how hospitals
16 receiving the largest IME and DSH add ons break down by type
17 of control. For reference here, we show the shares of non-
18 profit, for-profit and government hospitals industry-wide at
19 the right side of the table. Then among those receiving the
20 largest DSH only payments, we have a somewhat surprising
21 representation of for-profit hospitals, 36 percent of those
22 DSH only hospitals are for-profit. The IME group is almost

1 completely non-profits, 94 percent, as you see. And then
2 among those getting both IME and DSH payments, we have
3 somewhat of an over-representation of government hospitals,
4 36 percent of those are government hospitals. And a number
5 of these are the large inner city public hospitals like
6 Grady Memorial in Atlanta, Bellevue Hospital in New York,
7 that sort of institution.

8 Turning to the issues that you raised at the last
9 meeting, one side of the argument on the appropriateness of
10 the DSH and IME payments being much higher than the
11 empirically justified level centered on the accuracy and
12 equity of payments. Under this view, the primary goal of
13 Medicare ratemaking is to make the best possible estimates
14 of the cost of services, and that would be the cost of
15 efficient providers to the extent possible. And then to
16 align payments as closely as we can to those costs.

17 IME and DSH payments have distributed large sums
18 of money in a way that is poorly related to the costs of
19 treating Medicare beneficiaries and the result has been
20 inequitable payment outcomes.

21 The other side of this issue is -- the other side
22 stresses the importance of the teaching and social benefits

1 that hospitals provide. This side notes that Congress made
2 a conscious decision to double the IME adjustment rate
3 because analyses conducted by CBO at the time had suggested
4 that teaching hospitals would fare poorly under the PPS.

5 We went back and located that CBO analysis from
6 actually 23 years ago. We found that CBO had estimated that
7 with the introduction of the PPS teaching hospital payments
8 would go down by 7 percent and payments to non-teaching
9 hospitals would go up by 7 percent. So all else being
10 equal, that would put teaching hospitals 14 percentage
11 points behind on the inpatient margin. And all else being
12 equal, doubling the IME would bring hospitals closer, but
13 not quite to parity with non-teaching hospitals.

14 We all know that that isn't the way it turned out.
15 In the first year of PPS teaching hospitals' margins were 5
16 percent points higher than non-teaching and that gap has
17 widened over time. Several observers have suggested that
18 the reason teaching hospitals fared better than CBO was
19 expecting was because they substantially improved their
20 coding of DRGs. We have to remember that before PPS, most
21 hospitals had almost no experience with patient
22 classification.

1 Returning to the argument, it was pointed out that
2 in addition to teaching hospitals' role in graduate medical
3 education, that hospitals of all kinds, teaching and non-
4 teaching, DSH and non-DSH, provide other social benefits.
5 These include uncompensated care, broad-based community
6 services like patient ed and screening programs, especially
7 services that frequently operate at a loss, like trauma
8 care, burn care, and so forth, and standby capacity for
9 responding to natural disasters, potential epidemics and the
10 like.

11 Finally, it was pointed out that IME is not the
12 only payment mechanism that serves a broad social goal. We
13 have several rural payment mechanisms, some of which we just
14 talked about, that are aimed at protecting access to care in
15 rural areas. That's sort of the prime example.

16 If the federal government is to have a role in
17 underwriting social benefits that hospitals provide, the
18 obvious question then is what's the best way to provide the
19 funding? One side of the argument here is that the best
20 funding source is general revenues, allocated through the
21 appropriations process. These are public goods that we're
22 talking about that benefit all patients. In fact, arguably

1 they benefit the entire population, so ideally society as a
2 whole, through some sort of broad-based revenue source,
3 should provide the funding.

4 This side also argues that it's not clear how much
5 of the IME and DSH monies have actually gone to paying for
6 social benefits, rather than to improving the competitive
7 position of hospitals that receive them.

8 Then on the other side of this particular
9 argument, the other side is that IME and DSH adjustments are
10 an appropriate way to fund social benefits, although it is
11 difficult to account for hospitals' use of the funds. Some
12 of the commissioners noted that an advantage of using the
13 IME and DSH adjustments is that they are protected within
14 Medicare's mandatory funding while appropriations are
15 subject to uncertainty and change.

16 And finally, that if broader based federal
17 programs are to be used for funding social benefits,
18 Congress should create and fund the alternative before the
19 subsidy portion of IME and DSH is redistributed.

20 Those are essentially the arguments that were laid
21 out. And now we're going to focus on one particular issue,
22 one of the several issues on the table, the effect of

1 teaching and care to the poor on hospitals' costs.

2 MR. LISK: Good afternoon. I'm going to tell you
3 about our analysis on the relationship between Medicare
4 costs and teaching and care to the poor. In this study we
5 used regression analysis to estimate the empirical effect of
6 both teaching and cost of care to the poor on hospitals'
7 Medicare costs per case. Our analysis uses 2004 Medicare
8 cost reports.

9 In looking at costs per case, we were looking at
10 the operating capital cost together. Per case costs were
11 standardized for wages using Medicare's wage index. They
12 were also standardized for case-mix and outlier payments
13 using the Commission's DRG refinement proposal.

14 Regressions were also run using the 2004 DRGs as
15 they were in place at that point in time, and I will note
16 what differences we have in the results as I go along.

17 Our analysis controls for cost-related payment
18 factors. On the left-hand side of the regression we include
19 as independent variables resident intensity in our IME
20 regression. And when looking at DSH we also include low-
21 income share as an independent variable.

22 This approach in coming to the empirical level

1 allows the resident-to-bed ratio and low-income patient
2 share variables to pick up the effect of any remaining
3 variation in costs not accounted for in the payment system.
4 This approach could lead to result in an upward bias in our
5 estimate of the empirical effects of teaching and low-income
6 care to the poor. Our empirical estimates will be lower if
7 we controlled for other factors such as bed size and standby
8 capacity, for instance.

9 Let's first turn to our results on the IME
10 analysis. The empirical level of the IME adjustment is a
11 measure of how different teaching hospitals' patient care
12 costs are compared to other hospitals after controlling for
13 payment system factors. Our analysis shows that teaching
14 hospitals' costs increase about 2.2 percent for every 10
15 percent increment in the resident-to-bed ratio. It's 2.1
16 percent not accounting for the DRG refinements, so just
17 slightly lower.

18 Our estimate of the empirical effect is
19 substantially less than the current payment adjustment,
20 which in 2007 is 5.35 percent and will be 5.5 percent in
21 2008. The current IME adjustment is roughly 2.5 times the
22 empirical level. In 2004 roughly \$1.9 billion out of the

1 \$4.9 billion in total operating capital IME payments could
2 be empirically justified. Thus, about \$3 billion in IME
3 payments went to teaching hospitals beyond the cost effect
4 of teaching.

5 This next graph here shows how IME adjustment
6 changes with increases in the resident-to-bed ratio. It
7 provides you with a visual look at the payment adjustment
8 and the cost relationship. The top green line is the
9 current adjustment and the orange bottom line is what the
10 adjustment would be set if it was at the empirical level.
11 As you can see, there is a big difference between these two
12 lines. This difference shows the amount by which teaching
13 hospitals are being paid over the empirically justified
14 level. The higher you go in the resident-to-bed ratio, the
15 wider the gap becomes.

16 We also show in this graph the yellow line, which
17 is our empirical estimate that was based on the 1999 data
18 when we estimated the relationship to be 2.8 percent for
19 each 10 percent increment in the resident-to-bed ratio. Our
20 research has consistently shown, if we look at our analysis
21 over time, that the level of the IME has been going down
22 consistently from one analysis to the next.

1 Some policymakers have noted that teaching
2 hospitals are often major providers of standby services, and
3 they have suggested that the IME adjustment covers some of
4 the higher costs associated with these services. In our
5 analysis we added selected standby services to our
6 regression equation, which already included the resident-to-
7 bed ratio, to observe how the provision of these services is
8 related to patient care costs. What we found was the per
9 case costs were higher in hospitals with standby services,
10 roughly 4 percent for hospitals that had Medicaid certified
11 transplant centers, 3 percent for hospitals with certified
12 burn care, and 1 to 2 percent for hospitals with trauma
13 care.

14 Of course, there were other standby services that
15 could be considered but these were the ones that we could
16 easily do in our analysis.

17 With the introduction of these variables into the
18 regression, however, the IME coefficient dropped
19 substantially, from 2.2 percent to 1.4 percent, which means
20 that the 2.2 percent empirical IME estimate captures more
21 than just the cost effect of teaching. It's picking up some
22 of the effect of these other services.

1 This next slide shows how the provision of these
2 selected standby services are concentrated. We identified
3 teaching hospitals based on the ratio of residents-to-bed,
4 and that's shown on the left-hand side. We find that a
5 large share of teaching hospitals with a resident-to-bed
6 ratio of 0.5 or better provide these services. The
7 proportions fall as you go to hospitals with lower levels of
8 resident intensity or to non-teaching hospitals.

9 What's also important to get across is that not
10 all teaching hospitals provide these services, and that
11 these services are not exclusively provided in teaching
12 hospitals. 91 out of 143 teaching hospitals with an IRB
13 over 0.5 provided trauma care, for instance. But there were
14 also 143 non-teaching hospitals that also provided trauma
15 care.

16 Something we also looked at was whether academic
17 medical centers, which are the primary teaching hospitals
18 for medical schools, might have higher costs compared to
19 other teaching hospitals. Costs in AMCs may be higher
20 because of the participation of medical students in addition
21 to residents in patient care delivery and the hospital and
22 physicians, with their close ties to the medical school, may

1 affect patient care delivery in those settings.

2 Our analysis separated teaching hospitals into two
3 groups, academic medical centers and other teaching
4 hospitals. We found that AMC costs increase about 2.6
5 percent for each 10 percent increment in the resident-to-bed
6 ratio, and other teaching hospitals the cost increase was
7 1.5 percent for each 10 percent in the resident-to-bed
8 ratio. So there was a fair difference there.

9 We also identified hospitals that received a large
10 amount of research funds as reported on the Medicare cost
11 reports. Research funds may be an indication of hospital's
12 missions, but we did not find a cost relationship here.

13 Some of the commissioners raised the question of
14 whether better measures of resident intensity are available.
15 Resident-to-bed has been the traditional measure used in
16 most research that examines teaching hospital costs. Some
17 of the criticism of the measure is that it does not reflect
18 actual patient load and that the IME payments can also
19 increase if hospitals take beds offline.

20 Alternatives to the resident-to-bed ratio include
21 residents-to-average daily census, which does reflect the
22 inpatient load of patients. But one of the concerns with

1 this measure relative to the resident-to-bed ratio, is that
2 it would provide higher IME payments to hospitals with lower
3 occupancy rates and lower payments to hospitals with higher
4 occupancy rates.

5 A third measure that has been used in some
6 research is a straight count of residents. An advantage to
7 this measure is that the adjustment is not tied to inpatient
8 care alone. Under this approach, hospitals with the same
9 number of residents would get the same payment add on. A
10 500 bed hospital with 10 residents would get the same
11 payment add on as a 100 bed hospital with 10 residents, for
12 example, but the 500 bed hospital would get five times as
13 much IME payments, assuming the patient volume in the 500
14 bed hospitals is five times as great.

15 All three of these measures produce similar
16 estimates of the total cost effect of teaching in aggregate.

17 Now I want to move on and discuss the DSH
18 adjustment. In this analysis, we measure what relationship
19 might exist between Medicare costs per case and the low-
20 income patient care percentage used in the current DSH
21 formula. Entering low-income patient share into the
22 regression along with resident-to-bed ratio, we found that

1 the cost for teaching increases about 0.4 percent for each
2 10 percent increment in low-income patient share. This is
3 doing the relationship across all hospitals.

4 A stronger and much larger effect is observed,
5 though, if we limit our look of low-income effect to urban
6 hospitals over 100 beds. In this case, costs increase 1.4
7 percent for every 10 percent increment in low-income share.
8 The effect, not accounting for DRG refinement, is 1.6
9 percent per 10 percent incremental in low-income share. So
10 it's a little bit higher under the current system.

11 The cost effect of treating a large share of low-
12 income patients, therefore, comes to about \$1.7 billion.
13 DSH payments in 2004, however, totaled \$7.7 billion,
14 therefore about \$6 billion over the empirical level.

15 The cost effect is substantially less than what
16 the adjustment currently is. If we look at this chart, the
17 green line shows the payment effect for urban hospitals over
18 100 beds. The orange line shows the empirical cost effect
19 for this group. The gap between the two lines essentially
20 shows how much more we are paying than the empirically
21 justified amount for DSH. In other words, the subsidy being
22 provided to these hospitals over and above the cost

1 relationship. As you can see, the gap widens as we go to
2 higher levels of low-income patient share.

3 The yellow line shows the payment adjustment for
4 rural hospitals and urban hospitals under 100 beds and our
5 analysis found no positive cost effect for this group.
6 Thus, the difference between the yellow line and the bottom
7 of the graph is really the subsidy being provided to these
8 hospitals above the cost effect.

9 It's also important to point out that there are
10 some interactive effects of DSH and teaching. With the
11 introduction of low-income patient share for urban hospitals
12 over 100 beds in the regression, the IME coefficient drops
13 substantially from 2.2 percent 1.7 percent, which means that
14 the 2.2 percent empirical IME estimate captures some of the
15 cost effect of care to low-income patients.

16 The total non-cost related subsidies provided for
17 IME and DSH adjustment in 2004 totaled over \$9 billion. In
18 other words, less than \$4 billion out of \$13 billion total
19 IME and DSH spending in 2004 could be considered cost
20 related, empirical to higher cost in those facilities for
21 Medicare patients.

22 Before Jack moves on to discuss the relationship

1 of these things to uncompensated care, I wanted to lastly
2 move on to discuss capital payments and whether a separate
3 capital payment system with separate payment adjustment
4 needs to be maintained. As we pointed out at the last
5 meeting, hospitals have no obligation to spend payments on
6 hospital construction or equipment purchases and that
7 operating and capital payments can be used interchangeably.
8 Thus, there really is no need to maintain separate payments
9 with separate payment adjustments.

10 Despite this, we wanted to see what differences
11 there might be in the cost relationships and essentially
12 this is what we found. The empirical estimate for teaching
13 for capital costs alone was about half the operating
14 adjustment. That for DSH we did not find any significant
15 cost effect with low income patient share, and this was true
16 for large urban hospitals where the current capital payment
17 system provides a 3 percent payment add on. Again, we found
18 no cost effect here.

19 So the combined adjustments that we report on
20 throughout the paper are essentially a weighted average of
21 the operating and capital adjustments that you see.

22 With that, I'll have Jack move on to discuss

1 uncompensated care.

2 MR. ASHBY: In this analysis, we compared the
3 uncompensated care hospitals provide -- measured as a share,
4 by the way, uncompensated care costs as a percentage of
5 total costs -- compared those shares to the IME and DSH
6 payments that they receive. Our primary data source for the
7 analysis was the reporting systems of the five states you
8 see listed here, using data that was compiled by GAO.

9 This source offers several advantages. First, the
10 reporting is mandatory, so we cannot have sample bias within
11 any one state. Second, the hospitals must follow specified
12 reporting guidelines put out by the applicable state agency,
13 although those rules are not necessarily the same in every
14 state. And thirdly, the data are frequently, although not
15 uniformly, audited.

16 These five states account for about one-quarter of
17 all PPS hospitals, but of course we are left without
18 representation from the rest of the states. So we
19 replicated the exact same analysis using data from the
20 American Hospital Association annual survey where there is
21 less monitoring of what hospitals report as uncompensated
22 care and there's no auditing but where we do have data from

1 all 50 states and D.C. We found basically that the patterns
2 that we'll be looking at in the next couple of charts are
3 basically the same with either data source.

4 In this graph, we divided the hospitals into 10
5 equal sized groups according to their uncompensated care
6 share. Group one devotes the largest share of their
7 resources to uncompensated care and group 10 the smallest.

8 As you can see, the uncompensated care is quite
9 concentrated. The top 10 percent of hospitals provide 41
10 percent of all unpaid care. But we found that IME and DSH
11 payments are poorly targeted to individual hospitals'
12 uncompensated care shares. The decile group accounting for
13 over 40 percent of the uncompensated care receives only 15
14 percent of the IME payments and only 10 percent of the DSH
15 payments. And then, at the low end of the distribution, the
16 groups are receiving higher shares of IME and DSH than their
17 uncompensated care alone would dictate.

18 In this next chart, we focus on hospitals with the
19 largest DSH and IME add ons. That was defined as those
20 above the 75th percentile of add ons. This analysis
21 provides more evidence that DSH and IME track poorly to
22 hospitals' uncompensated care shares. The hospitals getting

1 the largest DSH only adjustments have uncompensated care
2 shares that are below the average of all hospitals. That
3 would be 5.0 versus 6.6 in the first column. And hospitals
4 getting the largest IME-only adjustments have even smaller
5 uncompensated care shares, 39 percent on average. And
6 you'll notice that their uncompensated care tracks below the
7 average of all hospitals throughout the distribution.

8 Then hospitals getting the largest DSH and IME
9 payments, and we have to keep in mind that in this group
10 every hospital is getting at least a 35 percent add on,
11 these hospitals do have uncompensated care shares well above
12 average at 14 percent. But as you can see, that average is
13 an amalgam of some unusually high shares, the 90th
14 percentile is 28 percent, but also a substantial number of
15 quite low shares.

16 So it would appear that hospitals most involved in
17 teaching and those treating the most Medicaid and low-income
18 Medicare patients are by and large not the ones that devote
19 the most resources to treating patients who are uninsured or
20 have large copays they cannot pay.

21 For a number of years now policymakers have been
22 considering options for the federal government to help

1 hospitals with their uncompensated care costs as a number of
2 states have done. This could be done within the Medicare
3 payment system or, perhaps more logically through a broader
4 mechanism funded by general revenues or a provider tax.

5 To support such an initiative, Congress, in the
6 BBRA, mandated that CMS collect uncompensated care data from
7 all PPS hospitals and CMS has done so. But as we said at
8 the September meeting, the effort has not resulted in
9 reliable or consistently reported data.

10 We've been working with CMS on revising the forms
11 and instructions, and we had quite a bit of input from
12 experts in doing that, including Nancy Kane. But even with
13 that effort, we are at least two years away from having
14 usable data.

15 That completes our presentation. With this new
16 information, particularly the data on the empirical levels
17 and the uncompensated care, you can continue your discussion
18 of the equity and the objectives of the DSH and IME
19 adjustments.

20 MR. HACKBARTH: I'm guessing Ralph has something
21 to say.

22 MR. MULLER: I must say after the discussion last

1 time on critical access, I regret I forgot to bring my
2 cowboy hat today.

3 But I think one of the concerns we've had over the
4 years were the higher inpatient margins, obviously, in these
5 hospitals. So I just want to make some points I've made
6 before.

7 Let me start with DSH. The way the DSH
8 calculation is done in statute, by looking at both Medicare
9 and Medicaid patients and then comparing to costs, we
10 obviously, by definition, have a high margin because we
11 don't have the Medicaid patient in the cost base. So by
12 payments appropriately so in the policy for Medicaid
13 patients but not having them in the base, the denominator is
14 obviously lower. So just by definition we're always going
15 to have a high DSH margin. I try to make that point each
16 time we discuss this, that you, in some ways, expect to have
17 high DSH margins because that's the way the program is
18 defined.

19 Let me talk about the IME. I'm very grateful for
20 the data on page three, because I think oftentimes we look
21 at the high inpatient margins in teaching hospitals. By the
22 nature of our conversation we tend to focus an awful lot on

1 the IME adjustment. And I think this table shows that it's
2 driven as much, if not more, in most cases by the DSH
3 adjustment. It's just something for us to remember, that
4 it's as much DSH driven as IME driven. So that by just
5 looking at most of our discussion -- I regret I wasn't here
6 last month. But even looking at the discussion last month
7 in the minutes, almost the entire discussion was around IME
8 and the empirical factor, not so much on DSH. But the
9 margins here are more DSH driven than IME.

10 I think they both have very worthy social
11 purposes, but we tend to focus, in terms of remediation, on
12 what we should do about the empirical factor.

13 I also want to remind us that while the teaching
14 hospitals and the urban hospitals have higher inpatient
15 margins in Medicare, they do have lower Medicare margins and
16 they definitely have lower total margins. So in terms of
17 our concern, this is in the text as well, that perhaps these
18 high Medicare margins are used for some kind of competitive
19 advantage. I think I'm paraphrasing the phrases in there.

20 The fact that they have lower total margins and
21 have negative operating margins is an indication that they
22 may not be using this for a competitive advantage but one of

1 the important purposes that IME has served in these 23 years
2 is, as the original congressional intent indicated, and I
3 think Jack corrected quoted it, was in fact to equalize the
4 playing field a little bit for the relative disadvantage
5 that teaching hospitals have in general in the competitive
6 environment largely because of all of the social functions
7 and uncompensated care that they provide.

8 I know this commission, in the past, has not
9 wanted to focus as much on total margins. But as I think
10 about the accountability question, I think we should take
11 that very seriously, as the commission as both in the text
12 and its discussion has shown in the past.

13 One of the ways I think we can think about
14 accountability is looking at the total margin of the
15 hospital. Because I think that, in fact, can show that the
16 broader purposes served by the hospital do not lead to big
17 total margins. They basically run pretty much at a break
18 even or modest margin than other hospitals do.

19 One way of thinking about the tables at the end, I
20 have a little different interpretation of them than Jack
21 does, is -- I remember when the Commission discussed this
22 three years ago. One of the things that at that time the

1 Commission was very sympathetic to, or at least was
2 concerned about -- as the text indicates -- was a lot of the
3 IME being used for uncompensated care. One of the things we
4 can do in terms of better targeting of this is, in fact,
5 perhaps consider rather than having some kind of linear
6 form, whether we could perhaps have higher weight on the
7 resident-to-bed ratio for hospitals that have higher DSH or
8 higher uncompensated care. So if one of the social purposes
9 we really want to meet, in addition to educating and
10 producing the next generations of physicians and nurses, et
11 cetera, we also want to support uncompensated care, we may
12 want to consider some ratios that give higher weights on the
13 teaching to bed ratio for hospitals that do more
14 uncompensated care.

15 MR. HACKBARTH: Let me ask you about that
16 specifically about that, Ralph. If we have a robust measure
17 of uncompensated care, why not just allocate all of the DSH
18 money on that basis, as opposed to Medicaid and low-income
19 Medicare share? Or at least all of it above the empirically
20 justified amount, that is all of the DSH money that isn't
21 based on higher cost for Medicare cases due to low income
22 share.

1 MR. MULLER: Allocate all of the DSH money or the
2 IME?

3 MR. HACKBARTH: All of the DSH.

4 MR. MULLER: I wish we had a better measure of
5 uncompensated care, as the text indicates. In fact, in the
6 DSH measure where, again, it's a measure of Medicare and
7 Medicaid, in fact, I think Medicaid is not as good a proxy
8 anymore of uninsured and uncompensated as it was at the time
9 this formula was put into place. To have a measure of the
10 uninsured now, Medicaid is not the best proxy anymore. So I
11 think having that would be helpful. Obviously, as the text
12 indicates, we don't have that.

13 I would like to see some measure that takes into
14 account the uninsured as well as Medicaid, if we're going to
15 have that kind of --

16 MR. HACKBARTH: I think we're saying the same
17 thing in that regard. But what I heard you proposing is
18 change the IME adjustment to reflect uncompensated care,
19 whereas it seems to me a cleaner path is to dedicate all of
20 the DSH money, at least all of the DSH money above the
21 empirically justified amount to uncompensated care, assuming
22 that you've got data that you feel reasonably comfortable

1 with.

2 And in keeping with what Arnie often reminds us,
3 you have to compare your new data to the existing
4 alternative, not perfection. You don't have to be very good
5 in terms of uncompensated care data to do a better job of
6 targeting than we are using Medicaid and low income share.

7 MR. MULLER: Let me also note that in the text I
8 received in advance it points out that the teaching
9 hospitals have done a better job of managing cost growth
10 over the recent years. That, in a sense, makes the
11 empirical factor lower. So in a sense, we may be penalizing
12 teaching hospitals for having lower cost growth by then
13 saying now the empirical factor goes down. I think that's
14 not something we want to do is just penalize people for
15 better management of cost growth.

16 Let me also note, in the discussion of whether we
17 should fund this from general revenues, the issue of -- to
18 quote from the text -- whether these kind of vaguely defined
19 benefits are any better found in the general revenue
20 calculation versus IME calculations is not clear to me. If
21 we have a problem of whether these benefits are well
22 defined, funding them through general revenue doesn't do any

1 better specification of those benefits. It just takes them
2 out of general revenues. And one could argue that's the
3 place perhaps for those benefits to be found but it doesn't
4 do any more specification.

5 MR. HACKBARTH: There are two aspects to the
6 general revenue argument. One has to do with things like
7 the Medicare Trust Fund and what's the appropriate tax base
8 to finance social goods. That's one set of arguments.

9 A second set of arguments though is if you base
10 these payments on Medicare volume and case mix, that
11 severely limits your ability to get them to serve your
12 social purposes because it's always driven on how many
13 Medicare patients you've got. It's some percentage add on
14 to a Medicare case number. And to me that's the most
15 fundamental problem with trying to use a Medicare payment
16 system to accomplish social objectives beyond the program.

17 DR. REISCHAUER: The illogical of that would be if
18 100 percent of your case load was Medicare then, by
19 definition, none of it would be uncompensated care and you'd
20 be getting the highest payment.

21 MR. ASHBY: Only if you put it on a per case
22 basis, which is not again unnecessarily --

1 MR. MULLER: I think while we've had -- I'll close
2 where I began. The total Medicare inpatient margin has been
3 going down the last 10 or 12 years and will likely keep
4 going down. So with that kind of reduction, and I think
5 it's been more than 10 or 12 points since 1997, whether this
6 is an appropriate time to keep looking at taking that down
7 even more by going to empirical levels is something that
8 puzzles me as to why we would look at it at that time when
9 it's been going down that dramatically over the course of
10 these years.

11 But I appreciate that Jack and Craig did take the
12 time to look up some of the questions that I voiced to them
13 over the phone.

14 MR. HACKBARTH: Let me just pick up on Ralph's
15 point. We discussed this a little bit last time, Ralph, in
16 your absence. Last time we looked at the IME payment, the
17 draft recommendation that I offered was to cut the payment
18 and take it as budget savings. That's not what we've been
19 talking about this time because of what Ralph just
20 mentioned.

21 There has been, in the intervening years,
22 significant and ongoing decline in the average Medicare

1 margin. And so the idea that we've been talking about here
2 is different than last time. And that would be to say this
3 is really an issue of payment fairness and equity. We're
4 not talking about budget savings, but rather should some
5 piece of the money be put back in the base to be
6 redistributed to hospitals overall?

7 I just wanted to underline that again.

8 MR. BERTKO: I'd like to amplify on the first half
9 of Glenn's comment about the Part A Trust Fund solvency or
10 insolvency. First of all, I would say all your last
11 comments about is the money needed? Sure, I completely
12 agree with that.

13 But the implications on the trust fund are that in
14 2018, as of current latest projections, we stop paying for
15 Part A benefits, which won't happen. Or that's got the
16 other implication that payroll taxes go up. Or a third
17 implication, that benefits get cut or some combination of
18 those.

19 And so whether it's outpatient stuff should have
20 more from general revenue because it goes back to break even
21 margins or something else. This has lots of interconnected
22 implications that we should at least perhaps discuss in

1 whatever comment we have.

2 MR. HACKBARTH: Other comments?

3 DR. KANE: First, I think Craig and Jack have done
4 a terrific job here of trying to tease out the different
5 reasons why the DSH and IME don't really hit the target that
6 they're supposed to hit on social costs.

7 I just want to address something that Ralph said
8 because I can't let it go by with out a comment, which is
9 that if you're in a better competitive position you wouldn't
10 necessarily have better margins. Many hospitals use their
11 better competitive position to underbid or to add capital
12 costs or to spend in such a way that they can attract
13 doctors and patients back. And so they wouldn't necessarily
14 come out with better margins. But they may come out with a
15 better market position. And I think that is the case in
16 some states where teaching hospitals compete head on with
17 community hospitals that don't have the additional money to
18 play with.

19 The only other thing I have to say is that total
20 margins are not the right thing to look at if you want to
21 understand -- if you want to compare hospital outcomes at
22 this point, for a variety of accounting reasons that you

1 probably don't want to hear about. But that's my specialty,
2 so I'm just going to name a couple of them.

3 One is that some hospitals decide to consolidate
4 into their operations, their losing physician practices,
5 whereas others don't. And so it's sort of a major of choice
6 what's in there and what's not. That's not a comparable
7 apples-to-apples margins.

8 The other is something that I've noted, is that
9 the hospitals that tend to be the most profitable try to get
10 rid of those through very conservative efforts of what they
11 owe back so that their revenue is slightly below what it
12 really is and what it becomes over time. So it's very
13 difficult just to get at total margin.

14 Medicare margin, you've got a very formulaic way
15 of getting at it. But when you go to total margin, you're
16 dealing with a lot of estimating of revenue that can throw
17 off the bottom line by a lot. And there is some systematic
18 bias to that that understates for the more profitable
19 hospitals.

20 So I don't recommend using a total margin
21 comparison to decide whether or not something is equitable
22 or one hospital is disadvantaged over another.

1 MR. HACKBARTH: Before I forget, I just wanted to
2 associate myself with another one of Ralph's comments, and
3 that was related to the DSH payment and then looking at
4 Medicare margins without the other patients in the
5 denominator. By definition we're saying the DSH payment is
6 being made for non-Medicare patients and you include the
7 revenue in the margin calculation but not the other costs,
8 it of course is going to pump up Medicare margins. So that
9 is, I think, a very legitimate issue that Ralph has raised.

10 DR. REISCHAUER: Just a question of fact. Was the
11 DSH payment, when it was initiated in Medicare, designed to
12 offset lower payments for Medicaid?

13 MR. ASHBY: It was not designed to offset lower
14 payments. In fact, the original adjustment was associated
15 rather closely to the added costs of Medicare patients.

16 DR. REISCHAUER: I confess, I knew the answer.

17 [Laughter.]

18 MR. HACKBARTH: The rationale for both the DSH and
19 IME adjustments have migrated, shall we say, over time.
20 Initially, they may have been based on higher Medicare costs
21 per case and a desire to compensate institutions for those
22 higher Medicare costs. But I think most people now believe

1 that, in fact, they are supporting something beyond higher
2 Medicare costs. There may not be unanimity on exactly what
3 it is we're supporting but there is, I think, a general
4 believe.

5 The reason I draw that inference is that now for
6 many, many years Congress has seen work like that which
7 Craig represented here today, showing that these payments
8 are not related to higher Medicare costs. And in the face
9 of that evidence, Congress hasn't said oh, wait a second, we
10 have to reduce it. They've said we're going to keep the
11 payments. And that's a clear policy statement to me that
12 they think that they're buying something else other than
13 just compensating for Medicare costs.

14 The issue then becomes are those dollars well
15 targeted? Do we know what we're getting for them? Are
16 there still some remaining issues of payment equity even
17 within the Medicare system for different types of hospitals?

18 I'm talking too much. Somebody else raise their
19 hand.

20 DR. WOLTER: It's kind of a niche question but I
21 understand that there are caps on the number of residents
22 that can be counted for these purposes. When we look at the

1 shortages of physicians that people are predicting and the
2 need to train more, how many institutions are training
3 residents over the caps? Do we need to be thinking about
4 that, in terms of how we look at the empiric level now
5 versus what it might need to be over the next few years? I
6 don't know if you guys have tried to look at those kinds of
7 issues?

8 MR. LISK: In terms of how we do the estimate, we
9 based the estimate based on how many residents they actually
10 have, not regarding the capped number, because Congress made
11 decisions on the caps. One of the reasons for the caps is
12 we are paying more than the empirical level, too, so it was
13 one way of controlling some of the growth that was happening
14 here.

15 You could conceive, if you went close to the
16 empirical level, if you're paying close to the empirical
17 level on costs, then there may not be as much of a reason to
18 have the caps, have this trade off. But when you're paying
19 much more than the cost, you kind of have this incentive
20 potentially for increase in the number of residents, which
21 we saw dramatic increases in the number residents over time.

22 In terms of the number of hospitals that are over

1 the caps, I can get you numbers back on those. I've done
2 some stuff on that.

3 DR. WOLTER: There might be legitimate reasons for
4 want to plan for increasing the numbers of residents. And
5 if we looked at it going forward, plan around how to think
6 about IME, we might want to include that thinking.

7 DR. MILLER: The only thing I would say about that
8 is we did some work on a cap-related issue a couple of years
9 back. I can't remember how many years back. And I know you
10 know this.

11 But that issue gets really complex much faster.
12 It's not just caps. You can have hospitals working above
13 the caps but still unable to fill entire disciplines of the
14 numbers of slots that are open to them. For example,
15 primary care, gerontology, those types of things. And
16 what's happening out there and how they define those
17 programs and, of course, all other kinds of issues, some of
18 which we were discussing at lunch, lifestyle issues and
19 those types of things, you could still set the cap higher
20 and still not be filling all of your slots or the slots that
21 you might want to fill in terms of a future supply issue.

22 But I know you know all this, Nick.

1 DR. WOLTER: But you could set the cap higher but
2 only count the spots that get filled, too, I suppose.

3 MR. LISK: That's how the current system is done.

4 DR. BORMAN: Just to clarify, when you said you
5 counted all residents not the cap number, you counted all
6 people in ACGME accredited resident positions? Or how did
7 you come to the all resident total?

8 MR. LISK: The total is what would qualify for IME
9 payments if there were no cap. What is reported is they
10 report an uncapped amount and it's basically -- it's the
11 uncapped amount that I have that we put in for analysis.

12 DR. BORMAN: I would echo Ralph's comment about
13 separating out a little bit the relative proportion of DSH
14 and IME as shown on page three. I do think that's an
15 important thing.

16 I personally also find page 21 pretty instructive.
17 And as you've made the very well, in the presentations and
18 the text, about the skewed distribution so that the top
19 quartile is getting a fairly substantial, added up, multiple
20 amount. And I think that I've heard a fair amount of
21 discussion here in a short period of time about equity. I
22 think maybe some of this speaks to, if we come to the

1 assumption that there are social purposes here that the
2 Congress and we, to some degree, agree with that the issue
3 of equity perhaps is one that still transcends whatever
4 political volatility that may be out there.

5 And some of this started, if I understand right,
6 Glenn, from your concern and other commissioner's concerns
7 about equity at other hospitals. And I think that some of
8 what we're seeing here is that our mechanisms for managing
9 this may not be supporting equity now. And that may relate
10 to some of the statistical or calculated kinds of elements
11 that Ralph and Nancy brought up about what's the right proxy
12 and part of what we're getting here is the self-pay or
13 guarantor group, to put other names on it. And that maybe
14 of our work needs to look at the equity distribution within
15 this, as well.

16 I personally continue to struggle with the notion
17 of the resident-to-bed ratio, and I'm well aware that it's
18 the historical number and all that kind of thing. But in an
19 era in which so much care is delivered on an ambulatory
20 basis and, in particular when we sit here and talk about
21 beefing up ambulatory care as a piece of better Medicare
22 beneficiary care, to not be looking for, pushing for,

1 thinking about a better measure or something else to tack
2 this to than inpatient beds -- now obviously that is skewed
3 because this comes under the inpatient PPS, but I think that
4 in the background some creativity about what is a better
5 number to use? Is there a better one? And maybe there just
6 isn't one that we can measure. But I start to wonder about
7 relating this -- particularly for teaching hospitals that
8 have hospital-based clinics where there is a tight linkage
9 to the hospital and there's some ambulatory number that
10 might be able to get dialed into this, particularly as you
11 start to think about the workforce piece that Nick has
12 brought up, that very clearly there's projected shortages in
13 lots of specialties. Even if the projections are 50 percent
14 off, there are still significant shortages in lots of
15 specialties.

16 Even if we say well, we have capacity related to
17 people in our training systems other than U.S. medical
18 graduates, we start to get into a lot of fuzzy issues there.
19 We do need to look forward a little bit. This is not the
20 place to resolve all the workforce issues. But I do think
21 some flexibility going forward as some real benefit.

22 MR. MULLER: Let me ask a follow up. Have we ever

1 made any estimates of IME on the outpatient side?

2 MR. LISK: No, we haven't. We do know that the
3 outpatient margins for the teaching hospitals are a little
4 bit lower than for other hospitals.

5 MR. MULLER: Obviously we have no IME adjustment
6 on the outpatient side and I would say they're a lot lower.
7 But it gets obviously reflected in total Medicare margin.
8 Is that something that's very hard to do?

9 MR. LISK: In the short time frame, it would be --
10 you could conceive of coming up with what would happen if
11 you just applied let's say the empirical IME adjustment you
12 got to outpatient payments and see what you got from that,
13 for instance, would be one simple way then trying to derive
14 something.

15 MR. HACKBARTH: You're saying still use a
16 resident-to-bed ratio, just relate it to outpatient
17 department costs?

18 MR. LISK: Right.

19 One thing I want to get back to on Karen was to
20 make clear, in terms of the resident-to-bed ratio, the
21 resident count is the residents in the hospital. And that's
22 both the residents who are in the outpatient portion of the

1 hospital and the inpatient portion of the hospital. So if a
2 hospital has a large outpatient activity and smaller
3 inpatient care, the resident-to-bed ratio is actually going
4 to be even higher than they otherwise would be. So they
5 would actually be getting potentially more money than
6 another hospital where it wasn't as active and they had just
7 more beds.

8 DR. BORMAN: Only if they have a lot of inpatient
9 Medicare patients, though.

10 MR. LISK: Right. That's an issue of in terms of
11 where you're making the adjustment to. I just wanted to
12 say, in terms of the resident intensity measure, it is a
13 problem coming up with -- what would you get? I think there
14 would be a lot of controversy over what you'd do if you said
15 resident to average -- to some measure of -- help me, Jack,
16 in terms of some of the numbers that we sometimes used.
17 Adjusted admissions, for instance. There could be a lot of
18 controversy over that.

19 So that's one of the problems that you arrive at
20 when you come up to considering some of these alternative
21 measures.

22 DR. BORMAN: My concern is that we don't know, and

1 I frankly don't know on a database that the proportionate
2 add on of teaching, whether there is some significant
3 variation across the site of service and how that plays out
4 in making some of these projections. As Ralph pointed out
5 when you talk total Medicare margin, perhaps you sweep some
6 of that up. But I think as we continue to push things to
7 the outpatient side of things, also I think that a fair
8 number of teaching hospitals -- and mine may be a little
9 different than Ralph's in this regard -- that a lot of stuff
10 gets done in perhaps a hospital outpatient department
11 setting that in other areas might get done in an ASC or an
12 office or a different site of service setting that perhaps
13 drives some of the teaching costs.

14 I continue to worry a bit about are we reflecting
15 current delivery systems? And then as we start to talk
16 about what are the measures and the accountability pieces
17 that we should put to this to try and pick those out to the
18 care delivery system that we see? And that is an outpatient
19 weighted one.

20 MR. HACKBARTH: What I would suggest, I think your
21 point is a good one. I don't think that it's something that
22 we can resolve in his cycle. But we can certainly flag it

1 as an issue in the text, both for our own future reference
2 and for others.

3 MS. HANSEN: My point really goes hand in hand
4 with what you brought up, Karen, about the teaching locus
5 that is shifting over time because of the delivery systems,
6 where more and more chronic disease is going to be managed.
7 How do we look at that?

8 But a broader question, and I know it's not the
9 issue here, per se, because it's more the question of the
10 interrelationship of GME and IME. I'd like to bring it back
11 to the question of what we buy for the Medicare funding and
12 how oftentimes there seems to be such little tangible
13 product of the issue of geriatric care, as part of what
14 we're buying for the Medicare funds.

15 By that I mean there are teachings within the
16 disciplines of cardiology, urology and so forth. But the
17 whole aspect of looking at the interplay of geriatrics, and
18 since this is Medicare funded, and even on the inpatient
19 side about 40 percent of the patients oftentimes are older
20 patients, the ability to have the accountability for
21 educating for that content.

22 So again, I know the IME is different certainly

1 for what you pay for the GME. But on the beneficiary side,
2 which I oftentimes come back to, ultimately are they getting
3 the best practices, the best evidence, the safest care
4 because of their oftentimes comorbidities.

5 So that is, again, beyond this. But it goes raise
6 both the IME and the GME for me.

7 DR. HOLTZ-EAKIN: Just briefly, these dollars
8 clearly seem to have suffered big mission drift. At this
9 point, we have this large sum of money that's above the cost
10 of either care in a teaching setting or to low income
11 people. And my instant reflex was yours, which was budget
12 savings.

13 But if that's not really a feasible route, there
14 are all these situations which we want to have funds to
15 pursue coordination in care, bridging the inpatient and the
16 docs, whatever. We ought to get something, in moving this
17 agenda forward, for this money. We ought to pull them aside
18 instead of plowing them back in the base, and get something
19 specific for the money above the empirical level.

20 We've got long list of things we started the day
21 with.

22 DR. CASTELLANOS: I think what we're trying to do

1 is realign payments to costs.

2 One of the concerns that I have is a point that
3 when Nancy was here -- Nancy's here -- brought up last time
4 as to whether the underlying policies, the objectives of the
5 underlying policies. Are they still applicable? And is
6 this what we should be looking at before we made some
7 adjustments?

8 Karen made a very good point about measurement.
9 We've talked about the resident-to-bed measurement. We've
10 talked about a lot of ways of measuring that.

11 I had lunch with Ralph today and we talked about
12 the costs of post-graduate education. That's a rapidly
13 changing thing. Are we really capturing those costs, what
14 it costs the hospital or the university to teach these
15 residents, the workforce in the future? It's a dramatic
16 change out there.

17 Karen, I know there's an -- residents now only can
18 work 80 hours.

19 MR. HACKBARTH: Are you talking about the direct
20 side Ron?

21 DR. CASTELLANOS: I'm talking about aligning costs
22 to make sure we're capturing the right costs. And

1 especially in IME, I'd like to make sure that the costs that
2 are being -- it's outstanding what it costs now to teach
3 residents. There are a lot of hidden costs going on now and
4 there's one that residents can only -- residents are our
5 workforce. They can only work 80 hours a week now. After
6 that, they leave and you have to hire somebody to take their
7 place. And that's an added cost to medical education.

8 I'm very, very concerned about that because of the
9 downstream effect. If we start cutting the residents or
10 putting out the residents or putting out the skilled
11 workforce in the future, we've already talked several times
12 about the effect that that may have on access to care to the
13 Medicare patient.

14 MR. HACKBARTH: Let me get some help here. If
15 we're talking about the specific example that you raised,
16 that you've got to hire another physician to make up for the
17 fact that residents are only working 80 hours, that would
18 show up in the Medicare cost report. A piece of it would be
19 allocated to Medicare based on Medicare's share of the
20 total.

21 When you do the empirically justified amount, you
22 would see that hospitals that have more intensive teaching

1 activity would have higher costs and that would push up the
2 empirically justified amount; right?

3 MR. LISK: Right.

4 MR. HACKBARTH: There's a lag in the data. We're
5 doing 2004 data and it may not reflect the most recent
6 developments there. But it should flow through these
7 calculations.

8 DR. KANE: Glenn, that should actually lower your
9 costs.

10 DR. REISCHAUER: It should raise your revenues and
11 keep your costs the same.

12 DR. KANE: You could pay a resident \$40,000 a
13 year to see patients, and that was cheap. What's happening
14 is you can't do that anymore. It's not a cost of training.
15 It's a cost of taking care of your patients, that you have
16 limited to 80 hours. The doctor who's coming in to replace
17 it is a full doctor, who can bill as a doctor. That's not a
18 training cost.

19 MR. ASHBY: But the resident's salary is in GME,
20 though.

21 DR. KANE: It's not a training cost. It's not a
22 training cost.

1 MR. LISK: There are two things that happen. One,
2 if it's a physician, the physician may bill for the service
3 where it otherwise wouldn't, so it might show up in Part B
4 services. If it's not a physician, it may show up in higher
5 patient care costs. Not training costs, but higher patient
6 care costs. Our estimate would reflect that, to that
7 extent.

8 The other things that were being talked about are
9 direct GME costs, which we have excluded from this analysis.

10 DR. BORMAN: Before we throw out the baby with the
11 bath water on this one, I just need to make one comment.
12 Getting away from this staffing hours business, because
13 there's a whole host of issues wrapped up in that and I
14 don't think we want to go there.

15 But there are, as Ron has pointed out, medical
16 education, like lots of education, is changing a fair
17 amount. And for example, simulation education is a pretty
18 expensive thing that's not an employee cost, a supply cost.
19 But it is something, for example, all the general surgery
20 programs by 2008 will have to have in place, onsite, a
21 fairly sophisticated simulation laboratory. So the
22 physicians who come out of that will be taking care of

1 Medicare beneficiaries. So there are some education costs
2 that are, I believe, IME potential costs that are changing.
3 That's important to know.

4 DR. MILSTEIN: This is, I think, I want to speak
5 in support of at least the text reflecting Jennie's comment
6 about at least putting our toe in the water with respect to
7 getting information on the nature of what we're getting back
8 in exchange for our medical education dollars. For example,
9 one interpretation of Jennie's comment would be that maybe
10 we don't start out linking the payments to the percentage
11 geriatrics training, though I personally would favor us
12 ultimately landing there. But at least getting information
13 on percentage of faculty FTE that specialized in geriatrics.

14 I feel the same way about this issue that a number
15 of us have commented on with respect to content of medical
16 teaching. So it would not -- maybe the text might also
17 reflect the broader concept, that irrespective of whether we
18 "right-size", what we're paying for this to approximate what
19 it really costs based on the empirical model. I would
20 suggest that the text reflect Jennie's comment and other
21 aspects of information about what we're getting that we
22 believe is important to the objectives we were talking about

1 this morning, such as the percentage of faculty FTE that
2 reflect a faculty whose primary area of research and
3 teaching is clinical systems engineering, clinical
4 informatics, the things that are key to improving the
5 efficiency of the Medicare program.

6 MS. BEHROOZI: On the subject of looking at
7 overall margins and mission drift. I guess, in fact, there
8 has been mission drift, and Congress has endorsed it by
9 continuing to maintain the higher than empirically justified
10 levels of payment. And so as we go forward and look at what
11 else we can do with that excess money, readjusting it to
12 meet some of the goals that have now become part of the
13 drifted mission or whatever might be successful. But I
14 think we would need to look at the impact on things like
15 loss of standby readiness or trauma centers or things like
16 that, and not just look at it from the perspective of what
17 are we paying for. But what would we lose if we shift the
18 payments over?

19 Will there be hospitals whose overall margins go
20 down significantly enough that they can't provide those
21 services, those other social goods that seem to be
22 encompassed in what Congress keeps paying that extra money

1 for?

2 MR. HACKBARTH: Just a couple of concluding
3 thoughts. One is Ralph noted at the outset that last time
4 we talked more about IME than DSH. I know I'm guilty of
5 that, if it's a crime. The reason I tend to do that is that
6 actually DSH seems like a much simpler problem to work
7 through.

8 Conceptually, I think that Congress has made it
9 clear that it sees this not as a Medicare issue but a
10 broader social mission. How do we help to provide support
11 to institutions that care for people that otherwise might go
12 without care? Namely people without insurance and who are a
13 burden to institutions, a financial burden.

14 The solution to that is relatively
15 straightforward. Let's not use Medicaid and low-income
16 Medicare share numbers to allocate the dollars. Let's get
17 data on uncompensated care and rewrite the formula on that
18 basis. I don't think that's mysterious. I think it's
19 doable. We've had sort of a false start here with the
20 collection of those data.

21 I would like to see us, in this report, reiterate
22 our eagerness to have those data collected. We support

1 Congress on that. It had mandated that they be collected.
2 Let's get it done and let's get it done quickly so that we
3 can evaluate policy options for how to distribute those
4 dollars.

5 That's why I tend not to talk about DSH. At least
6 in my mind it's a pretty straightforward thing to address.
7 I see Doug doesn't think so.

8 IME, I think, is more complex. I think that --
9 this is just my perspective again -- is that there's a blend
10 of social missions here, and also some Medicare payment
11 policy involved, if I understood the history of this
12 particular adjustment. At least part of the rationale, as
13 was pointed out by Jack at the beginning, was an expectation
14 that teaching hospitals would fare poorly under Medicare
15 under prospective payment. And a piece of that concern had
16 to do with severity and the possibility or likelihood that
17 teaching hospitals would be handling systematically
18 different patients than the average community hospital, more
19 complex patients and more costly patients.

20 We know that there are more direct ways to deal
21 with that issue. In fact, MedPAC has recommended multiple
22 times, including very recently, adoption of a severity

1 measure in the payment system so that we fairly compensate
2 those institutions who do care for the sickest patients.

3 I think that relates to the IME adjustment
4 potentially and that at least some piece of IME may be
5 appropriately put back in the base concurrent with a
6 severity adjustment that will move money to those
7 institutions.

8 That's an idea that I think is worth our
9 considering.

10 So let me just stop there for now. This is an
11 issue on which we won't be voting next month. Any votes we
12 have on this will come in January, so we'll have a couple of
13 other opportunities to get our heads together and decide
14 what sort of draft recommendations we want to consider. I
15 don't think we need to belabor it more right now.

16 I think we're making progress, but it's going to
17 take a lot longer to get to a destination.

18 Thank you very much and let's move on to wage
19 index. We're going from the major philosophical to the much
20 more operational, shall we say.

21 MR. GLASS: Good afternoon. We're going to
22 discuss the wage index, another one of those payment

1 adjustments, this one a little less arcane. The idea is to
2 adjust because it costs more to hire a nurse in some parts
3 of the country than others. That's the basic idea of it.

4 We talked about this in April. I'm going to try
5 to hit the things that have changed, the progress since
6 then. But if there are any questions, of course, we can
7 answer them at the end.

8 The current approach uses data from hospital cost
9 reports. The IG has raised some questions about the
10 accuracy of some of that data. They use that data to
11 calculate an average wage for market areas. The market
12 areas used are MSAs, metropolitan statistical areas and a
13 statewide rural area for all the counties that aren't in an
14 MSA in a state.

15 The area's average wage is then compared to
16 national average wage and that gives the wage index.
17 There's a separate adjustment for operational mix, which
18 we'll talk about in a minute. And geographic
19 reclassifications, rural floors and such like end up
20 changing about a third of the hospitals' calculated wage
21 index. So there are a lot of exceptions, as Glenn
22 mentioned. Exceptions tend to breed exceptions in the

1 Medicare program.

2 What we have been looking at is exploring the idea
3 of using another source of data, namely Bureau of Labor
4 Statistics data and the Census data to form a wage index, to
5 try to get away from some of the problems that have been
6 seen in the current one. What we do is we use the BLS data
7 in our first step to calculate relative wages for each
8 market area. We do that using the data from all employers
9 in an area for each occupation in the area. And then we
10 look at the weight of occupations in a particular industry
11 such as hospitals for the nation as a whole and use that
12 fixed occupational weight technique to create something
13 called a Laspeyres index, which has some nice properties.
14 That would give us a wage index for each market area.

15 We then use Census county level data to adjust
16 within each market area to a county level. So at the end of
17 the second step we essentially have a county level wage
18 index.

19 And then finally, in a third step, we smooth
20 between adjacent counties to reach what we call a target
21 difference that we find acceptable between bordering areas.
22 The point of all this is to lesson the need or desire for

1 exceptions by making sure that areas that border each other
2 don't have profoundly different wages index. This is easier
3 to see, really, than to talk about.

4 If you look at this, this is the CMS wage indexes,
5 and you can see that there's sharp differences between
6 market areas here. The dark red is the highest wage index
7 here, and that's the Atlanta MSA. This is the state of
8 Georgia.

9 In the Atlanta MSA, you'll note that it's a dark
10 red and that all the counties in that MSA -- and there's 28
11 of them or something -- are all the same color. You'll also
12 note that it's right next to the yellow, which is the lowest
13 wage index, and that happens to be the statewide rural value
14 for Georgia. It's those big differences that drive people
15 to seek exceptions to the wage index and that raise
16 questions about it.

17 The other colored areas there, the red and
18 oranges, are also smaller MSAs in Georgia, and in other
19 states, too.

20 These differences are more gradual when we move to
21 the BLS/Census kind of county level index. Here what we've
22 done is, within the Atlanta MSA, for example, we've allowed

1 the wage index to differ by county. And using the Census
2 data we do that. We discovered that the central counties
3 there tend to have a higher wage index than the counties at
4 the periphery of the MSA. This results in less abrupt wage
5 index cliffs between the MSA and the statewide rural and in
6 other bordering regions. That's our step two.

7 Finally, if we look at our BLS/Census smoothed
8 wage index, as we call it, no sharp difference remain. Here
9 we've taken an algorithm, which we detail in the paper, and
10 basically we've eliminated any difference over 0.1. So here
11 presumably the desire for exceptions from the wage index
12 would be less because you wouldn't be across the border from
13 a neighboring hospital who has a much higher wage index.

14 So that's generally what we've been attempting to
15 do.

16 Here's some differences between the approaches, as
17 I mentioned hospital data only versus all employers. That
18 kind of goes to what is the goal of the wage index. Are you
19 trying to account for underlying wage differences or match
20 hospital costs? If you're trying to account for underlying
21 wage differences, then the new approach might make more
22 sense.

1 One limitation of the new approach is it looks at
2 wages only as opposed to wages and benefits in the current
3 approach. Of course, in the current approach some of those
4 benefit costs, particularly pension costs, are the ones that
5 the IG has found may have some difficulties involved with
6 them.

7 The new approach, the Laspeyres technique,
8 automatically adjusts for occupational mix. So you don't
9 need to go through the other. In the current system you
10 have to have an additional survey and an adjustment needed
11 for occupational mix.

12 Occupational mix means that your average wage is
13 different because you are using a different mix of workers,
14 more skilled workers and fewer unskilled workers, for
15 example, would give you a higher occupational mix.

16 They now have a survey that they're doing to ask
17 hospitals about that mix of nursing in particular. They
18 then use it to adjust the wage index. There's been some
19 issues about that, as well.

20 Finally, the smooth county approach gives you very
21 little difference between neighboring areas and presumably
22 would lessen the need for exceptions.

1 So we looked at a couple of measures of
2 performance, if you will, for the wage indexes. And we
3 found that if you look at the year to year changes, they're
4 small under the new approach. You can see here that they're
5 smaller at the median, the 90th and 95th percentile.
6 They're about half, in fact.

7 Since you wouldn't expect the wage index to change
8 a lot from year to year, that makes sense. It makes sense
9 also because the BLS numbers are a three-year running
10 average so you would expect not to have major jumps.

11 We also find we have less extreme wage index
12 values under the new approach. Although the two wage index
13 are very highly correlated, the two being the CMS and the
14 one we came up with -- and we're talking about 0.87 at the
15 market level or 0.92 at the hospital levels, they're very
16 highly correlated. The new approach has lower values than
17 the current values when those current values are very high,
18 above 1.2. And it also tends to have fewer very low values.
19 That could be because ours automatically takes occupational
20 mix into account.

21 So in the next steps we're going to compare it to
22 the new occupational mix adjusted wage index, which was

1 released Friday at five o'clock or something. So we're
2 going to do some analysis there and try to understand where
3 the differences lie and do things make sense? Does their
4 new occupational mix adjustment move their index closer to
5 ours, and that sort of thing?

6 We wanted to understand the explanatory power. We
7 wanted to see if we could predict hospitals' costs per case.
8 The results, though very similar, the new approach may
9 explain a little less which again kind of makes sense
10 because payments may influence costs. That is, if you've
11 been paying a hospital a lot they may have raised their
12 costs to match the payments. So that doesn't seem
13 unreasonable. And also, the new data doesn't include
14 benefit costs. So since the costs per case we're measuring
15 against does, that also would tend to explain a little less.

16 As we said, you don't need an occupational mix
17 adjustment under the new approach. I guess I won't go
18 through this at length. The point is that this was due to a
19 recent court case that they've had to move to 100 percent
20 adjustment to occupational mix in FY '07. Both the survey
21 and the calculation are untested. So we've looked a little
22 bit at this new index that they've come out with and it

1 seems to not have changed things too much. For half the
2 hospitals, the adjusted and unadjusted are within about 1
3 percent and there are not too many cases with really extreme
4 values.

5 That's the current approach. The new one you
6 wouldn't need to be doing any of that.

7 The final one that I'll talk to a little bit is
8 that the new approach can tailor wage index for other
9 sectors. Currently, most of the other payment systems in
10 Medicare use the pre-reclassification hospital wage index.
11 That's before you make any of the exceptions. There are
12 some difficulties with that. First of all, there really may
13 be no IPPS hospitals in an area where you do have a nursing
14 home or where you have home health residents. And so the
15 index may not be really accurate for those areas.

16 About half the counties no longer have a PPS
17 hospital in it. And that's partly because CAHs are no
18 longer in the prospective payment system for inpatient and
19 therefore are not in the wage index calculation. So that
20 can be a problem if you're in the far east of the state and
21 the only PPS hospital is in the far west part of the state.
22 That's a difficulty.

1 Another one that seems to really rankle providers
2 is that the hospital that you're a neighbor to in your area
3 could be reclassified. Now when they get reclassified, they
4 get a higher wage index. However, say the SNF that's
5 neighboring that hospital gets their pre-reclassified wage
6 index and therefore doesn't get the higher wage index. That
7 does rankle providers and they raise that as an issue of
8 equity.

9 The new approach, you basically can use the same
10 data because the data in the area wages for each occupation
11 would stay exactly the same because they're from all
12 employers to begin with. The only thing that would differ
13 would be the vector of occupational weights that you use for
14 home health agencies or nursing homes or hospitals because
15 they use a different mix of employees.

16 We also include employer data from all counties so
17 we don't have to worry about this thing that there's no
18 hospital in your areas.

19 So we think that this would certainly seem to
20 theoretically be a better model for the other sectors. And
21 it would be relatively easy to compute it, not a tremendous
22 amount more burden on CMS.

1 It also might not make a tremendous amount of
2 difference because the occupations, though different, may
3 not differ by all that much. The indexes may be very
4 similar. We're investigating that.

5 So in summary, the new approach would have a
6 couple of advantages. The data represents the entire
7 market. It reduces circularity. And by circularity we mean
8 now if your hospital is a very good manager and keeps the
9 wages down, your reward from CMS is that your wage index
10 will be lowered. So some hospitals come to us and say this
11 just really isn't fair. We're keeping our wages under
12 control and every time we do it we get hammered on the
13 calculation of the wage index.

14 Because this would look at data from the entire
15 market, versus just hospitals, it would resolve, to some
16 extent, the circularity problem.

17 We find it to be less volatile over time,
18 automatically adjust for occupational mix. Smaller
19 difference across borders, which is very important to reduce
20 the exceptions and the desire for reclassification. We
21 think it would be more equitable for other types of
22 providers, that is SNFs, home health agencies, et cetera.

1 There would be less data burden on hospitals. In fact,
2 there would be no data burden on hospitals because they
3 wouldn't have to provide any additional data, fill out any
4 additional surveys or anything.

5 The disadvantage is the data is not hospital
6 specific. That goes to this question of do you want to look
7 at underlying wages or do you want to try to match hospital
8 costs exactly? So if you think you want to do the latter,
9 then this is a problem.

10 It's wages only not wages and benefits. That's
11 one that we want to look into a little bit more, to see if
12 that really is an important thing.

13 As we've said, it explains slightly less variation
14 in hospital costs. And of course, it would create new
15 winners and losers, which is the big issue for many people.

16 Thank you.

17 MS. DePARLE: This sure seems like it could be a
18 giant leap for mankind. I'm wondering what I'm missing,
19 because if you just took the number of person hours that
20 have been spent by so many staffs around this town and
21 computing these numbers and trying to get hospitals from one
22 area into another.

1 So on your list of caveats, you've talked about a
2 couple of them. But one of them I wanted you to talk a
3 little bit more about, which is -- well, you just mentioned
4 one, about it not being hospital-specific. But I don't see
5 that as a problem. I think really what you've proposed here
6 gets more to what should be our policy objective anyway.
7 And it's simpler for the hospitals, administratively less
8 burdensome, and creates a level playing field for others who
9 are trying to hire the same people, which is a complaint we
10 hear from other providers a lot. So I like that.

11 But you make a point in here about the data do not
12 report wages for some occupations in some geographic areas
13 because there are not enough people in the sample, and that
14 you've used some techniques to get around that. Can you
15 elaborate on what that problem is and how significant it is?

16 MR. GLASS: I should mention that Abt Associates
17 actually did many of these calculations for us, so they know
18 the great details of this.

19 But particularly in the Census data, Census data
20 is from the Decennial Census long form. If you have a
21 county with a very low population, the sample there is going
22 to be pretty small. So they may not catch every occupation

1 that we may want to look at, respiratory therapist or
2 something small like that.

3 So what we've done is, if the Census data is
4 missing a value in say some small county, then what we do is
5 substitute the market area wage for that occupation and then
6 do the calculation from there. I think that works fine.

7 MS. DePARLE: How big would the market area be?
8 Let's say you are dealing with a rural county and you don't
9 have a number for respiratory therapist.

10 MR. GLASS: Then it would be the statewide rural
11 market area.

12 MS. DePARLE: Which would be likely to be higher,
13 wouldn't it? Because it would also include urban areas.

14 MR. GLASS: Yes. In general, yes.

15 DR. MILLER: Statewide, not rest of state.

16 MR. GLASS: Statewide rural, which is the rest of
17 the state. All the counties that are not in an MSA.

18 MS. DePARLE: Statewide rural.

19 MR. GLASS: Yes, but if it's the county that's
20 way out in the corner instead of the one right next to the
21 MSA, then the wage we're substituting might be a little bit
22 higher. And that's why we did it that way, because it kind

1 of retains the integrity of the market area a little bit.

2 MS. DePARLE: It would be interesting and look at
3 some counties and pretend they don't have that data, and
4 what decision role would you use? And what result would
5 come up with? To see if it really would be unfair.

6 Because just not having to spend the time
7 collecting this data and calculating it and auditing it and
8 all that would be billions probably.

9 MR. GLASS: And again, as someone mentioned, you
10 have to compare it to what they do now. And what they do
11 now would be comparing it to the data gathered from
12 hospitals. There's probably not a hospital there either.
13 And if it is, it's a CAH and doesn't count in the wage
14 index. So compared to the current, I don't think you're
15 losing a lot of information.

16 MR. HACKBARTH: David, the current system hardly
17 seems to justify the term gold standard. But it is where we
18 are. So a practical consideration is how dollars would
19 shift under this system compared to the existing one. And
20 set aside the reclassified hospitals for a second, where you
21 might have quite dramatic shifts.

22 But if you just take non-reclassified hospitals,

1 current system versus the new system, do we have any sense
2 of how much money is moving around the system? Or what
3 patterns might exist in that redistribution?

4 MR. GLASS: The one major pattern is that in
5 places where you have very high wages, the wage index is now
6 above 1.2, those areas will see a lower wage index under the
7 system we've been exploring. That's the real bottom line
8 biggest difference. Otherwise, it's very closely correlated
9 but there's a lot of bouncing around.

10 DR. HOLTZ-EAKIN: I'm just curious. I gather one
11 of the complaints with the current system is year-to-year
12 volatility. Did you do this for more than one year?
13 Because if you're going to have these small cells and these
14 sampling problems, I could be concerned that from 2006 to
15 2007 you might very different answers in some of these
16 locations.

17 Do you know what the year-to-year --

18 MR. GLASS: We showed the year to year volatility.

19 DR. HOLTZ-EAKIN: In the new approach?

20 MR. GLASS: In the new approach versus the old
21 approach. It's this one.

22 Remember, the BLS data that we're using is

1 actually -- say the 2005 BLS data includes data from 2003,
2 2004, 2005. So that cuts it down a bit. And the Census is
3 decennial. It doesn't change at all, which could be a
4 problem.

5 MS. BEHROOZI: Remember, I provide benefits to a
6 unionized workforce in the health care industry. So
7 starting from there, take this for what it's worth.

8 Unlike the things that we were just discussing
9 previously, which had a pretty low correlation to the things
10 that they were supposed to compensate for, and you should
11 correct me if I'm wrong, this seems to have a relatively
12 higher correlation to what we think we're paying for. In
13 other words, the money that we're giving institutions, they
14 are passing along to people who do the work of providing
15 care for the most part. More than IME pays for the
16 empirically justified level of IME or DSH pays for --

17 MR. GLASS: Yes.

18 MS. BEHROOZI: Two heads nodding, great. I'll
19 move on from there.

20 So it seems to me to the new method would explain
21 slightly less of the variation in hospital costs or, as you
22 said, those that are currently at a high wage index level

1 would come down and those that are currently at a low wage
2 index level would come up, you're moving away from the
3 correlation to the actual costs. In other words, people or
4 institutions that are currently paying less, have a lower
5 wage index level, would be rewarded not for passing along
6 that additional payment that they would then receive to
7 their workforce, but it would go into their margin or
8 whatever.

9 And those that experience the higher cost would
10 have to find some other way to cover those higher costs.

11 MR. GLASS: Jeff, do you want to talk about the
12 regression results a little bit?

13 DR. STENSLAND: You're basically right. That
14 concept is right. But I don't want to oversell the
15 difference here. And we're still fine-tuning the regression
16 results. But this is what percentage of the costs can be
17 explained by these different models? And maybe if we switch
18 from the old model to this new model, maybe we're talking
19 about explaining maybe 1 or 2 percent less of the cost, kind
20 of on an r-squared basis for the economists out there. It's
21 a 0.01 or 0.02 difference.

22 So it's a real slightly less explanatory power.

1 And it's not clear that you actually would think that's a
2 bad thing. And that gets back to that circularity idea.
3 It's kind of a fundamental, philosophical question that's
4 really beyond what we do. And that's what do you want to be
5 paying fo. Do you want to be paying for the hospital's
6 costs or do you want to be paying for the underlying wages
7 in the area?

8 MR. HACKBARTH: Even under the current system,
9 since it's a prospective system, the hospital is not being
10 paid for its wage levels. It still has the incentive to pay
11 as little as it can relative to others because the wage
12 index isn't made up of its wages alone, but it's a
13 composite.

14 So that incentive exists under both the current
15 system and this system. If you pay more wages, you're not
16 reimbursed for those under either system.

17 MR. GLASS: You can also say do you want to move
18 to --

19 MS. BEHROOZI: Not directly. I understand.

20 MR. GLASS: We're trying to stay away from cost-
21 based reimbursement, in general.

22 MS. BEHROOZI: I understand it's not direct, but

1 if you're in a market where the employers in the industry
2 have valued the labor that's put into the product at a
3 certain level, for that product, they're going to be able to
4 see the recognition of that in their rates, as opposed to
5 having less recognition of that.

6 But one of the particular items that you
7 mentioned, I think you list it right there, that benefits
8 are not included in the calculation. And that, to me,
9 that's a big red flag that you're going towards some kind of
10 notion of what's valuable that frankly I couldn't support.

11 I'm sorry, so explain that to me. It's leaving
12 out the cost of benefits, which we provide health coverage
13 via Medicare. We should want the employers who provide
14 those services to be covering health care for their
15 employees.

16 MR. HACKBARTH: Basically, you would be assuming
17 that benefits are proportional to wages on a fairly
18 consistent basis.

19 MS. BEHROOZI: But that's not necessarily true,
20 because especially as health care has gotten so much more
21 expensive there are places -- and again, I'm coming at this
22 from a collective bargaining perspective, where workers and

1 management negotiate over how labor costs should be
2 allocated. And so you may find in some markets where there
3 is a conscious decision to essentially defer wage increases
4 and put them onto the benefit side instead. And you can't
5 presume that that's consistent across the country or across
6 different industries even within a region, which is all
7 collapsed in BLS data.

8 MR. GLASS: That's exactly correct. And that's
9 why we raised it as a point. And we're going to try to do
10 some analysis to see really if we can tease out what the
11 effects of that are. One of the difficulties will be that
12 in the hospital cost reports one of those benefits is
13 pensions. And the way that's accounted for, apparently, as
14 I understand it, is kind of abstruse and not only
15 consistent. The IG seems to be finding some -- what they
16 consider, at least, to be incorrect reporting of pension
17 costs.

18 Your point is right, but we're going to try to
19 understand it a little better. It's not clear exactly how
20 it all works out and whether the wages and benefits being
21 reported in the current wage index are exactly right anyway.

22 MS. BEHROOZI: One last point, in terms of

1 adopting BLS data, obviously we would be adopting whatever
2 methodological flaws it had. You were referring to Census
3 data earlier. But in your paper you refer to the fact that
4 they use surveys of employers. I don't know how reliable
5 that is, what the sample sizes are, whether that could be
6 audited. I understand, Nancy-Ann, that it's a nightmare to
7 have to do it all yourself. But to use something else as a
8 substitute, I think we would want to have some -- we would
9 want to be able to rely on it.

10 MR. GLASS: We went in and we talked to people at
11 BLS to get some understanding of what they do. What was the
12 number? It's in the paper, the number. It's like 200,000
13 establishments are sampled every six months or something.
14 And this would be six of those, so 1.2 million
15 establishments.

16 I think they're pretty rigorous about how they do
17 it and they even send people out to the establishments in
18 some cases and see what they're reporting and whether
19 they're reporting the correct thing for each. So as data
20 goes, it's pretty good.

21 MR. HACKBARTH: Other comments?

22 DR. REISCHAUER: If you wanted to make an

1 adjustment which would largely be a social value statement,
2 you could take there are certain fringe benefits that are
3 related to wage levels, pension contributions and things
4 like that usually are -- I'm having a hard time. I'm going
5 to look over here.

6 [Laughter.]

7 DR. REISCHAUER: And then there are certain things
8 like health insurance which are flat amounts across all and
9 you can create notional components and just add them on to
10 your system and you'd get a rough adjustment.

11 MS. BEHROOZI: But if employers are not providing
12 it, then they shouldn't get that adjustment; right?

13 DR. REISCHAUER: But the same flaw exists now in
14 the system. And the question is are you improving on what
15 you have now?

16 MR. HACKBARTH: Nick, the last word on this one.

17 DR. WOLTER: I had the same question you did,
18 Glenn. And specifically are we going to see any more
19 modeling and quantification of the redistribution effects,
20 other than the amount above 1.2? And are there qualitative
21 aspects of that we should look at, rural/urban, large/small,
22 et cetera? Or is it so minor that that's not worth doing?

1 And then the other question I had, if we do a
2 recommendation on this, would we be accompanying that with a
3 recommendation that reclassification be eliminated,
4 including those that have already been reclassified? Or is
5 that a separate topic?

6 MR. HACKBARTH: It is a separate topic logically,
7 but it's an immediate topic on the path to actually getting
8 any change. One of the biggest challenges in changing this
9 area of the payment system is that there has been so much
10 reclassification. So many institutions now have
11 substantially higher wage index than either the old system
12 or the new system would give them, that they will resist,
13 understandably, any change.

14 So even if you have a perfect analytic system, the
15 transition is a very big part of the challenge.

16 Would you respond to the first question?

17 DR. MILLER: I think the expectation is we're
18 going to work through a few more problems that David and
19 Jeff pointed out, and that the sense would be that we would
20 give you some sense of what the impacts of this would be.
21 We wouldn't expect you guys to consider it in the absence of
22 that.

1 To your second point, I hadn't even gone far
2 enough to start thinking about recommendations. Off the
3 cuff, I think you would probably have to think about that at
4 the same time that you were thinking about proposing
5 something like this, because otherwise I think it would
6 defeat the purpose.

7 But the sense is to work through some of these
8 problems, including the benefit problems and a few other
9 things that we tried to point out here, and then give you a
10 more complete run-through of things, another pass at this.
11 And then get up to so what do you want to do?

12 MR. HACKBARTH: Mark, is this an item on which you
13 expect to see us drafting a recommendation and voting this
14 year?

15 DR. MILLER: If we did this, and I'm looking at
16 Sarah for some confirmation here, I would expect it in the
17 second part of our cycle, after the January meeting. Do you
18 agree?

19 If Sarah says so, then that's what we were
20 thinking.

21 MR. HACKBARTH: Thank you.

22 The last item for today is an update on Part D,

1 trends in enrollment and some payment issues.

2 DR. SCHMIDT: I'm just glad my husband has daycare
3 pickup duty today.

4 Today I'm going to brief you on an updated
5 analysis we've done on Part D plans.

6 Recall in our June reports, that included a
7 chapter that discussed plan offering, including the benefit
8 designs, premiums and formularies of Part D plans. And now
9 that the initial enrollment period for Part D is well over,
10 we can give you a sense of the characteristics of plans in
11 which most beneficiaries enrolled.

12 You may have heard that CMS released some
13 information late last week about the benefits and premiums
14 of Part D plans for 2007. Let me say from the start here
15 that most of my briefing will be describing what's happening
16 for 2006, not what will be available next year. However, we
17 will discuss some recent decisions about CMS about how it
18 has set payment rates and low-income subsidies for 2007.

19 Here are the main takeaway points for this
20 briefing. Before the start of Part D estimates were that
21 about 75 percent of Medicare beneficiaries had drug
22 coverage. Today CMS estimates that about 90 percent of

1 beneficiaries have either Part D coverage or another source
2 of drug coverage that's at least as generous as Part D.

3 Beneficiaries enrolled in Part D plans tend to be
4 highly concentrated in plans offered by a small number of
5 parent organizations where that organization is offering a
6 similar benefit design across most or all of the country.
7 Part D enrollees are currently paying a premium of about \$24
8 per month, which is much lower than what was originally
9 predicted. So enrollees tend to be concentrated in lower
10 premium plans.

11 More than half of all enrollees in stand-alone
12 PDPs receive Part D's low income subsidies, which are extra
13 benefits that pay for most or all of the premiums and cost
14 sharing on behalf of those beneficiaries. That's a much
15 larger share of total enrollment than the low-income subsidy
16 beneficiaries make up for Medicare Advantage prescription
17 drug plans.

18 Under current law, CMS is supposed to use
19 enrollment information for 2006 to help it set monthly
20 payments and enrollee premiums and low-income premium
21 subsidy amounts for 2007. This enrollment weighting would
22 have had the effect of lowering plan payments and increasing

1 plan premiums for all enrollees. It also would have lowered
2 the number of plans that low-income subsidy recipients can
3 enroll in without having to pay a premium.

4 Instead, CMS has begun two demonstrations for 2007
5 to set monthly payments to plans and low-income premium
6 subsidy amounts in a way that's similar to what they did for
7 2006 when the Agency didn't know any sorts of enrollment
8 levels for individual PDPs. This leads to fewer transition
9 problems for enrollees, but higher Medicare program
10 spending.

11 Let's take a look at the enrollment levels for
12 Part D. These are data as of mid-June. There is some more
13 recent data for certain categories that CMS has released but
14 it hasn't fundamentally changed this picture.

15 About 16.4 million beneficiaries -- that's shown
16 in the box up on the screen there -- are people who are
17 enrolled in PDPs, stand-alone prescription drug plans. This
18 includes people who enrolled on their own plus dual
19 eligibles that were auto-assigned into plans by CMS. I'll
20 describe that process in a minute.

21 Another 6 million are in Medicare Advantage
22 prescription drug plans. So 52 percent are in Part D plans.

1 Other individuals have other sources of coverage that are at
2 least as generous as Part D. For example, Medicare pays
3 some employers to remain the primary source of retiree drug
4 coverage. Plus there are other sources of creditable
5 coverage. All together, the combination of those other
6 sources and Part D enrollment make up about 90 percent of
7 beneficiaries who have such coverage. Again, that's
8 compared to about 75 percent before the start of Part D.

9 I'm going to show you several pie charts that
10 based on enrollment data that we got from CMS that reflect
11 enrollment levels as of July 1st. The total numbers of
12 beneficiaries are going to be slightly different from what I
13 just showed you in the previous slide because we've excluded
14 certain types of plans, employer-only groups, plans in the
15 U.S. territories, cost plans, SNPs, PACE, et cetera. We did
16 this to give you a sense of what Part D enrollment looks
17 like among plans that are open to most beneficiaries.

18 So in our data file we've got a total of 15.5
19 million PDP enrollees and 5 million Medicare Advantage PD
20 enrollees.

21 This chart is showing you that Part D enrollment
22 is highly concentrated into plans offered by just a few

1 parent organizations. Among stand-alone PDPs, on the left
2 hand side, the top three parent organizations make up nearly
3 60 percent of total PDP enrollment. Among MA-PDs, on the
4 right, the top three make up about half of total MA-PD
5 enrollment. UnitedHealth, PacifiCare and Humana were the
6 big winners.

7 Let's take a look at the types of benefit designs
8 in which most Part D members are enrolled for 2006. I won't
9 go over Part D's defined standard benefit structure now, but
10 remember that plans can offer either that benefit structure
11 or one that has the same actuarial value. For example,
12 substituting tiered copayments for 25 percent coinsurance.
13 Both a defined standard benefit and actuarially equivalent
14 benefits are called basic benefits, and they're shown here
15 in the orangish-yellowish sort of color there.

16 Enhanced plans are shown in blue. Enhanced plans
17 are ones that include both basic coverage and supplemental
18 benefits. That supplemental coverage can, but doesn't
19 necessarily, take the form of filling in the standard
20 benefits coverage gap. In fact, for 2006 the main form of
21 enhancements seems to be including getting rid of the
22 defined standard benefit's \$250 deductible rather than

1 filling in the coverage gap.

2 Notice that about three-quarters of enrollees in
3 Medicare Advantage prescription drug plans -- shown in the
4 right-hand pie -- have enhanced coverage. By comparison,
5 only about 17 percent of PDP enrollees have enhanced
6 benefits. Notice, too, that many PDP enrollees with basic
7 benefits are in plans that are using actuarially equivalent
8 benefit designs. They don't have the defined standard
9 benefit with its 25 percent coinsurance.

10 There are two basic reasons for this big
11 difference between enhanced and basic coverage across PDPs
12 and MSA-PDs. One reason is that a large number of PDP
13 enrollees are dual eligibles, who CMS auto-assigned to lower
14 premium PDPs. That means that plans with basic benefits.

15 A second reason is that organizations that offer
16 Medicare Advantage PDs are allowed to use some of the
17 difference between their plan payments for Parts A and B
18 services and their bid for those services, called rebate
19 dollars, for providing those services to enhance the Part D
20 benefit or lower its premium. So most MSA-PDs are offering
21 low premium enhanced plans.

22 Remember that Part D also includes a low-income

1 subsidy and the specifics of this extra benefit differ
2 depending on an individual's income level and whether or not
3 they're a dual eligible. But essentially, the low-income
4 subsidy fills in most or nearly all of the cost-sharing
5 requirements for beneficiaries who have low incomes and low
6 assets. So far about 9 million individuals are receiving
7 this extra help, including about 6 million full duals. This
8 extra help also pays for some of all of the enrollee
9 premiums and fills in much or nearly all of the coverage
10 gap.

11 CMS auto-assigns duals and other low-income
12 subsidy recipients into Part D plans. Your mailing
13 materials gave you some detail about this process, but in
14 most cases beneficiaries who have been in fee-for-service
15 Medicare are randomly assigned among qualifying stand-alone
16 PDPs. People who are auto-assigned to a plan have a chance
17 to change plans at the time CMS goes through this auto
18 assignment process, and full duals can change plans up to
19 once a month.

20 Not every plan qualifies to receive auto-
21 enrollees. PDPs need to have premiums that are near certain
22 regional threshold values that are calculated by CMS.

1 On the surface you may not think that this
2 population would be attractive to drug plans that are
3 bearing insurance risks, especially full duals, who tend to
4 be sicker on average and have higher drug spending. But
5 there are some important reasons that plans want these auto-
6 enrollees.

7 At the start of Part D there was a lot of
8 uncertainty, you may recall, about how many Medicare
9 beneficiaries would actually sign up for Part D. This auto-
10 enrolled population was at least one group that plans could
11 count on for initial enrollment. And they also were
12 particularly desirable because, from a plan standpoint, they
13 had lower marketing costs. Since Medicare pays for the
14 premiums and most of the cost sharing, plans can be assured
15 that these low-income subsidy enrollees come with a reliable
16 payment stream. And CMS also uses a special risk adjustment
17 factor for plan payments on behalf of low-income
18 beneficiaries to provide even more incentive to enroll them.

19 So about 9 million beneficiaries are receiving
20 extra help today and CMS estimates that there are another 3
21 million others who are eligible but have not yet signed up.
22 Recipients of low income subsidies make up about 52 percent

1 of all PDP enrollees, compared with about 15 percent of
2 total enrollment in Medicare Advantage prescription drug
3 plans. It's really fairly straightforward to explain why.
4 The 15 percent share in Med Advantage PDs largely reflects
5 how many duals and other low-income enrollees MA plans had
6 prior to the start of Part D, and most duals and other low-
7 income beneficiaries who are in fee for service Medicare
8 rather than Medicare Advantage before the start of Part D
9 had been auto assigned by CMS into qualifying PDPs.

10 I'm telling you this because over time having a
11 high proportion of low-income subsidy enrollees could affect
12 PDPs operate. Since this extra help fills in most of the
13 cost-sharing requirements, plans can't necessarily rely on
14 differential copays to steer beneficiaries towards preferred
15 drugs to the same extent that they can for other types of
16 enrollees. They may have to use other sorts of management
17 tools such as prior authorization, step therapy, tighter
18 formularies to a greater degree.

19 This is a bit striking because Medicare Advantage
20 drug plans are in a better position to use those sorts of
21 management tools since they already have established
22 relationships with prescribing physicians through their

1 networks and they have experience administering a drug
2 benefit to their Medicare population. Their networks of
3 providers, they already have some familiarity with the
4 plan's formularies and non-formulary exceptions policies.
5 PDPs do not have that same sort of history or those
6 relationships necessarily.

7 It's important to keep in mind the trends I just
8 described in the low-income subsidy enrollees for thinking
9 about the issue of Part D's coverage gap. If you compare
10 Medicare Advantage PDs and stand-alone PDPs, MA-PDs are much
11 more likely to offer gap coverage as part of their benefit
12 package. About 28 percent of MSA-PD enrollees have it
13 versus 6 percent of PDP enrollees. But remember that a
14 large proportion of PDP enrollee also receive these low-
15 income subsidies. So essentially, these individuals are
16 bringing gap coverage with them to whatever plan they sign
17 up for.

18 Among MA-PD enrollees, about 11 percent are in
19 plans that don't have a benefit design with gap coverage,
20 but these employees effectively have gap coverage through
21 their extra help through the low-income subsidies. A much
22 larger share of PDP enrollees are in a similar circumstance,

1 51 percent, again reflecting the fact that CMS auto-assigned
2 most of these beneficiaries to PDPs.

3 When plans submitted bids last year for 2006, the
4 average premium offered by plans was \$32 per month. But
5 most enrollees are paying less than \$32 a month for a couple
6 of reasons. Again, CMS auto-assigned many individuals into
7 qualifying plans, particularly stand-alone PDPs, and those
8 plans had premiums below low-income subsidy premium amounts,
9 so a certain threshold value, they tended to have lower
10 premiums.

11 The other reason that other beneficiaries tended
12 to pick lower premium premiums. So on average today Part D
13 enrollees are paying about \$24 per month.

14 Here's the distribution of enrollment by the
15 monthly amount of plan premiums. I've got stand-alone PDPs
16 on the left-hand side and Medicare Advantage PDs on the
17 right. For each chart the yellow bars are showing you plans
18 that have enhanced benefits and orange shows you basic
19 benefits.

20 Notice that the PDP enrollees are paying higher
21 premiums than Medicare Advantage enrollees on average.
22 Remember that MA-PD enrollees get their entire package of

1 Medicare and supplemental services through the MA plan, and
2 they pay the Part B premium and an MA premium typically for
3 those services. But many Medicare Advantage prescription
4 drug enrollees don't pay any additional premium for their
5 drug benefits.

6 Also note that there are a lot more MA-PD
7 enrollees in enhanced plans than in basic ones. So MA plans
8 are using the rebate dollars I described earlier to enhance
9 their Part D benefits and charge no or reduced premiums.

10 Last April Cristina and Jack Hoadley showed you
11 some analysis we did on plan formulary designs and tier
12 structures. For this slide, we asked Georgetown University
13 and NORC to update some of their previous work to reflect
14 plan enrollment by tier structure.

15 Enrollees in defined standard benefits are shown
16 in orange and they pay 25 percent coinsurance for covered
17 drugs. But just remember that, particularly among the PDPs,
18 a number of these individuals also come with low-income
19 subsidies. So they're effectively paying nominal copayments
20 of \$1 to \$5 per prescription, rather than the 25 percent
21 coinsurance.

22 A key thing to note among both PDPs and MSA-PDs,

1 on the left and right-hand side, most enrollee are in plans
2 that use specialty tiers. Plan sponsors use specialty tiers
3 for particularly expensive products or unique drugs and
4 biologicals. Under CMS guidance, plan enrollees may not
5 appeal the cost-sharing amounts for drugs listed on
6 specialty tiers. Plans also tend to charge higher cost-
7 sharing for these products in specialty tiers, typically on
8 the order of 25 percent coinsurance.

9 So specialty tiers are a way for plans to limit
10 their financial liability on very high cost drugs. Remember
11 that Part D includes catastrophic protection. So once an
12 enrollees out-of-pocket spending reaches very high levels,
13 the plan covers most or all of that additional spending and
14 Part D has extensive subsidies for that.

15 Plan sponsors turned in their bids for Part D
16 benefits for 2007 last June, and they can start marketing
17 their 2007 products as of next Sunday. The open enrollment
18 period for the coming year will run from November 15th
19 through December 31st. Late last week, CMS released some
20 information about 2007 benefits and premiums for PDPs, the
21 stand-alone plans. The information for Medicare Advantage
22 PDs is not available quite yet.

1 I haven't prepared slides on what those plans look
2 like but I can give you a general sense of things.
3 Generally it appears that once again there was strong
4 competition among plans for 2007. There will be about 30
5 percent more PDPs in the market for 2007 than for 2006.
6 There's a median of about 55 PDPs per region across the
7 country. 17 organizations are offering at least one plan,
8 one plan name, in all 34 PDP regions, compared with about 10
9 such organizations last year. Some of these new national
10 organizations participated in Part D last year but weren't
11 quite national and they've just kind of broadened the
12 regions in which they're operating. Others are relatively
13 new entrants into Part D.

14 A larger proportion of PDPs will be offering
15 coverage in the coverage gap for 2007, 29 percent of PDPs
16 versus about 15 percent for 2006.

17 CMS expects that enrollees will pay about the same
18 average monthly premium in 2007 that they're paying in 2006,
19 which is again about \$24 a month. In general, the
20 distribution of premiums for plans offering basic benefits
21 is tighter and more compressed than it was last year. Many
22 of the higher price plans lowered their bids. The overall

1 average and median, they're a bit lower. So it's a more
2 compressed distribution. But it also appears to be the case
3 that premiums for enhanced plans are a bit higher than they
4 were for 2006, on average.

5 We've spent most of this briefing talk about what
6 2006 enrollment looks like. Under current law, these
7 enrollment trends for 2006 should affect Part D for 2007 in
8 a couple of different ways. First, the law says that CMS
9 should take 2006 enrollment into account when setting plan
10 payments and enrollee premiums for 2007. Second, CMS should
11 also use enrollment weighting when setting the threshold
12 values for low-income premium subsidies. CMS did not use
13 enrollment weighting in either of these ways for this
14 current year, 2006, because PDPs didn't exist before the
15 start of Part D and there was no information on which to
16 base the market shares of PDPs.

17 Under enrollment weighting, several things would
18 happen. First, in terms of plan payments and enrollee
19 premiums, the move to enrollment weighting would mean that
20 monthly payments to plans would be lower and enrollee
21 premiums would be higher than would be otherwise. Also,
22 fewer plans would have premiums below the low-income subsidy

1 threshold values. This means that enrollees in plans that
2 qualified for auto enrollee in 2006 but didn't qualify in
3 2007 would either have to change plans or begin playing a
4 premium to stay in the plan that they're in now.

5 Over the summer CMS announced that it has started
6 two demonstration programs for Part D. First, it will
7 transition to enrollment weighting to set all plan payments
8 and enrollee premiums. For 2007, CMS calculated the
9 national average bid using a composite approach --

10 DR. MILLER: Rachel, can I just interrupt you for
11 a second. I just want you to go through again the part
12 right before you come up to what they did in the
13 demonstration. So what would have happened with the low
14 income benchmark and what would have happened with the
15 premium. I think that blew by too fast. Just one more
16 time.

17 DR. SCHMIDT: Under current law, CMS is
18 calculating two different things, two major parts of Part D.
19 One is the national average bid, where all the organizations
20 are submitting their bids for basic benefits under Part D.
21 Under current law that is to be weighted under enrollment
22 levels for 2007.

1 Without doing that, that means that the national
2 average bid would be higher. That means that since a
3 portion of that is paid to plans on a monthly payment, if
4 it's higher, that payment would be higher and also enrollee
5 premiums would be lower.

6 Is that a little bit clearer?

7 So effectively, if you had gone to enrollment
8 weighting relative to current law then plan payments would
9 be lower than would otherwise be the case and beneficiary
10 premiums would be higher.

11 DR. MILLER: To be clear, the part that the
12 government pays would be lower and the part that the
13 beneficiary pays would be higher.

14 DR. SCHMIDT: If they had moved to enrollment
15 weighting.

16 MR. BERTKO: It's like moving a slide rule
17 indicator.

18 DR. REISCHAUER: If they followed current law.

19 DR. MILLER: And then the low income piece.

20 DR. SCHMIDT: There's a second calculation that
21 for each region across the country, these 34 regions, there
22 are these low-income subsidy premium threshold amounts.

1 Again, CMS looks at all the premiums now for each individual
2 plan operating in a region. And under current law it is to
3 use enrollment weighting, so taking 2006 enrollment into
4 account. If it doesn't do that, that means that these
5 thresholds are higher, more plans qualify to receive auto-
6 enrollees or keep the ones they have for 2006.

7 If they follow current law the opposite would be
8 true, you'd have lower threshold amounts, fewer plans would
9 qualify to receive auto-enrollees and there would be
10 disruption of low-income subsidy beneficiaries who would
11 need to switch to a lower premium plan that does quality, or
12 begin paying part of the premium.

13 So over the summer, CMS announced that it's doing
14 two demonstrations with respect to Part D. It's
15 transitioning to this enrollment weighting for the general
16 national average bid, the overall calculation that affects
17 plan payments and enrollee premiums. It's using a composite
18 approach. So it's using 20 percent enrollment weighting and
19 80 percent of a straight average among PDP bids.

20 In a second demonstration for the low-income
21 subsidy calculations is that they're not going to use
22 enrollment weighting at all for 2007. We don't know details

1 about how long -- this is a transition approach, is what CMS
2 has said.

3 DR. REISCHAUER: What is this a demonstration of?
4 Reduction in political outrage?

5 MS. DePARLE: Is it under general demonstration
6 authority? Or is there something in the MMA that said they
7 could do this?

8 DR. SCHMIDT: Yes, under general demonstration
9 authority?

10 DR. HOLTZ-EAKIN: All kidding aside, has anybody
11 contested whether they have this authority? Seriously.

12 DR. SCHMIDT: I think there's been quite a bit of
13 debate within the administration but...

14 DR. REISCHAUER: Does a whistle blower get 10
15 percent of the savings?

16 DR. HOLTZ-EAKIN: Can they have a program-wide
17 demonstration? Or is that an oxymoron? And is there
18 somebody who will review this as a matter of course,
19 automatically, the OIG in HHS or anyone like that? Does
20 anyone know?

21 DR. SCANLON: This is not the first program-wide
22 demonstrate. We had the program-wide demonstration with the

1 oncology surveys last year. There is an issue that the
2 demonstrations are supposed to demonstrate something for the
3 benefit of the program, that somehow that the program
4 operates better because of the demonstration. So the
5 question we might ask is what has CMS said about what
6 they're learning?

7 My understanding of the oncology demo was they
8 were learning whether physicians could actually submit
9 information.

10 The other thing that is a bit of a departure in
11 both of these cases is budget neutrality, which is not in
12 statute or in regulation but has been in tradition. In the
13 past, GAO has questioned both budget neutrality of
14 demonstrations as well as when it has overridden explicit
15 Congressional intent. The Department has said they can do
16 this.

17 MR. HACKBARTH: As a related but more narrow
18 question, with regard to part of this, you said it was a
19 transition.

20 DR. SCHMIDT: That's according to CMS documents,
21 but they have not provided details about over how many years
22 of what the next tier might look.

1 MR. HACKBARTH: That's what I wanted to nail down.
2 Well, transitioning to what the statute says presumably,
3 which is enrollment weighted.

4 DR. SCHMIDT: Right.

5 MR. HACKBARTH: I was wondering about over what
6 time period and what the path was.

7 DR. SCHMIDT: It's unclear.

8 MR. HACKBARTH: We've got ahead of ourselves.
9 Rachel, why don't you finish off.

10 DR. SCHMIDT: The last slide here and then I know
11 you're anxious to jump into this.

12 The Commission may want to consider the pros and
13 cons related to these two demonstrations and CMS's decision
14 to phase in enrollment weighting. On the one hand, this
15 approach leads to less disruption for plan enrollees. Fewer
16 beneficiaries receiving extra help will need to switch
17 plans, avoiding some of the transition issues related to
18 changing formularies, coverage polices, non-formulary
19 exceptions processes and pharmacy networks.

20 Also, the demo for setting plan payments, the
21 general national average bid demo, means that enrollees
22 won't face steep premium increases that they might have seen

1 under enrollment weighting.

2 One could argue that phasing in enrollment
3 weighting could give CMS and plans time to work on
4 information systems and other factors to better prepare for
5 the issues that come up with beneficiaries switch between
6 plans. On the other hand, phasing in enrollment weighting
7 raises Medicare program spending relative to current law.
8 Also, it may postpone but not avoid the transition issues
9 that could come up from year to year under this payment
10 system that's essentially based on bidding. As a result,
11 there's bound to be some of these transitions.

12 One might also, of course, question whether CMS
13 should use its demonstration authority for this purpose.

14 MR. BERTKO: Let me make one addition to Rachel's
15 very good summary on this. There was yet one more step,
16 which wasn't a transition. But it was an allowance of plans
17 to waive up to \$2 of their premium in order to retain their
18 duals and low income people. That had a not insubstantial
19 effect on perhaps as many as a million low-income retirees.

20 DR. SCHMIDT: Initially there was a de minimis
21 policy, they call of it, of about \$1. So if you're in the
22 low-income subsidy threshold calculation, if you're a plan

1 and your premium came in within a dollar of these
2 thresholds, you could keep your enrollees. That has been
3 subsequently changed to \$2, as I understand it and has
4 lowered the number of beneficiaries affected.

5 MR. BERTKO: My second comment, I'll argue against
6 our own company's business interests on this one, but
7 mention that in the management of an active market
8 competition process, getting all the companies to bid lower
9 actually is probably the biggest net benefit, which actually
10 happened here. So managing the competition process the way
11 that it was done may actually be a positive and should be a
12 benefit added to the less disruption part of it.

13 Now you could argue that that might have been done
14 in the absence of this, but managing competition in the way
15 that the FEHBP has occasionally managed competition very
16 quietly, to me, is a possible net good.

17 DR. HOLTZ-EAKIN: Can you elaborate on that?

18 MR. HACKBARTH: Help me understand that. Why
19 would enrollment weighted calculations lead to less
20 competition?

21 MR. BERTKO: Not less competition but to make the
22 whole process a little smoother. In a pure economic sense,

1 it doesn't increase competition. But in a sense of business
2 pragmatism, in terms of what your next year's enrollment
3 looks like, it makes it a more attractive business
4 proposition to go after the membership if the process is a
5 little smoother rather than being somewhat jagged or cliff-
6 like in terms of the way enrollment would move around.

7 DR. HOLTZ-EAKIN: So this announcement was made
8 prior to the bids?

9 MR. BERTKO: It was made about a week prior to the
10 bid and then we had an opportunity for an extra week to
11 rebid something that you thought you might have to do.

12 MS. DePARLE: Maybe you said this in the paper but
13 how much money was spent on this?

14 DR. SCHMIDT: No, I did not say that in the paper
15 because there have been no public estimates. CBO has not
16 done an estimate on this. I'm not aware that the Office of
17 the Actuary has released anything publicly on this.

18 To give you a sense of things, we did a back of
19 the envelope calculation about the costs for 2006. Let me
20 be very clear about this. This is for 2006, where there's
21 no question we would have had to probably use the approach
22 that CMS has done, where PDPs are not enrollment weighted

1 because there's no data by which to weight them. I have
2 looked at the 2006 bids and 2006 enrollment levels as of
3 July. My back of the envelope calculation is that the cost
4 is about \$1 billion for that one year.

5 Now having said that, for 2007, again I mention
6 that the bids for basic benefits are more compressed and a
7 bit lower on average. That would tend to lower the cost, in
8 addition to the fact that they're using at least a composite
9 approach, 20 percent of it is based on enrollment weighting.
10 So it would be a lower amount in 2007.

11 And if this is transitioned over time, it would be
12 probably lower still amounts in subsequent years. But
13 again, we don't know exactly what's going to happen.

14 MR. HACKBARTH: Let me just make sure I understand
15 the \$1 billion figure. You're saying that in 2006
16 enrollment weighted couldn't be used because there weren't
17 any enrollment figures. But if you went back, knowing what
18 we know now about actual enrollment and recalculated, it
19 would have been \$1 billion less in federal spending?

20 DR. SCHMIDT: Yes.

21 MR. BERTKO: But keep in mind in 2006, I have to
22 say this tactfully, there were a couple of companies that

1 bid correctly according to how the costs have come in, and a
2 number of companies that bid way too high. And so that way
3 too high goes into the bid.

4 In 2007, and I took a quick look at everything
5 last Friday just after they were out. The bid compression
6 that Rachel talks about has come into not full effect but a
7 great deal of effect, particularly on an enrollment basis.
8 So the \$1 billion, I think -- Rachel said this correctly,
9 because we don't really know the answer yet, either of us.
10 But it's, I think, considerably less than \$1 billion for the
11 actual cost against current law for 2007.

12 MS. DePARLE: When you say too high, too high
13 relative to what?

14 MR. BERTKO: To what their actual costs would be.
15 But they got no enrollment, so it doesn't matter.

16 MS. DePARLE: We have enough data to say that?
17 Because I heard that some of those plans actually had very
18 high costs. I may be thinking of free-standing PDPs.

19 MR. BERTKO: Some plans bid inappropriately and
20 got -- urban legend has it that one plan bid so high, being
21 conservative, and got one member.

22 DR. REISCHAUER: Huge profit but didn't make it up

1 on volume.

2 MR. BERTKO: Except, Bob, no huge profit because
3 of the risk corridors.

4 DR. HOLTZ-EAKIN: Some questions just to get some
5 magnitudes on the low-income subsidy population. There's
6 about a quarter of it which has not signed up at all for
7 drug coverage? Is that three out of the 12?

8 DR. SCHMIDT: That's right.

9 DR. HOLTZ-EAKIN: Given the participation in other
10 programs for similar populations, there's no great
11 expectation that they're going to show up? We're not going
12 to have another 3 million people of this sort that we'd have
13 to...

14 DR. SCHMIDT: There's a lot of work underway to
15 try to figure out how to get these people signed up. But
16 yes, given history of other programs, it's been a very
17 difficult process.

18 DR. REISCHAUER: What happens to a low-income
19 person who shows up late? Do they get penalized?

20 DR. SCHMIDT: No, I think they have a special
21 enrollment period and do not have to pay the late enrollment
22 penalty.

1 MR. BERTKO: No penalty this year.

2 DR. REISCHAUER: There's no incentive to join
3 until you meet the...

4 DR. HOLTZ-EAKIN: Do we know, based on even these
5 preliminary data, how many transitions will have to be
6 managed? There's the clear concern about the trade-off
7 between transitions in this population and the and the
8 formularies they'll have to figure out, versus other
9 consideration. So what are the magnitudes and transitions
10 that will be faced? Do we have some idea?

11 DR. SCHMIDT: Initially, as this de minimis policy
12 that I mentioned of \$1 around the threshold amounts was
13 announced, there were statements out of CMS that seven out
14 of eight low-income subsidy beneficiaries could stay in the
15 same plan. But that leaves one out of 8 that would have to
16 go through this transition.

17 Subsequently, they've changed that de minimis
18 policy to \$2. My understanding is that has brought the
19 number down to practically nil.

20 MR. BERTKO: To 5 or 6 percent.

21 MS. BURKE: Separate from the payment issue what,
22 if anything, do we know? Or is it way too early to know

1 what the utilization has been like in terms of actual
2 prescriptions? Are they yet able to determine anything?

3 I've had this conversation with them in the course
4 of the work on the FDA that we did, about data and about
5 beginning to analyze that data and beginning to share it.
6 Do we know anything at all?

7 DR. SCHMIDT: I've not seen detailed data, but
8 from equity research I've read and that sort of thing, I
9 think some plans have been surprised to find lower
10 utilization than they expected. I've heard that generic
11 fill rates are much higher than anticipated. That's the
12 general sense.

13 MS. BURKE: Do we know anything from CMS in terms
14 of when we, in fact, might be able to begin to see any of
15 that data? Why am I even asking this question? In our
16 lifetimes? Nancy-Ann and I will have retired from MedPAC
17 and gone on to glory.

18 DR. SCHMIDT: I can tell you that after the end of
19 calendar year 2006 there's still a long process that CMS has
20 to go through with plans to kind of recheck some of the
21 prospective payments they've been providing. I think that
22 could be easily a six month process until all of that is

1 cleaned up.

2 In terms of our ability to get such data, I know
3 that there is some push from some parts of the Congress to
4 look at legislation that would provide us with that sort of
5 data. It's still in question.

6 MS. BURKE: I wonder, Glenn, and this was
7 enormously helpful, Rachel. But I wonder, Glenn, what you
8 imagine given this last issue in terms of their making a
9 decision about a demonstration authority. Is it your
10 intention that we would, perhaps at the next meeting, think
11 about whether we want to comment on that?

12 In that context, I assume that might be the case,
13 I think there is some value in continuing to highlight, in
14 the course of that, the desire for data and the desire for
15 data in some reasonable time frame that can begin to inform
16 us in terms of utilization and behavior. I think we just
17 need to keep saying that and how important that's going to
18 be in some reasonable time frame.

19 MR. HACKBARTH: Thank you, Rachel. Good job.

20 We're now down to the very end and we'll have a
21 brief public comment period, with the usual ground rules,
22 which Karen knows by heart.

1 MS. FISHER: Hi. I'm Karen Fisher with the
2 Association of American Medical Colleges. We represent all
3 125 allopathic medical schools, as well as most of the major
4 teaching hospitals in the country.

5 I will be brief, although I did not speak at last
6 month's meeting, with the hope of reserving that time for
7 this month's meeting.

8 Let me first say that we do encourage the
9 Commission to at least look at and have as part of the
10 discussion the total margins in this discussion. They have
11 always been included in past discussions. They were
12 included in an earlier discussion today with critical access
13 hospitals. We think they should be part of the discussion.

14 In terms of the empirical level, it was a little
15 bit confusing because while the numbers seem similar there
16 was, at one point well, this is the empirical level with the
17 Commission's recommendations. This is the empirical level
18 with the current law. It got a little confusing.

19 It's also important to remember that very much is
20 still in flux in the CMS payment methodology. CMS is
21 continuing to look at the DRG methodology to see whether
22 additional changes are needed. They're continuing to look

1 at DRG refinements. We just had the occupational mix
2 adjustment released, which has an impact on the empirical
3 level. So there's still a lot very much in flux in this
4 area, and I think that empirical level is going to be moving
5 around.

6 We also support the Commission looking at the
7 outpatient arena and what is happening with teaching
8 hospitals and teaching hospital costs. This is a body and a
9 commission with a technical expertise that there is very
10 little of anywhere else, and we think it's a good staff that
11 could examine this issue that is not being examined by CMS
12 right now.

13 When the initial OPPS rule came out in 2000, CMS
14 did look at this and did find a significant relationship
15 with teaching hospital costs. It was not very large, but it
16 was significant. But they didn't implement it at the time,
17 one of the major reasons being that it was a new system and
18 they wanted to see what happened.

19 We'd like to know what happened, too, and we think
20 it's a good time to examine that. We think this is a good
21 body to do it.

22 On a practical level, I think it's important to

1 remember what was raised about the resident cap issue in the
2 resident counts. We did an analysis this summer looking at
3 that issue and there was about net about 1,500 residents
4 that hospitals are not receiving IME payments associated
5 with. That in aggregate, when you look at the capped count
6 and the total resident count, the difference is about 1,500.
7 It's about 600 on the direct GME side. There are different
8 counting issues for both of the payments.

9 The impact of that is teaching hospitals are
10 receiving zero payments associated with those residents,
11 which turns to be actually a cut. Interestingly, about 47
12 percent of hospitals are over their cap and about 40 percent
13 are under. Very few are actually at the cap, which we
14 think, rather than hospitals looking at this historically as
15 a money generator, which many cynics thought, that hospitals
16 actually are determining what their resident complement
17 should be, what their involvement should be in teaching is
18 based on what their unique circumstances are.

19 Some institutions believe that because of their
20 mission they must go over their cap even though they are not
21 going to receive Medicare support for those residents.
22 Others believe, for whatever reason, maybe financial, maybe

1 other, that they are not going to be at their cap or they
2 aren't in the particular year we looked at.

3 Next to finally, penultimately, we would encourage
4 the Commission to look at the issue of ambulatory area and
5 the Medicare role and policy in that arena. We're very
6 concerned about CMS's policies with ambulatory training and
7 counting residents in the ambulatory arena. In the
8 inpatient final rule, CMS made a pronouncement that said to
9 the extent that didactic and educational training occurs in
10 non-hospital sites, hospitals could not include that time in
11 their resident counts.

12 We think that didactic and educational training is
13 critical and integral to the patient care development of
14 future physicians. And yet the current CMS policy is that
15 hospitals cannot get paid for that time or receive Medicare
16 support for that. We're very concerned about that.

17 Finally, there's been discussion, both this month
18 and last month and in various sessions about, the education
19 of future physicians and medical school education, residency
20 education. We're happy to be helpful there, where we can,
21 to suggest people for you to talk to, to provide data. We
22 have a lot of data about curriculum. We have a database

1 that has the curriculum for all of the medical schools in
2 the country to determine what exactly they are teaching.
3 There's a lot of information and a lot of activity going on
4 with residency programs and residency training, in terms of
5 trying to develop professionalism, systems management,
6 quality, patient safety, all of these arenas. And we think
7 it would be useful for you people to hear about them. We'd
8 be happy to help out with the staff in any way we can.

9 Thank you.

10 MR. HACKBARTH: Thank you. We will reconvene at
11 9:00 a.m. tomorrow.

12 [Whereupon, at 5:37 p.m., the meeting recessed, to
13 reconvene at 9:00 a.m., Friday, October 6, 2006.]

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Friday, October 6, 2006

P R O C E E D I N G S

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MR. HACKBARTH: I'd like to get started, please.

Good morning, everybody. We have a really terrific panel this morning on physician groups. Cristina, do you want to do the introduction?

MS. BOCCUTI: Sure. As you said, we have some very distinguished speakers with us today. I'll first introduce them briefly. You have bios in your mailing materials. Dr. Casalino comes to us from the University of Chicago, but his background includes 20 years as a family physician in a California private practice that he co-founded. Dr. Casalino's research focuses on the organization of physician practice and, in particular, the kinds of organized processes that physicians use to improve the quality and control the costs of medical care. He has surveyed physicians groups through his own work and through the Community Tracking Survey, sponsored by the Center for Studying Health Systems Change. Dr. Burns, in the middle, is the James Joo-Jin Kim Professor at the Wharton School at the University of Pennsylvania. He is also the Director of the Wharton Center for Health Management & Economics. Dr. Burns has analyzed physician

1 organization integration over the past 20 years and his
2 research covers areas such as the structure and performance
3 of physician networks, the market forces that face the
4 growth of group practices and investor-owned networks, and
5 the organizational options for physicians in a consolidating
6 industry.

7 Finally, Dr. Schneider is the Chief Medical Officer of
8 Integrated Resources of the Middlesex Area and the Director
9 of Community Medicine for Middlesex Hospital where she is a
10 practicing family physician and faculty member. Dr.
11 Schneider oversees Middlesex Hospital's programs in diabetes
12 care, asthma, chronic heart failure and anti-coagulation.
13 She directs other public health and evidence-based medicine
14 initiatives at the hospital.

15 And finally, she directs the hospital's participation in the
16 Medicare Group Practice Demo, which she's been asked to talk
17 about today.

18 So I will turn it over to the three of you, but I'll be
19 right back here.

20 DR. CASALINO: Thanks for having me here. Reading the
21 transcripts of the meetings I'm very impressed by the level
22 of the discussion from both the commissioners and the staff.

1 So I'm not sure I actually have anything to tell you, but
2 I'll do so very briefly.

3 Rob Burns and I actually have a lot of the same things to
4 say, I see, looking at his slides. So I'm not going to read
5 my slides to you.

6 I think, in terms of the organization of physician practice,
7 there's just a few simple facts. We can quibble about
8 percentages, but basically most physicians are still in very
9 small practices in the United States. About 40 percent are
10 in one and two-physician practices and it's even a higher
11 percentage if you leave institutional physicians out and you
12 just look out in the community.

13 I think the 90 percent that I have there for under nine
14 physicians is probably a little high, but let's say
15 somewhere between high 70s and 90 percent of physicians are
16 in practices of nine or fewer physicians. This is changing,
17 but very slowly over the last quarter century. There's a
18 little bit of movement into medium-sized practices, five,
19 nine, 10, 15, 20 physicians, and a very, very slow movement
20 into larger groups.

21 Nevertheless, there are a lot of large, and what I might
22 call large medium, 20 physicians or so, groups in the

1 country. So there is something to work with there and I'll
2 address that in a second. In fact, I'll address that now.

3 In terms of groups of 20 or more physicians, there is at
4 least 700 multispecialty groups that include primary care
5 physicians. As you can see, there are another 150 that are
6 multispecialty but have only primary care only specialists.

7 Specialist groups of 20 or more are still relatively
8 uncommon. Again, as you can see from the slide there,
9 there's only about 155 or so single specialty groups of 20
10 or more physicians in the country. These are medical
11 groups. We're not talking about IPAs now.

12 During the '90s, there was a bit of a push to form large
13 multispecialty groups and this was because people thought
14 that the California model of capitation and gatekeeping and
15 risk-taking for even hospital services by large physician
16 groups was going to be the future. But when that has turned
17 out not to be the case, we've seen -- and this is really
18 through the Community Tracking Study and other sources --
19 formation of large multispecialty groups has just about
20 completely stopped over the last six or seven years. Not
21 that it was happening all that rapidly before, but there's
22 just about none now. But what we are seeing is some

1 movement, although again not rapid, and not in huge numbers.

2 But there is much more interest among specialists now in
3 forming single specialty groups. We're seeing some of that.
4 There's a few advantages to specialists of being in a single
5 specialty group. These are not necessarily advantages for
6 the health system, though. One is you can get negotiating
7 leverage with a health plan even at a relatively small size
8 in some communities if you're a single specialty group. A

9 multispecialty group has to be pretty large almost
10 everywhere to get leverage. But 50 cardiologists, say,
11 could have a lot of leverage even though that's not that
12 many physicians. Investing in an expensive imaging
13 technology, you know that imaging costs are a big problem
14 now. And this is clearly a reason for single specialty
15 group formation.

16 And then now that they don't need primary care gatekeepers
17 anymore to get access to patients, why should we have to
18 quibble with them about income? And so specialists aren't,
19 by and large, interested in being in multispecialty groups
20 anymore. Rob will, I think, have more detail on some of
21 this.

22 IPAs and PHOs, the numbers are declining for really the same

1 reasons as the fact that we're not seeing large
2 multispecialty groups being formed any more. There still
3 are a lot of IPAs and PHOs out there, but a lot of them are
4 fairly non -- they're not doing much now. For one thing,
5 they can't negotiate contracts jointly if they're not taking
6 financial risk or if they're not clinically integrated, and
7 most of them are not either right now. And as some of you
8 probably know, the FTC has been quite active in going after
9 IPAs and PHOs that are negotiating jointly without financial
10 or clinical integration. But there are a pretty small
11 number of quite effective IPAs out there, like Hill
12 Physicians in Northern California. And there are again a
13 handful of PHOs that seem pretty functional, as well, like
14 if you want to call the Partners Health System in the Boston
15 area a PHO.

16 The advantages, potentially, of large groups I think are
17 fairly obvious. Rob talks about this, as well, I think.
18 They can afford clinical IT, although still it's surprising
19 to see how little clinical IT a very high percentage of even
20 quite large groups still have. They can afford to pay
21 physicians and non-physicians to dedicate their time to
22 implement and organize processes to improve quality and

1 control costs. Similarly, they can afford skilled managers.

2 And then, of course, there's the old saw about large
3 multispecialty groups which is still true, that consultation
4 among physicians in different specialties in the same spot
5 is useful. And I think that that's true.

6 Also, and this is important, I think, large groups can serve
7 as a unit of analysis for measurement on cost and quality.
8 They can bear considerable financial risk sometimes, which
9 can be useful. Less useful for the health care system,
10 perhaps is the negotiating leverage, the capital to buy
11 technology.

12 And then there are real lifestyle benefits for physicians in
13 being in a large group. I think that's actually still one
14 of the main reasons that physicians who are interested in a
15 large group are there.

16 Why aren't there more? There are still an awful lot of
17 physicians who seem to prefer autonomy and although they are
18 complaining a lot and angry about their financial situation,
19 they're not hurting so much, I think, that they feel like
20 they have to get someplace where they can try to get some
21 negotiating leverage.

22 There's not great data on this, but it appears that there

1 are substantial number of physicians and patients who
2 actually prefer the small practice setting.

3 There's a real lack of skilled physician leaders and there's
4 a real lack of reward to physicians for creating or leading
5 a group. It's like if you're a physician and you want to
6 get a bunch of physicians together and form a medical group,
7 a large bunch, good luck. They're not going to want to pay
8 you. They're not going to want to invest any money in it.
9 They're going to criticize everything you do. It's almost
10 like common good or a free rider problem. We need more
11 medical groups but it's not in very many individuals'
12 interest to make the effort to create them.

13 There are diseconomies of scale and scope, pretty clearly in
14 large groups. They may be outweighed by the benefits.

15 There is quite a bit of data to suggest that younger
16 physicians are more likely to practice in medium and large
17 groups. This varies around the country but some large
18 groups, for instance Kaiser in Northern California,
19 definitely are having more applicants, including applicants
20 from community physicians who want to get out of their small
21 practices, than they can accept although it's not true
22 everywhere and it's not true in every specialty.

1 So we probably are going to see some movement, maybe a
2 little bit more rapid, to medium and large groups over the
3 next 20 years than we've seen over the last 20. But I still
4 think if we didn't change the current payment system, for
5 example, I don't think it will be very rapid at all.

6 I'm not going to say a lot about IPAs and PHOs.
7 Theoretically, they have some advantages. Ideally, they'd
8 have the best of both worlds of a large practice and a
9 system where -- a small practice setting for physicians and
10 patients. But in practice, it's very hard to govern them or
11 to have physicians committed to them.

12 You'd think there would be good data on which type of
13 physician organization performs best, but that's really not
14 the case. There are theoretical and anecdotal reasons to
15 think that the larger groups perform better. But as I'll
16 show you in a second, there isn't a lot of good data one way
17 or the other for that. And just my own personal bias is I
18 think it's fairly obvious that larger groups do have more
19 potential to do more good things and that some of them are.

20 There are also advantages to smaller practices. The
21 personal relationships with patients and close interactions
22 among staff should not be under estimated as a possible

1 benefit. Particularly in areas of quality that are not
2 likely to be measured in the next quarter century, those
3 things may counts. Things like diagnosis or getting
4 patients to cooperate with treatment. So although I myself
5 think that larger groups probably do better, I think it's a
6 mistake to assume that. And also, I don't think we know how
7 large is right. Is it 20? Is it 50? Is it 200? Is it
8 2,000?

9 Clearly, larger groups use more clinical IT. There's a few
10 studies, pretty good studies now, that probably use more
11 organized process of what I'm calling CMPs or care
12 management processes to improve quality.

13 This third bullet, tend to have lower patient satisfaction.
14 As I was going over the data again yesterday I thought that
15 may be a little exaggerated. There is some data to suggest
16 that overall, probably clearly not true with some of the
17 brand name groups. Also, patients probably pretty much sort
18 themselves, insofar as they have freedom to choose, into the
19 setting they choose. Some people love Kaiser, some people
20 want to be in a practice where there's one doctor.

21 The economies of scale literature is not very good but as
22 you can see from the slide here, it shows surprisingly small

1 groups. But this is really kind of based on what gets the
2 physicians the most income. It doesn't really include
3 considerations of where can you get the highest quality, for
4 example. So I don't think that literature is really worth
5 very much.

6 There's been some question before I came to talk here,
7 should there be deliberate attempt in payment policy to
8 foster a formation of a kind of medical group, large
9 integrated groups or whatever? Perhaps, but you can't
10 really justify it with the evidence right now because there
11 just isn't evidence. So it might be better to encourage
12 activities, to get physician groups to try to do things we
13 want them to do. And if those activities are sufficient
14 reward, then the kind of groups that can do them both just
15 by natural selection natural selection or competition will
16 presumably become more prevalent.

17 It's fairly obvious the things that we want. Although if
18 you look at this list, quite a few of them are things that
19 are not going to be paid for by pay for performance anytime
20 soon, such as accurate diagnosis and, in most cases,
21 appropriate therapy. That's, to me, a concern.
22 Care management processes, these are the kind of things that

1 go on between visits and not during visits, by and large, a
2 lot of which isn't done and probably shouldn't be done by
3 physicians but should be done by the physician organization.

4 So again, pay for performance shouldn't just be thought of
5 as a way to get an individual physician to try harder with
6 the individual patient in front of them, but actually to get
7 the organization to do better.

8 Medicare is already moving towards, at least in discussion,
9 a lot of the things on this slide. I haven't seen a lot of
10 discussion of the fourth bullet, trying to use medical
11 education to actually -- medical education right now still
12 teaches doctors that quality is what I do for the patient
13 that's in front of me while the patient is in front of me,
14 which is important. But I think physicians need to learn
15 that if that's all I do, I'm not a high quality physician.

16 And they're not really learning that yet in medical
17 education.

18 The last bullet, I honestly believe that if Medicare is
19 going to do much to improve quality in the country, there's
20 going to have to be some administrative funds for CMS to do
21 that. Just relatively trivial amounts of money compared to
22 the size of the program to help Medicare do pay for

1 performance or public reporting well would have an impact
2 far beyond their expenses, at least on quality and perhaps
3 on cost, as well.

4 I need to wind up, but just to really make clear, the
5 problem is, I think, in trying to devise a payment system or
6 an incentive system to reward better care is that it's
7 fairly easy, I think, to think of ways to do that with large
8 groups. But again most of the physicians in the country are
9 in small groups. So what can you do with the smaller
10 physicians?

11 On this slide, I just want to emphasize that the
12 demonstrations so far are with very large groups of
13 physicians, 150, 200, often part of larger integrated
14 systems. And there aren't really so many of them. So I
15 think one question to think about, maybe more than has been
16 thought about so far is how far can it be driven down, a
17 payment system that would reward quality to groups? Or how
18 small can groups be in demonstration projects?

19 I know there's one in process now that is aimed at smaller
20 groups and I think that's good.
21 For smaller practices, I think it's going to be really easy
22 to get pay for performance wrong for individual physicians

1 and that will be a disaster if that happens. It will be
2 another managed care backlash kind of thing. So I think
3 it's going to have to be done but it's going to have to be
4 done carefully.

5 Just the last slide, again to the lack of what we know, this
6 is a very good editorial by David Lawrence a few years ago
7 where we really don't know what the combination of
8 organization type, payment type, and organized process to
9 improve quality, what the best combination of those things
10 or what good combinations are. We have ideas about it but
11 we don't have data. And that's something that's very badly
12 needed.

13 DR. BURNS: Thank you for inviting me to speak. First off,
14 let me apologize for the lengthy paper I wrote that was sent
15 you as background reading. I didn't know that was going to
16 happen. Larry actually, I think, is the only person who's
17 ever read it. He claims to like it, so that's good enough
18 to me.

19 DR. CASALINO: He claims to have read it. No, I really did.

20 DR. BURNS: You cite it and that's good enough.

21 I was asked to talk about four topics. One was the
22 financial incentives to form group practices. Secondly, the

1 lessons we've learned from the formation of IPAs, PHOs and
2 PPMs. Sorry for the three-letter acronyms.
3 Third is what is clinical integration and how does it affect
4 physician performance? And fourth, how do financial
5 incentives work in groups? I'll try to cover these very
6 quickly here.

7 These are the basic consolidation options for physicians.
8 They run the gamut from horizontally integrating with other
9 physicians, forming the group practices that Larry talked
10 about; vertical integration with hospitals where hospitals
11 acquire physicians, purchase their practices, sponsor
12 hospital-based group practices; virtual integration with
13 hospitals using IPAs and PHOs. And finally, partnering with
14 Wall Street and venture capital firms. This was an
15 experiment we conducted in the 1990s that had tremendous
16 failure.

17 These are the incentives for physicians to consolidate and
18 they're not put in any necessary order or priority. But one
19 of the things we did in the background paper is show that
20 everybody else in the health care system is consolidating,
21 what about physicians? I think physicians got caught up in
22 that in the 1990s, and that's when the Wall Street firms and

1 the physician practice management firms entered the
2 industry. There was sort of a herd effect. The health
3 industry, in particular the provider sector, is vulnerable
4 to these herd effects. Hospitals and doctors do these
5 things all the time.

6 A second reason that doctors consolidated was seeking
7 bargaining power relative to payers downstream, trying to
8 charge higher prices or withstand discounting pressures.
9 And as Larry as mentioned, trying to enjoy greater autonomy
10 and discretion and the thinking that if we're a large group
11 we'll have more autonomy.

12 Larry was right in mentioning that there are some limited
13 scale economies there in forming these groups, but they're
14 not very big. Forming large groups can help. It doesn't
15 necessarily lead to the development but it can help to lead
16 to the development of infrastructure for clinical
17 integration, which might improve quality. Add on ancillary
18 services, just the convenience and ease, factors that Larry
19 talked about. There are also professional development
20 opportunities for those small number of intrepid doctors who
21 want to take leadership and management positions while
22 maintaining a full practice. And then finally, the vacation

1 and the call coverage.

2 This just shows that physicians are basically the center of
3 the universe in our health care system. They're in the
4 middle of the providers, right between the payers and the
5 producers of products. The reason I put this slide here is
6 that doctors and hospitals, at the end of the day, have to
7 figure out how to balance the reimbursement pressures from
8 the left with the unending innovation coming from the right.

9 And they basically collide in the middle. Doctors and
10 hospitals have to jointly figure out how to ration all the
11 technology with the limited funding they get.

12 But the doctors are in the middle for another reason, and
13 that's because they basically are the only ones, I think, on
14 that picture except for the government that has a monopoly,
15 a government-granted monopoly in this sector.

16 These are the data on what's happening with physician group
17 practice over time, and I want to thank the American Medical
18 Association for supplying these data to me on a just-in-time
19 basis. It shows you that the number of physician group
20 practices, according to the AMA's data, has been pretty
21 stable over the last 10 or 11 years, around 20,000 groups.

22 And the percentage of non-federal physicians who are in

1 groups has also been fairly standard, in the low 30 percent.

2 That's been dropping a little bit.

3 If you look at how group practices are distributed by type,
4 70 percent of all group practices are single specialty, 22
5 percent are multispecialty. The balance, that's not on
6 there, are the general and family practice. You can see
7 that's also been pretty stable, and that's stable over a 25
8 year period of time. It basically demonstrates that this is
9 a pretty stable industry. And physicians, by nature I
10 think, are fairly conservative and stable, too. We don't
11 see a whole lot of change taking place here.

12 One slide that I didn't put in here is the average size of a
13 group practice. That also has been stable, both in the
14 single specialty and in the multispecialty area. As Larry
15 mentioned, the average size of a single specialty practice
16 is six doctors. That's been stable over time. The average
17 size of a multispecialty practice is between 20 and 25
18 doctors. That's been stable over time. I don't think it's
19 any surprise that that's where the economies of scale are,
20 according to the limited econometric evidence that Larry has
21 talked about.

22 The one thing I would say is I put a little bit more

1 credence in that evidence than Larry does only because we
2 have multiple limited studies of economies of scale. They
3 all come up with the same results. But the thing that
4 really convinces me is what the econometric evidence finds
5 is the minimum efficient scale for a doctor's practice is
6 exactly what the doctors have done.

7 I don't think these doctors are stupid because basically
8 they're spending their own money if they're inefficient in
9 their practices. So what we observe as the average size of
10 a group is actually where the minimum efficient scale is,
11 and I think that's on purpose.

12 Why are the majority of physicians in single specialty
13 groups? I have two slides here which sort of lay out the
14 laundry list of reasons. It's easier to do it. The doctors
15 know one another. They're easier to control. They're small
16 groups. Much less of a free rider problem, as Larry has
17 correctly mentioned. They have much lower overhead because
18 the doctors are all in the same business. You reach the
19 scale of economies at a very small size and small group of
20 four, five or six doctors is much easier to manage than a
21 group of 30, 40, 50 doctors. They have common interests,
22 services. There are protocols available for these doctors.

1 do anything differently than they've already done. The
2 specialty orientation leads them to more fragmented
3 practices. Larry has mentioned there are antitrust issues.
4 Specialists can't form large groups in local communities
5 unless they have the financial or clinical integration. And
6 as Larry has mentioned, most of those groups can't
7 demonstrate any of that. They haven't had the capital or
8 taken the time to develop it.
9 I think one area to look at is how physicians could get more
10 capital to grow this infrastructure, and perhaps we ought to
11 explore other avenues for allowing physicians to retain
12 earnings without being subject to double taxation to allow
13 them to invest that in some of the infrastructure that they
14 need. So I think that's an alternate solution to some of
15 the things that have been discussed.
16 A definite lack of physician leadership. We have more
17 physicians going through MBA programs but I can tell you
18 right now, when they go through Wharton's MBA program, they
19 don't go back to practice. They go out to where the money
20 is really being made, and that's in venture capital. And
21 the unwillingness of group colleagues to financially support
22 a physician administrator in their midst.

1 What is financial integration? We'll go through some of
2 the definitions of financial and clinical integration, just
3 so we're all on the same page. Financial integration could
4 be either you have a capitated contract with a payer or you
5 have a risk contract with a self-insured employer that
6 includes bonuses and withholds for performance, and those
7 bonuses and withholds are tied to individual performance or
8 you have salaried physicians. But Larry and I have both
9 served as advisors in some of the FTC actions against these
10 physician networks. I can tell you most of this financial
11 integration is sadly lacking in most of the IPAs and the
12 PHOs out there. It just doesn't exist. Part of that is
13 because capitation has gone away.

14 On the clinical integration side, borrowing on Larry's work
15 and the work of others, there are a whole host of things you
16 could lump under the title of clinical integration. I won't
17 go through all these things. But here again, most of these

18 things are lacking in IPAs and PHOs as well. So the
19 clinical integration and the financial integration just
20 don't exist very much out there in the landscape right now.

21 And finally, what went wrong with the physician practice
22 management companies? Basically everything. Uwe Reinhardt

1 published an article in Health Affairs in 2000 that
2 basically summed it up as a huge Ponzi scheme. In addition
3 to that, there were so many other things and all of the
4 major players in this industry went bankrupt. So not a
5 whole lot of great lessons here to draw on at the moment.

6 DR. SCHNEIDER: I'm the test case here for virtual
7 integration, I think. Those were two really great
8 presentations. But shifting gears from academics to the
9 real world now.

10 The question I was asked to address was really can this
11 kind of network environment, virtually integrated group
12 support pay for performance in Medicare?

13 I need to tell you a little bit about who we are and what we
14 are because I think that probably does affect the
15 replicability of our model. I know you're probably familiar
16 with the PGP model, but I'll tell you a little bit about how
17 we're implementing it. I think probably my last four slides
18 are the most important and will kick off a discussion
19 nicely. So I will try to get to them quickly.

20 So here we are, Middlesex County, Connecticut and
21 surrounding towns. Long Island Sound down on the bottom
22 there, New Haven down to the left-hand corner, Hartford up

1 to the top of the screen, Connecticut River going through
2 there. Middlesex Hospital is the sole community hospital
3 within this system. Within Middlesex County proper, which
4 is 22 of those towns, about 85 percent of the FTE physicians
5 are on our medical staff and are solely on our medical
6 staff. So it really is kind of a cohesive community, very
7 good hospital-medical staff relations, as well.

8 About 10 plus years ago the IPA and the hospital came
9 together to form IRMA which is not quite a PHO, technically,
10 but mirrors many of the goals of the PHO in that it was
11 formed to do joint contracting under what we thought was
12 going to be a risk environment that was coming. What's a
13 little unusual about it is that the hospital actually carved
14 out all of its quality improvement, medical management, UM
15 discharge planning, risk, all of those functions into IRMA
16 as well. So we really did try to cover the gamut of the
17 continuum of care. And our mission statement, which has
18 stayed really the same throughout dramatic market changes
19 within our region, is to provide the tools, expertise, and
20 management necessary to develop and demonstrate the best
21 possible patient care in an ever-changing environment.
22 Initially we thought capitation was coming. That never

1 physician community within a geographic market area.

2 We felt the synergies for this were wonderful and aligned
3 with all of our other strategies that we were using with
4 commercial payers. And also, in my community medicine hat,
5 it included our strategies for the uninsured, who are our
6 biggest risk population, if you will. Many of our disease
7 management programs actually were formed both with the
8 commercial population as well as the uninsured in mind. We
9 actually outreached quite a bit to the uninsured over the
10 past 10 years.

11 Again, the hospital care is the low-hanging fruit. A focus
12 on continuum management, which we think we're very good at,
13 and with the full support of the medical staff, and to
14 support the medical staff because it's very important for
15 the hospital to have a successful physician community to
16 work with.

17 So our overall strategy was to save the money through
18 improved quality and safety and coordination of care. Very
19 importantly, we are not taking any kind of a UM approach.
20 That really was not successful for us under the limited time
21 that we were in a financial risk environment. And from our
22 perspective on the hospital side, we really feel it's

1 important for our physicians to be successful, and what we
2 know is this world of public reporting, pay for performance
3 coming up, and we prefer to be gently introducing them to
4 that at the leading edge of the curve.

5 I'll go quickly through some of our strategies. It's all
6 the same kinds of things that the big fully integrated
7 groups are doing: diabetes registries, quality data
8 collection. And I will say this is just an interesting
9 anecdote of can it be done within this kind of virtual
10 network? We had to collect data on 10 diabetes quality
11 measures. A few of those were claims-based measures.
12 But initially, when we signed everyone up for the PGP, it
13 was going to be a total of eight claims-based quality
14 measures that were collected, so we wouldn't have to do any
15 work collecting that data. After we all signed on, the
16 number of quality measures went up to 32, and the balance of
17 those were all chart-based. There's no money up front for
18 this, so this is all kind of figure it out on your own.
19 Thankfully, we convinced CMS that we should do this as a
20 sample and not 100 percent, which was their initial intent.
21 But this kind of thing makes it difficult to get the
22 physicians buy-in and trust.

1 But the end of the story was our baseline year diabetes data
2 collection, I actually ended up sending out to the doctors
3 500 single page data sheets, saying I know I said I wouldn't
4 ask you to do any of this, but I'm asking you to do it now.
5 Give me anywhere from two to six pieces of data on how you
6 do with your diabetics. I'll give you \$10 for filling this
7 out. And you don't even have to do it, have your medical
8 assistant do it. We sent out 500, we got back 483 within
9 two weeks. This was not a big financial incentive but they
10 know they're going to have to start doing this kind of
11 thing. They've been extremely cooperative.

12 Also, anecdotally, out of those 10 measures, when we compare
13 how we've done compared to the nine other groups in the
14 demo, we were best practice on two of them, above threshold
15 on seven of them. And the ones we weren't best practice on
16 we were right up there or middle of the pack. So in terms
17 of the quality, again, it can be done in a community like
18 this.

19 We do have several disease management programs, as you heard
20 in our introduction. We're a real believer in provider-
21 based disease management. Bob Berenson actually wrote us up
22 in a recent report published last week by the California

1 Health Foundation. These are really care management
2 programs of the train wreck patients, and very labor
3 intensive. We don't get reimbursed for this at all. The
4 hospital supports these programs as a community benefit,
5 even though again their primary outcomes are avoidance of
6 hospitalizations and ER visits.

7 Electronic record adoption is just kind of at the starting
8 point within our community, so we believe that in the next
9 three years that will become more widespread. But I think
10 importantly, to get them to opt in, I really had to promise
11 the physician offices that we're not going to ask you to do
12 anything that's going to burden the office, other than make
13 sure you post a beneficiary notification.

14 And what's been very interesting is that our IPA has
15 actually applied for the next iteration of the Medicare
16 demos, the 646. And they're proposing radical practice
17 change. So we'll see how that goes.

18 One reason that we applied for this is we really felt we do
19 good things in this community. The hospital is
20 participating in all of these quality and safety
21 initiatives. And if all the theory actually works out, we
22 should be saving some money by avoiding complications and

1 having anti-coagulation services, all of these kinds of
2 initiatives. So this was an additional motivator for us,
3 but honestly it's stuff that we want to do anyway.

4 Transition management, we do have a home care agency.
5 That's been very innovative and working with telemonitoring
6 and so forth. We have to be a little bit careful to make
7 sure we don't steer patients to our own home care agency,
8 but it's difficult when we've got one big one that offers
9 all kinds of interesting and effective programs and others
10 that really don't offer the kind of innovation within the
11 community. We've done more collaborative outreach to
12 skilled nursing facilities within our region. We don't own
13 any of those. We've implemented a new heart failure care
14 management program. Our cancer center has picked up the
15 ball on care management and is offering some great programs.
16 Again, these are all free of charge to the patients and not
17 reimbursed. And numerous safety initiatives, as we've
18 mentioned.

19 Putting my community medicine hat on, several community-
20 based strategies that we also think they're the right thing
21 to do, and eventually something should trickle down in the
22 way of savings on all of these.

1 piece of data to support this was that we have such market
2 penetration within our region that CMS had to come up with a
3 unique model to find a control group for us. Because out of
4 all of the 10 groups, basically there is virtually no
5 Medicare beneficiary within our service area that has not
6 received some care from one of our physicians. That was not
7 the case with some of the other groups that span a much
8 wider geographic area or a very specialty-specific base,
9 such as some of the academic centers. So we have our hands
10 around these beneficiaries very effectively, I think.

11 I also want to just point out that in those little tiny
12 practices where the CFO, CEO, COO and CIO are all the same
13 person, and that's the solo practitioner, those are the
14 places where we really see some radical innovation, very
15 early adoption of electronic records, open access, all of
16 that kind of thing.

17 Special challenges for us, this is often billed as a pay for
18 quality demo, but it's really not. It's a shared savings
19 model. I think the reward, it's a complicated method
20 comparing to this control group. There's risk adjustment.
21 It's very hard to explain it. It takes me about 15 minutes
22 to explain the model to a well-educated physician. So I

1 think there's quite a bit of cynicism that there may or may
2 not be a reward. It's unpredictable. It's very delayed so
3 even if we get one it's going to be three years after the
4 fact. So it doesn't have that kind of nice Pavlovian
5 incentivizing effect on the physician's behavior. Certainly
6 it's compounded by all of the SGR issues that you're well
7 aware of. The physicians will just sit back and say I hear
8 they're going to cut my payment by 40 percent over the next
9 five years. What's the point of this?

10 The midstream changes that we got after we signed up for the
11 program certainly had a very severe effect on physician
12 acceptance and cynicism, both on the quality measures that I
13 had mentioned earlier, as well as there were some
14 significant changes in the financial model that again just
15 kind of raised the cynicism level. But none of our
16 physicians dropped out after all of those. I think the
17 feeling was hey, we're in this to try it out and see what
18 happens.

19 I mentioned our data collection efforts, which were very
20 successful. We'll see if the others are as easy to do
21 because we had a lot set up for diabetes specifically.
22 Replicability, I think anyplace that you have some kind of

1 credible trusted community infrastructure, you can pull this
2 kind of thing off. It might be a hospital medical staff
3 structure. It might be a tightly integrated IPA network,
4 the large physician group. I'm not sure it really matters.
5 I think it's who's got the tools? Who's got the trust from
6 the physicians? And who's got the credibility among
7 physicians?

8 Certainly, when payers go in looking for HEDIS data
9 collection they're not getting back 483 within two weeks.
10 The physicians know me. They know yes, we're trying to make
11 an effort, that these are their patients, that the data is
12 coming out of our own systems. And I think that helps.

13 Certainly, the degree of market penetration and
14 standardization of pay for performance within that region
15 are very important. Again, that's driven a lot of change in
16 what I think is a good direction. But the more fragmented
17 that these programs are, if you're trying to answer to 10 or
18 15 or 20 different sets of standards, their definitions are
19 all different, it gets to be very difficult.

20 Even within my own practice I was asked to come and report
21 on how are we doing on these various P4P programs. I had to
22 bring in five different report cards and they all had

1 similar measures, but not quite the same. Doctors will just
2 glaze over at that point. So we're actually hoping to work
3 on a big data aggregation project through a Robert Wood
4 Johnson grant, and we think that will help.

5 A final caution, this is something I feel very strongly
6 about. Pay for quality is wonderful. Pay for outperforming
7 the other guy is probably not the way we want to go in
8 health care. For us, the biggest bonus for participating in
9 this has been sharing of best practices. I really think
10 that if you're incentivizing just out-performing somebody
11 else, that's going to go away.

12 I just wanted to add one other thing to follow up on an
13 early comment about medical education. I'm also a faculty
14 member in a family practice residency program where we
15 actually do this. The physicians are trained you use
16 registries, you use care management processes. And so this
17 is normal for them.

18 So the ace up my sleeve is that over the past several years,
19 I've put out a couple of dozen young physicians into my own
20 community that think this is normal. And they do it. So I
21 really think that's a huge issue that more attention should
22 be paid to.

1 is fairness.

2 A second is that performance might be more readily assessed
3 for organized systems, as opposed to individual clinicians
4 in a fragmented system. Providing good high quality
5 efficient care is not necessarily the act of individual
6 physicians. They contribute to it. But groups of
7 physicians. They may or may not have formal relationships
8 for one another, but many providers put their hands on the
9 patient, especially when we're talking about the most
10 complicated patients that account for the largest portion of
11 Medicare expenditures.

12 So a second reason for creating an organized opt out, if you
13 will, is that it would move the system towards better
14 assessment of performance.

15 A third reason that I've heard as we've begun this
16 discussion is that allowing this sort of opportunity might
17 itself prompt desirable changes in the organization of care.
18 So the model is that changes in payment drive organization,
19 as opposed to saying the payment needs to conform to the
20 existing organization of care.

21 And then finally, the most optimistic people might say if
22 you do all of these things you may actually have a cascading

1 effect that in the long run alters cost trends. You get not
2 just changes in cost trends but perhaps organizational
3 changes that improve quality in the long run for Medicare
4 beneficiaries.

5 So that's the basic discussion that I've heard to this point
6 about the affirmative case for this. I'd like to just get
7 you to react to that basic case. Are there pieces that
8 sound plausible, implausible? What do you think?

9 Don't everybody rush at once.

10 DR. CASALINO: To me, I think the idea of if you're taking a
11 large group or a relatively integrated system like the
12 Middlesex system we just heard about, and allowing that
13 organization to opt out of whatever kind of SGR there is and
14 be paid in some other way. And then, of course, there's the
15 question is it a matter of just opting out of SGR or are
16 they actually going to be paid differently period? In other
17 words, not be paid by Medicare fee for service but by some
18 other method. So that could go either way.

19 To me that idea is attractive and should work, except that
20 there are a few problems with it. One is, of course, if you
21 make it more attractive then if physicians in other forms of
22 smaller practices see that physicians in larger forms of

1 practice are getting "a better deal" you can imagine the
2 political ramifications of that, even though it would in
3 fact drive physicians into that kind of structure.

4 On the other hand, if it's a worse deal then it's unfair to
5 the larger groups. So it will be a little tricky to get it
6 right, is something that I haven't seen discussed I don't
7 think but probably has to be thought about.

8 The other question on the group side or the integrated
9 system side is how big do you have to be? If you have to be
10 really big, then we're talking about a relative small number
11 of physicians and patients in the country. If you can do it
12 if you're relatively small, then we're talking about say a
13 50 physician group or a 25 physician group, then we're
14 talking about an administrative burden on Medicare. That
15 would have to be thought about carefully.

16 Personally, I wouldn't want to see it assumed without
17 thinking that the administrative burden would be undoable.

18 I'd want that thought about, I guess. And again, what I
19 said during my presentation, it may be that for the
20 expenditure of what, in relative terms, is a small amount of
21 administrative dollars, benefits might be very large.

22 Another possibility would be to group a number of small

1 groups, 25 physician groups, in an area into a payment pool.

2 But that has some of the same problems as the SGR as it is
3 now.

4 I'll say one more thing and then I'll be quiet. In terms of
5 paying at the hospital staff level, my initial reaction to
6 that when I first saw it was pretty negative because so many
7 hospital medical staffs, if not the great majority, are
8 highly dysfunctional, to say the least.

9 On the other hand, just about all physicians are in hospital
10 medical staffs. Hospitals do have some resources. We
11 actually do want physicians in hospitals to cooperate in
12 improving care, because some of the payment models, as
13 you'll know, if the hospital's not part of it the hospital
14 actually can lose money by the good things the physician
15 group does.

16 So I guess dysfunctional as hospital medical staffs are, if
17 there was pay being directed through a hospital medical
18 staff, and essentially that was the SGR, was the hospital
19 medical staff, there's no question that it would lead to
20 real attempts to improve the way things are done among the
21 physicians and within the hospital. I think the fighting
22 would be bitter at many places, I think.

1 But the more I think about it, aside from some dead hospital
2 administrators -- and some physicians would think some of
3 them deserve to be dead probably -- but the results could be
4 good in the long run. And it has the advantage that you
5 then have something you can do with the great majority of
6 physicians who are in small practices.

7 DR. BURNS: I was just going to pick up on Larry's last
8 comment. I've spent most of my professional career studying
9 the relationships between physicians and hospitals. Larry
10 is dead right on, in terms of, at best, the ambivalent
11 relationship between the two of them. So any payment
12 mechanism that goes that way is probably going to run into a
13 lot of obstacles.

14 I think the classic definition of a hospital medical staff
15 is a group of anarchists united by a common parking lot.

16 [Laughter.]

17 DR. BURNS: So the ability to get consensus between these
18 two parties that have a deteriorating relationship, where
19 the whole shift is to outpatient and ambulatory care and the
20 physicians are increasingly competing with the hospitals. I
21 think trying to affect some payment mechanism through that
22 is going to be really tough.

1 Now there are some illustrations where that's actually been
2 successful, in going back to the Medicare CABG demonstration
3 where you gave the hospital and its medical staff one
4 bundled rate. Three out of the four of those practice sites
5 that were funded actually seemed to work. There are people
6 out there now suggesting that's actually a pretty good model
7 for trying to affect changes in how to pay physicians.
8 I think the whole Bridges to Excellence model is largely
9 predicated on things like that.

10 MR. HACKBARTH: I think I heard a little difference of
11 emphasis. I heard Larry say that at first blush he thought
12 the hospital-based model probably wasn't a good idea. But
13 he closed on a more optimistic note that maybe if the
14 incentives change the dynamic of the traditional
15 dysfunctional relationship can change with it.
16 I heard a little emphasis on you. I just want to make sure
17 I'm hearing accurately.

18 DR. BURNS: He's probably a little bit more optimistic and
19 I'm probably a little bit more pessimistic. But hospitals
20 and doctors have had 100 years of trying to make this thing
21 work and they haven't done it.

22 MR. HACKBARTH: Katherine, anything you want to add?

1 DR. SCHNEIDER: I think those were all good comments. And
2 I'm thinking of myself as one of the dead hospital
3 administrators, probably.

4 I think what made it an easy sell in the PGP was that
5 essentially it really did kind of preserve the fee for
6 service and it was an add on to that, as far as the
7 physicians' viewpoint. I think as soon as you introduce
8 anything that is kind of complex and distribution models
9 that need to be -- I think the devil is in the details on
10 how that new model of payment would really be implemented.
11 And I think there would be bitter fighting, even within a
12 highly functional hospital medical staff relationship.
13 The other thing to throw in there is where does all of the
14 quality measurement come in? I mean, I've heard loud and
15 clear from CMS that quality, quality, quality, public
16 reporting, pay for quality is the direction that they want
17 to go in. The difficulty we have right now is that most of
18 the quality measures are very heavy on primary care and the
19 primary care docs don't even come into the hospital anymore.
20 From a medical staff perspective, we're always trying to
21 find ways of continuing to engage the primary care
22 physicians when they're all admitting to a hospitalist's

1 service. So how do we promote that?

2 So where does the quality measurement fit in? The devil is
3 in the detail, I guess, is my final comment.

4 MR. MULLER: Those were superb presentations.

5 Rob and Larry, both you noted, and I think Katherine showed
6 it in her illustration, that in the 90s we had these various
7 efforts to aggregate physicians largely around dollars and
8 payments, the California capitation efforts,. The roll up of
9 the physician practice management groups like Caremark and
10 MedPAR, et cetera, FICO that all, for the reasons you noted,
11 fell on hard times and collapsed. As you said, they were
12 not well structured to begin with. In the last few years
13 we've had the efforts to try to get physicians organized
14 more around quality.

15 In each of your presentations you also pointed out that the
16 thing we don't talk about as much but it really is shaping
17 this is how do you manage these practices? How do you
18 manage care? How do you get the infrastructure? How do you
19 get the kind of coordination of these processes? As you
20 noted, you can in some ways make that more implicit when the
21 groups are six or 12. But once you get beyond that, you
22 have to have a real managerial structure and so forth.

1 I think we've shown that trying to do this just around
2 dollars alone doesn't work. I could easily argue, and I
3 think it's in some of what you said, trying to do it just
4 around clinical quality is probably not sufficient either
5 because there may not be enough of a motivating traction
6 there.

7 But let's speak a little bit about how one gets this system
8 more managed and more organized so it can achieve either
9 financial ends or quality ends. I think, to go back to
10 Glenn's opening comments around alternatives to SGR, one has
11 to deal with both quality issues and financial issues. My
12 sense for many years has been until you figure out how to
13 manage these relationships in a more powerful way -- and as
14 Rob said, in 100 years of trying this, it isn't exactly that
15 we got it right.

16 But perhaps could you speak a little bit about how one
17 thinks about these what are I call the management issues and
18 interrelationship with the financial issues and the clinical
19 quality issues?

20 DR. BURNS: I'll take a first stab at that. It's a big
21 global question.

22 I think we're going to have to be patient for these things

1 to happen. I think the biggest changes that take place in
2 the practice of medicine may have to do with subsequent
3 cohorts of physicians coming out of medical schools and
4 residency programs. Larry talked about how medical schools
5 need to be training physicians and the residency programs
6 need to be training physicians more in the management side
7 and the quality side and things like that. And I know those
8 are now part of the American College guidelines. But those
9 were just put in place a couple of years ago and we may have
10 to be waiting several cohorts for new physicians coming into
11 this industry to have that sort of training and have that
12 kind of mindset.

13 So in the short term, I don't see much changing. I think
14 this is a very stable, resilient industry that doesn't
15 change very much. I remember talking to the physician CEO
16 of the Northwestern Health Care Network, may it rest in
17 peace. But he said what would it take to be able to pull
18 all of these things together? Because he had multiple
19 hospitals with different kinds of physicians all over the
20 place. He said it would probably take about 20 years of
21 genetic reengineering to make all these people work
22 together.

1 And I'm thinking or the alternative is cohorts later on down
2 the line of physicians who have been trained differently, to
3 think of some of these issues and who get practice earlier
4 on maybe in the kinds of settings that my two physician
5 colleagues have talked about, have them have experience in
6 doing this.

7 But boy, I don't see anything happening in the short-term.

8 But here again, I could be pessimistic and I'll yield to
9 more optimistic voices here.

10 DR. SCHNEIDER: Just a comment on linking the quality and
11 efficiency. The difficulty or what makes me bristle about
12 the PGP being described as pay for quality is that the
13 quality measures, they tend to be underutilization kinds of
14 measures. And so there's very little in our 32 quality
15 measures that if we did well are going to save us within
16 that short-term time frame.

17 On the inpatient side, I think that's easier. But on the
18 outpatient side, more breast cancer screening, more testing,
19 which yes, 10 years down the road may have a significant
20 impact. But we're in a three-year demo. And there's very
21 little linkage between those two. So that's a challenge.

22 DR. CASALINO: It's interesting to find myself perhaps more

1 optimistic than Rob. I think that in the one sense, I have
2 a sense of urgency. Because I honestly think that if you
3 just read the studies that if you just think that your own
4 experience as a patient may be exceptional, and if you're
5 not actually out there in the health care system like I
6 spent 20 years doing, you don't know how really bad it is
7 and how pathetic the quality is compared to what it ought to
8 be.

9 I'm not talking about individual interactions between an
10 individual doctor and patient or an individual surgery or
11 whatever. There are marvelous things that can be done. But
12 in general, it's terrible. It really is. And it's so far
13 from what it could be.

14 The same with costs. There's so much waste. You can almost
15 say that most of what is spent is waste, without it being
16 too much of an exaggeration. So on the one hand I'm
17 impatient to have something be done.

18 On the other hand, what Rob says makes a lot of sense to me.
19 I think that clearly things can be done, as Middlesex shows.

20 In certain situations they can be done.

21 But I think that as long as there's no real financial reward
22 for investing in quality, it's just not going to become the

1 rule. It will always be the exception because the majority
2 of people over time are just not going to invest money that
3 they're not going to get back. It's just not going to
4 happen except in exceptional cases. So again, the trick is
5 to find a way to do that.

6 I'm impatient to see that happen. But on the other hand, I
7 think it's quite possible, in fact likely, that CMS and
8 others may move too quickly to payment models without
9 sufficient -- there are some great demonstration projects
10 underway in CMS now, and I think there probably need to be
11 more. I'm particularly concerned that pay for performance
12 at the individual physician level could be put in by CMS
13 fairly quickly and I think it's going to be very hard to get
14 that right. I think the consequence of getting it wrong for
15 the whole health care system will be lasting and negative.

16 So on the one hand, I don't want to wait a couple of
17 generations of physicians. On the other hand, I am willing
18 to wait two or three or four years to try to get things
19 right. We've had them wrong for a long time and I think a
20 few more years of having them wrong to get them right sooner
21 is probably worth it.

22 DR. MILLER: If I could just ask you to say just a few more

1 things. I definitely understand the point about how bad
2 things are, and I've talked to enough physicians to have a
3 sense of the feeling between the physician and the medical
4 staff and physicians with insurers and that type of thing.
5 But I wonder if you could just say a few more words about
6 the point that you were making about marvelous things
7 happen, there's good transactions from physician to
8 physician, but quality is so bad. Can you just say more
9 about where in the system, when you make a statement like
10 that, what you see specifically as being bad?

11 DR. CASALINO: The list is long, I would say. And some of
12 the things are things you've talked about here. Certainly,
13 transitions of a patient between physicians or across
14 settings generally are terrible. And the academic medical
15 centers are by far the worst offenders with this, by and
16 large.

17 I think that in terms of all of the things that could be
18 done for patients with chronic illnesses between visits, in
19 other words everything that could be done separate from the
20 10 minute encounter between the physician and the patient.
21 By and large, that doesn't get done because it doesn't get
22 paid for. And also, physicians aren't really trained to

1 think that it's important.

2 I kind of naively, in my own practice started doing it. I
3 was in a nine-physician primary care practice. And
4 basically my nurse or medical assistant and I did it, the
5 two of us, without any assistance for 20 years. And really
6 the result was that, without exaggeration, we went home
7 about 10 o'clock at night and that's when we ate dinner for
8 20 years.

9 And I don't think we did it as well as we could. And yet I
10 still knew, as I started to go around and interview
11 California medical groups, that I wasn't doing it as well
12 because we didn't have an organized system. We were just
13 substituting our own labor with no infrastructure.

14 So all of that, for patients with chronic diseases, or to do
15 preventive care in an organized way, it just isn't there.

16 It isn't being paid for.

17 I'll say one more thing because this is something that
18 probably one could list -- I could spend the rest of the day
19 talking about problem areas. I think the whole model
20 actually of how physicians spend their time is probably
21 wrong. The model that physicians are just going to go
22 through patients as fast that they can all day long, whether

1 calls, other methods of communication would be.

2 MR. BERTKO: I'd like to aim this at Katherine and follow up
3 a little bit on Glenn. This is just to get your reaction.

4 You're not committing yourself.

5 Let's suppose that one of the alternatives to the current
6 SGR were smaller pools. And my consulting experience
7 overlaps that of Larry and Rob, to some extent, in
8 California. But my experience now tells me that most parts
9 of the U.S., 80 percent of the population, looks more like
10 Middlesex County in one way or another.

11 So if the revised SGR, with administration assumed -- I'll
12 pretend I'm an economist here -- and other quality measures.
13 And your choice, as Middlesex, was the current national SGR
14 by default, whatever new model looked like, the state of
15 Connecticut, or the Middlesex delivery system, which do you
16 think your docs would opt for?

17 Three. National as now, whatever that residual national is;
18 the state of Connecticut; or your Middlesex, Connecticut
19 delivery system.

20 DR. SCHNEIDER: This would be to determine what's the pool?

21 MR. BERTKO: Yes.

22 DR. SCHNEIDER: And it would be by residence of the

1 beneficiary? Or what's the attribution model?

2 MR. BERTKO: It would be by groups of physicians and DEA
3 numbers, tax IDs, however, UPNs.

4 MR. HACKBARTH: I think Katherine was asking a different
5 question. I think what I heard Katherine say is the results
6 are based on the costs of what group of people? And so it
7 would be based on the residence.

8 DR. SCHNEIDER: You would say county or service area.
9 I think they would take the latter, just because I think we
10 have enough data that we do it at least a little bit enough
11 better. The objections would be we can't steer the
12 patients, there's leakage everywhere, they still have choice
13 to go anywhere. And by the way, we don't do any tertiary
14 care. We don't even do open heart. So they're going to
15 Yale or Hartford or Boston or New York or they're snowbirds
16 going to Florida. Those would be all the kinds of
17 objections I would hear.

18 But I guess if we're being pitted against beating national
19 essentially, is what you're saying, I think that they would
20 choose that.

21 On the other hand, if you're comparing it to the way it's
22 done now, where we have a cut across the board but then it

1 gets repealed -- I guess devil in the details. But my sense
2 would be that they would go for where there is at least some
3 control.

4 DR. REISCHAUER: John, you're describing the localized SGR,
5 no quality or performance --

6 MR. BERTKO: My comment about making the economist
7 assumptions was to say there's all the other parts of it.

8 But on the payment financial end of it, it would be as I
9 indicated here. So it's just what's the pool that does it?
10 But there's quality measures, there's financial measures, et
11 cetera. The choice there is which of those three
12 alternatives would they choose?

13 DR. SCHNEIDER: If I could just add to that, too, I'm
14 thinking about the issues we're struggling with right now,
15 in terms of physician manpower, planning, how do we make it
16 attractive to recruit physicians into our area. It would
17 have a huge impact not only on the cost of care and patterns
18 of care but just even who we are as a health care delivery
19 system.

20 DR. MILSTEIN: I think there's probably general agreement
21 that it's hard to find industries that fundamentally and
22 continuously reengineered their basic processes when the

1 participants in that industry did not face either a burning
2 platform or a very competitive environment. And in your
3 presentation you indicated that one of the characteristics
4 of physician practice today is that it's not a highly
5 competitive environment.

6 Is there anything, or what are some of the things that
7 Medicare is not thinking about that you think would have the
8 highest probability of leading to the evolution of something
9 equivalent to the Southwest Airlines of American health
10 care? In other words, half of the current cost at equal or
11 higher levels of quality and customer services/

12 While you're thinking about that outlandish question, let me
13 also make the observation that folks like Clay Christianson,
14 in observing fundamentally disruptive innovations that have
15 delivered big value in other industries have made the point
16 that they generally come not from the mainstream players but
17 from the margins, from small players.

18 Southwest Airline is a great example. That model was not
19 invented by any of the major carriers. It was invented by
20 an organization that initially was very small, maybe the
21 airline equivalent of a one or two doctor practice, and was
22 initially laughed at as something that is not really as good

1 as the mainstream airlines.

2 Is there anything Medicare is not thinking of that it should
3 be thinking of, if that's the vision we'd like to get to not
4 in three or four generations but in five to 10 years?

5 MR. HACKBARTH: Will we be able to get seat assignments in
6 this?

7 [Laughter.]

8 DR. REISCHAUER: No baggage but everything else is okay?

9 DR. MILSTEIN: How much are you willing to pay for the seat?

10 DR. BURNS: First off, let me agree with your general
11 premise that most of the radical change does come from the
12 periphery. I think that some of the things that show up on
13 the periphery are the demonstration projects that Medicare
14 is funding. And Medicare's been doing this over a series of
15 years. The earliest one I remember that was like this was
16 the CABG demonstration, which I actually thought was pretty
17 interesting. It fits into a model of paying doctors based
18 on case rates where the doctors actually have to coordinate
19 their own activities with other specialists. And then
20 they're essentially taking on risk at the small group level
21 to manage cases in a defined area.

22 That whole issue of case-based rates has been out there a

1 long time. And a lot of people still believe in it. And
2 actually, if you look at it as an economist would, it
3 actually makes some sense for doing things that way. I'm
4 not exactly sure of all the reasons why that hasn't gotten
5 off the ground. It could be maybe the demonstration funding
6 is removed and then there's some inertia in the provider
7 settings, things like that. But we've had continued
8 experiments in things like that.

9 One thing is I would encourage Medicare to continue funding
10 demonstrations basically because they're all these little
11 pilot projects. They're demonstration projects or
12 development projects, whatever you want to call them. The
13 literature on innovation shows that that's where the
14 subsequent big ideas come from. And later on we ought to
15 take credit for it and say that was our strategy.

16 But really, you're just basically throwing a lot of balls up
17 in the air and a couple are going to hit. And programs like
18 the one Katherine is in is such a thing. But I think the
19 case-based rate is another one that's probably worthy of
20 revisiting only because it makes so much sense theoretically
21 or conceptually in terms of what we do. But implementing
22 it, given our fragmented specialist oriented medical

1 community is, I think, one of the big transition problems.

2 There are probably some other reactions, too.

3 DR. KANE: About demonstrations, when the demonstration is
4 done, what happens at CMS? I mean, do we have any -- I know

5 On Loc sat around demonstrating for 25 years or something

6 before anybody said we're going to now mainstream it.

7 What is the method at CMS for taking demonstration and

8 trying to turn it into more diffused practice?

9 DR. MILLER: I love getting questions like this, the ones
10 that don't have any answers.

11 There is generally no clear mechanism that often -- either a

12 demonstration is created internally. But often externally,

13 it's asked for in legislation. The demonstration runs.

14 There's supposed to be an evaluation, and then something has

15 to happen. Usually, if you're going to mainstream it, it

16 takes a change in law.

17 There is one recent change in that. The disease management

18 demonstration, which has gone through three different name

19 changes and I can't remember the current one. Health

20 Support.

21 MS. THOMAS: Medicare Health Support.

22 DR. MILLER: That one actually is cast as a pilot with the

1 notion that if it is successful the Secretary has some
2 flexibility to go forward. That is a little bit different.

3 DR. SCANLON: That was in statute as a pilot.

4 DR. MILLER: The Secretary was given that path in statute,
5 that's right, explicit.

6 DR. CASALINO: Arnie, as usual, you have this talent for
7 asking this question in a way that first makes the
8 respondent think oh come on. And then it's like no, you
9 really have to think about this. It does force one to
10 think. I think it's a very good question.

11 I think that, let's say CMS were to say beginning three
12 years from now, or whatever, the equivalent of the SGR is
13 going to come to each physician, either because they're a
14 member of a medical group of a certain size -- whether it be
15 50 or more or 100 or more or whatever -- or through their
16 hospital medical staff. And that's the way it's going to be
17 for everybody. And also, in the first year we're going to
18 pay 2 percent of -- you couldn't just do that because it
19 would leave the fee for service system untouched, and that's
20 no good.

21 But you could say that a very small percentage of fee for
22 service payment, that pool is going to be shifted into pay

1 for quality, also at the level of your group or the hospital
2 medical staff. And that's going to increase each years at
3 such and such a rate.

4 It's a doable thing. I think there would be a lot of
5 kicking and screaming. But doctors don't like the current
6 system and it actually would force people to -- there would
7 be consternation and you would see hospitals and their
8 medical staffs screaming at each other but working together
9 because they have to to try to do something about this.
10 So it could be done. That kind of thing, combining a shift
11 to SGR kind of mechanism at the group or the hospital staff
12 level, doing both at the same time, and then gradually
13 increasing the amount that goes to pay for quality around
14 fee for service, I think it would promote relatively rapid
15 change of the kind that I know you'd like to see.

16 MR. HACKBARTH: Can I pick up on that? Implicit is this is
17 an A and B system, as opposed to the current SGR which is a
18 Part B only.

19 DR. REISCHAUER: A part of Part B.

20 MR. HACKBARTH: A part of Part B, the fee schedule piece of
21 Part B. Do you think that is an important part of driving,
22 encouraging constructive organizational change, that

1 whatever Congress decides to do it ought to break out of the
2 Part B only model and think about A and B together?

3 DR. CASALINO: Yes. I think that would be one way to --
4 hospital physician cooperation is important, especially for
5 some of the most expensive things. And that would be a way
6 to do it. Gainsharing is another way. And I haven't
7 thought this through far enough to know, if you did what I
8 just perhaps rashly suggested in response to Arnie's
9 question, I don't know if you'd have to make gainsharing
10 exceptions to -- if you were going to shift the SGR to a
11 hospital medical staff model.

12 But yes, having these be separate silos obviously doesn't
13 really make sense, the A and the B.

14 DR. BURNS: When you think back, the whole integrated
15 delivery system movement started right after prospective
16 payment was passed. I remember I was working -- I did an
17 internship at Hospital Corporation of America and they were
18 right on top of the legislation at the time. And they said
19 my gosh, hospitals are being paid differently now than
20 physicians are because hospitals now get this fixed budgeted
21 prospective payments, doctors are getting retrospective fee
22 for service. What's wrong with this picture? The

1 incentives are not aligned.

2 And that's what launched 15 to 20 years of efforts by
3 hospitals to try to integrate their delivery systems with
4 doctors, basically because you had two different silos of
5 payment with differing incentives to it. And those human
6 behavior management techniques to try to engineer what had
7 been broken asunder through the separate payments and the
8 different incentives, those just didn't work.

9 Going back to your original question about whether changes
10 in financing could drive changes in organization or
11 behavior, it might be worth experimenting with pooling those
12 two funds, the case-based payments as one of them. This
13 might be another one.

14 I think the problem going forth, and here again I don't mean
15 to be really negative, but I think the trend data shows that
16 physicians are spending less time in the hospital now than
17 they used to. And so hospitals are going to have to work
18 with their doctors as a group who are spending less and less
19 time in the hospital.

20 And I see that as one of the fundamental challenges for
21 anything we do here.

22 DR. SCHNEIDER: I think it's very well said and the silo

1 issue is very important. In fact, in thinking about the SGR
2 and the previous question, I actually had on my PGP model
3 that where it wasn't just Part B. I'm thinking total pool
4 because the incentives really do need to be aligned. And I
5 think that's where the PGP Demo, I think Herb Kuhn from
6 Medicare described it as the first attempt to demo better
7 alignment between Part A and B pools.

8 If I could take a politically incorrect attempt to answer
9 Dr. Milstein's question, I don't see anything in Medicare
10 around the whole kind of consumer directed health care model
11 and patient incentives. That just may be impossible. But
12 certainly from the provider point of view, that's the other
13 piece that we need to align in there somehow. And I don't
14 know how to do that politically.

15 DR. CROSSON: I'd like to thank the panel for really fine
16 presentations, and also helping us, I think really quite
17 quickly, get to the core of some of the issues that we have
18 to address as we get ready for this mandated report.
19 I'd like to ask you one question. It's a little similar to
20 Arnie's question but I think a little bit broader. In so
21 doing, I'm going to use again the assumptions that the
22 economists like to use, as John said. We have a tradition

1 here we're developing on the Commission, and that is that
2 the economists like to talk like doctors and the doctors
3 like to talk like economists. So I feel perfectly free to
4 do that.

5 DR. REISCHAUER: There's more of you.

6 [Laughter.]

7 DR. CROSSON: I won't talk about how evenly we're matched.

8 We'll leave that for later.

9 So the assumptions are that we're going to think about a
10 10-year period and we're assuming -- and while there is
11 urgency, the level of change here we're talking about is
12 going to take some time. So assuming a 10-year period of
13 time, and assuming that the Medicare program not only has
14 the opportunity to change itself for the purposes of making
15 a better program, but it also has the opportunity to lead
16 change in the broader health care environment in the country
17 as a very larger payer and bully pulpit and all the rest of
18 that.

19 And the third assumption is that we're going to assume that
20 somewhere along the line somebody decides that there is a
21 compelling public policy reason to promote the kind of
22 organized delivery systems that we're talking about. Now we

1 haven't gotten to that point and we understand the data is
2 missing. And we also understand we really don't know what
3 we're saying when we say organized delivery system.
4 But I'm going to suggest that there are some elements to it,
5 and one of those is having physicians actually working
6 together across specialties.

7 I'm not going to say anything about size because I think
8 Larry has pointed out there are still some questions about
9 size and economies of scale or diseconomies or practicality
10 or the like. But another element is that the hospitals and
11 the physicians are also working together. So I would say
12 that when I'm saying organized delivery system, I would mean
13 a model that contains those characteristics.

14 So here's the assumption, that over a 10-year period of
15 time, at some point somebody decides that it's in the
16 interest of the country to evolve to a point where that is
17 the majority model 10 years from now.

18 So the question is, if you accept all those assumptions,
19 what could CMS do? What could the Medicare program do over
20 time to lead and shape that outcome? If you could start
21 with a blank slate and say if only Medicare would do this or
22 that, we might be able to get to a better place in terms of

1 how delivery of care is organized.

2 DR. BURNS: I'll scratch the surface on that. I think you'd
3 probably want to hold out to aspiring physicians or smaller
4 groups that are thinking that might be the way to go how do
5 they actually get there? I can't think of too many case
6 studies that actually show how you develop these kinds of
7 large or medium-sized multispecialty networks. We've done
8 one on Hill Physicians, so I'm familiar with how they did
9 it. But it took them 20 or 30 years to do that and you're
10 talking about a 10-year period. So you'd probably want to
11 look for some illustrations of groups or collections of
12 physicians partnering with whoever who have been able to do
13 that.

14 I think Larry's research shows that the single biggest
15 barrier is IT. But even before you get to the IT it's even
16 having the capital to afford the IT. And one of the things
17 you're going to have to address is where the money's going
18 to come from to finance the aggregation of physicians into
19 these larger groups? Where's the pot of money?
20 One pot of money I think that's been overlooked is the fact
21 that -- or not been allowed to develop is that physicians
22 and physician groups can't retain earnings. And why not

1 allow -- and maybe it's some change in the tax code, I don't
2 know, whatever -- but to allow physicians to retain earnings
3 such that they could invest themselves if they so wish in
4 developing these kinds of things. That's sort of a radical
5 proposal and that's not something that CMS can do.

6 But I'm looking at physicians have the incentive but they
7 don't have the ability to grow.

8 DR. CASALINO: One way to encourage the formation of let's
9 say large multispecialty groups, whatever large means, would
10 be just to pay them better. That is a political non-starter
11 probably; right?

12 But another way would be, as I tried to suggest in my
13 presentation, to pay for results in some way. And then if,
14 in fact -- and in a meaningful way, so it isn't just a tiny
15 fragment of a physician's income.

16 If that were done and a certain kind of group, say large
17 multispecialty groups, were able to get better results and
18 therefore higher pay for its physicians and/or hospitals,
19 presumably we'd see rapid migration of physicians into that
20 kind of group. But this would be politically much more
21 acceptable because you're not saying we're going to pay a
22 certain kind of group better. No, we're going to pay for

1 results. We may think that bigger groups are going to do
2 better.

3 So I think that's a pretty good way. I think if every
4 physician was paid through Medicare, either as part of their
5 hospital medical staff or as part of a large group, it's
6 quite possible that many large groups would do better and
7 that would lead to a movement of physicians into that kind
8 of group.

9 So those are the three best things I can come up with. Only
10 two of them are viable.

11 I think, in terms of retaining earnings or the double
12 taxation that physicians have that Rob has mentioned a
13 couple of times, I have mixed feelings about that. It's
14 very real for physicians. Our group and every other group
15 I've talked to, people sit there and they say we can't have
16 any money left over at the end of the year. We're damned if
17 we're going to be taxed twice on this. It does keep
18 physicians from retaining earnings. There's no question
19 about that.

20 On the other hand, that's true for every business and why
21 should physicians be an exception? There actually is
22 potentially capital there. Most physicians are fairly

1 highly paid and they could retain some earnings if they
2 wanted to. But really, even if you try to get a physician
3 who's earning \$400,000 a year to kickback \$1,000 or \$2,000
4 that year for their group's growth, you're going to have a
5 hard time about it. And I'm not exaggerating. It's amazing
6 what this is like.

7 So that's a problem that I think probably shouldn't be
8 solved by giving physicians a special exemption to the tax
9 code, but by just making the incentives to perform well so
10 high that they see -- as Kaiser physicians I think
11 understand -- that no, we have to, in effect, retain some
12 earnings because this will let us do things that are good
13 for our patients and that don't cost us money and may even
14 make us some money.

15 If I can ask you a question back, what would you do if you
16 were going to try to encourage the formation of large
17 groups?

18 DR. CROSSON: I have a lot of ideas but I think some of the
19 commissioners have heard them and don't particularly need me
20 to reiterate that.

21 But I do agree with you, I think, that as we saw in the
22 '90s, although as you pointed out it gave rise to some

1 model. But really the question fundamentally is what's the
2 outcome that you want, even from the beneficiary point of
3 view? What is rational care at the end of life? What is
4 rational evidence-based care of chronic diseases?
5 And that's what you want to incentivize somehow. If you're
6 going to build it from scratch, what do you want it to look
7 like? And then kind of let the market find its way.

8 MR. HACKBARTH: At least some commissioners, and I know Jay
9 is in this group, some commissioners as well as people
10 outside are saying one basic characteristic is that we need
11 providers to work together to collaborate to provide better
12 care and more efficient care. And the current fee for
13 service payment system in Medicare actually pushes in the
14 opposite direction. And so one basic design feature would
15 be to urge that collaboration, reinforce that collaboration.
16 Or at a minimum, create an option that rewards people that
17 voluntarily engage in that collaboration. That's the
18 genesis of this whole group opt out notion.

19 DR. BORMAN: Notice the surgeon was patient.

20 MR. HACKBARTH: This is the second time, I think, Karen.

21 DR. BORMAN: That's right, in my lifetime.

22 [Laughter.]

1 DR. BORMAN: Just a couple of things. Number one, great
2 presentations. Very thought provoking. A couple of things
3 that you said certainly, I think I want to make sure that I
4 iterate them correctly because I think they're important.
5 One, the honesty that data about some of these issues is
6 sorely lacking. I was once told that surgeons use the
7 literature much like alcoholics use lampposts, more for
8 support than illumination. And I do think it's important
9 that we try to go back to what are the things that we're
10 building on. Sometimes we have to take the big leap, but I
11 think that we need to acknowledge that a lot of these issues
12 don't have great data.

13 In follow up to that, I would say the demonstration project
14 issue is, I think, a very important one. CMS has invested
15 money in it. There are things to be learned. And I think
16 we should be maybe perhaps considering for our report a
17 better process to see those results, particularly as we're
18 facing the sizeable issues to make recommendations about.

19 I think, particularly Katherine talked a fair amount or
20 implied a lot about getting it right, as you guys did, as
21 well. I think from working doc end of this, this is going
22 to be just hugely important and that the backlash will

1 indeed be substantial if it's not. And so that's the
2 tension between the urgency and the caution and perhaps
3 where the demonstrations can help.

4 I think one thing that Katherine said really resonated with
5 me, which is the be careful about this turning into
6 outperforming the other guy. This is really not what this
7 is about. That reinforces the notion that's kind of growing
8 out there, that quality is just another name for taking
9 money out of the system or cost reduction. And that will be
10 the fastest way to lose the practitioner of any way that I
11 know. And I think the outperforming the other guy concept
12 is a huge one in here.

13 The piece about that physicians haven't felt enough pain,
14 I'm going to offer you an alternative construct, which is
15 we're getting pain every day anyway, so why should I sign on
16 to yet a different version of pain? And whether there's
17 rationality to that or not, I think I can tell you -- and I
18 think perhaps Ron would agree -- that there's a fair amount
19 of that kind of sentiment out there. And so we need to be a
20 little bit careful about how we characterize it.

21 My questions relate about, number one, you've made some
22 comments and observations and raised good questions about

1 the behavioral qualities of physicians, if you will, in
2 terms of the autonomy versus at times the herd effect that
3 you talked about. Do we have anything from social science
4 that you're aware of that links the autonomy with a
5 behavioral cluster that is different when autonomy isn't a
6 strong portion of somebody's personality or makeup? Because
7 if we change the piece of physicians that is driven by
8 autonomy, will we be selecting people for characteristics
9 that may, in fact, be inimical to the kind of health care
10 system that we want physicians to be a part of?

11 And so my guess is we don't know that but I'd be interested
12 in any data that you have. That's my first question.

13 DR. BURNS: I have a short answer, and that is I think you
14 could leverage the natural autonomy and entrepreneurship of
15 physicians and marry it to small startup projects,
16 development projects, pilot projects, whatever you want to
17 call them. There's a natural fit there.

18 I think the problem physicians have is that they either
19 aren't paid for or they're not given the time to or they
20 don't feel like they have the time to engage in these
21 things.

22 There was an article written how several years ago how

1 physicians could actually be the innovation engine in health
2 care. Because most of the innovation in health care takes
3 place in the product sector, pharma, biotech. We don't have
4 a whole lot of innovation taking place in the provider
5 sector. Physicians are natural people to lead an innovation
6 effort in the provider sector, just because of the clinical
7 autonomy and the strong need for entrepreneurship and the
8 bent that they have there. It's just a question of can we
9 unleash that in some way and support it?

10 Going back to one of Arnie's comments about changing coming
11 from the periphery. It's not just coming from the
12 periphery. Any change effort has to be sustained over a
13 period of time. And you're looking for two things here,
14 which you may not have. And that is time and money. But
15 most innovations, the really significant innovations,
16 gestate over a long period of time. They're given continued
17 seed funding. They're nourished. They're someone who's
18 championing the effort. This is what all the innovation
19 literature shows.

20 And oftentimes the things that really pay off in the long
21 term are things that you sustained in terms of interest,
22 time and money over a long period of time. Rather than

1 looking at it in terms of the short term.

2 I'll just give you one illustration, a very interesting
3 statistic. That is they compared American firms and
4 Japanese firms in terms of their commitment to total quality
5 management. Now I think most people would still agree that
6 the Japanese cars are probably made a little bit better than
7 ours. But American firms devoted roughly two to three years
8 to total quality management programs, may not have seen the
9 results, then they drop it and they move on to the next
10 thing. The average Japanese firm committed 30 years to
11 total quality management. I think they saw the results.
12 That's why I'm suggesting oftentimes I think it's a question
13 of time and money and sustained interest to see any of these
14 kind of development projects take off.

15 DR. CASALINO: I think that once again I'd go back to the
16 training. We don't want individuals to be selected who
17 aren't able to function autonomously, nor do we want them to
18 be trained in such a way they don't feel that the buck stops
19 with them. This is particularly clear with surgeons, but
20 with all physicians. I mean, you don't want your surgeon
21 turning around and saying well, I'm sorry things didn't go
22 well, it was the nurse's fault.

1 That is probably the strongest aspect of medical training,
2 that the buck stops with you, you use your own best
3 judgment, don't ever make an excuse. We don't want
4 physicians to ever be any different about that. But we need
5 to train physicians equally strongly that that isn't the
6 only thing that physician professionalism is about. It's
7 not the only thing that quality is about. It's equally
8 important to pay attention to the organized processes that
9 your practice, whatever size it is, uses to improve quality
10 for patients. And if you're not doing that, it's just as
11 bad as not getting out of bed at three o'clock in the
12 morning when a patient calls or when a nurse calls. So
13 that's the training side.

14 I think in terms of the other side, I think that physicians
15 are, in fact, naturally, I think pretty entrepreneurial and
16 pretty creative when they need to be. And also, they have
17 the most intimate knowledge of the health care system. But
18 the average physician rank and file, that isn't really
19 unleashed because, as I said earlier, physician
20 organizations by and large don't want to pay anyone to lead
21 them. And there isn't a strong enough impetus yet, as Arnie
22 was getting at, to make them say we really need to pay

1 somebody to lead us. It's worth our while to do that.

2 So on the one hand, we don't have very many physician
3 leaders with the time to create change. And the rank and
4 file physician, there's really very little room for any kind
5 of innovation to come from there because they're just
6 slogging from one patient as fast as they can until late at
7 night. And then they don't have the time or energy or
8 training to think of how things could be done even in their
9 own little narrow sphere.

10 So again, I think we want a payment system that will
11 encourage physician groups of whatever size to be willing to
12 pay people to lead, and those groups to pay their own
13 physicians for something other than churning patients as
14 fast as they can.

15 DR. BORMAN: In the vein of the question of what would you
16 have Medicare do, we've had some discussions about what the
17 program should benefit, for example, from graduate medical
18 educational support as delivered through the program. What
19 would you propose is a program to identify or to help
20 generate physician leaders? Katherine obviously probably
21 has some thoughts about that, as well.

22 If you were going to say okay, to get your full IME

1 allotment you would need to show us what you're doing with X
2 percentage of your residents to encourage them in
3 acquisition of leadership skills.

4 DR. SCHNEIDER: I think you could build exactly the same
5 incentives for the training programs that you build when
6 you're in practice. We've talked a lot about this within my
7 residency program, that maybe we should pay our residents on
8 some kind of quality incentive program. Because they walk
9 out the door, they've been salaried employees, and suddenly
10 they're out there and they're getting report cards, they've
11 never seen any of this before.

12 So in a surgical program, for example, the American College
13 of Surgeons has a wonderful bench marking voluntary quality
14 program. Why not have the training programs adopt some
15 version of that and be able to demonstrate the same kind of
16 outcomes and so forth?

17 The trainees have to be very cognizant of the skills they're
18 going to need once they step out the door. And this goes
19 back forever and how bad we do with practice management
20 skills in general in training folks.

21 I've asked big academic centers how many of your third or
22 chief residents in internal medicine have ever heard of

1 National Quality Forum or safety measures or Leapfrog? It's
2 zero. Where do you build that in?

3 DR. BORMAN: I would just throw out just as an example, at
4 my own place we use the NSQIP 30-day occurrence measures as
5 the platform for our monthly morbidity -- conference that's
6 focused only on morbidities and mortalities for just some of
7 the reasons that you outlined.

8 With regards to just a couple of comments about education.

9 I would say to you that one of the things that will
10 accelerate change actually will be the evolution in our
11 current graduates. I think it's going to be a bit shorter
12 than perhaps you folks implied that you believe, or at least
13 that you implied.

14 I see tremendous difference now, in terms of focus not
15 necessarily for good or for ill but in terms of how one
16 invests oneself. And so I think -- and they will be some of
17 the drivers of IT. These will be people that don't know how
18 to function without IT and they will demand it as part of
19 practice.

20 Now that doesn't necessarily get it all funded, but it will
21 start to set expectations for practice. And as graduates
22 come out who have been in a primarily hospitalist versus

1 other environment, they will expect to go to environments
2 where there are hospitalists and other kinds of things, and
3 there's the sort of surgicalist kind of splinter thing
4 happening, as well.

5 So I think those things actually are going to accelerate the
6 pace of this change perhaps more than we think it's going to
7 accelerate.

8 My last is a very specific question for Katherine. You
9 mentioned that you had all these claims-based measurements
10 and you had hoped to confine it to that, and then you had
11 what had to be chart-based measurements. Were you able to
12 look to see that if there were one or a composite of the
13 claims things that could have served in retrospect as a
14 proxy for what you measured with the chart things?

15 DR. SCHNEIDER: That's a great question and I don't have
16 enough data to be able to answer that. But I will give CMS
17 credit for having listened to the participants on this
18 point, in that they weighted the claims-based measures at
19 the fourfold weight, compared to the chart-based measures,
20 recognizing that there are some things that we just may not
21 ever be able to capture, like blood pressure at every visit
22 for a 12-month period for a heart failure patient. When

1 I've got a 600 square mile radius that the charts are all
2 spread out in it's just not possible. I don't know. That's
3 a great question.

4 I think administrative burden of collecting this data is
5 just a huge, huge issue. So where there is something that's
6 a pretty good proxy, certainly using that. That would be a
7 great evaluation question at the end of this would be to
8 look at how did the groups do? If they're doing great on
9 the eight measures, does that have a correlation to doing
10 well in all of those others? That's an excellent point.

11 MR. HACKBARTH: A quick question for Katherine and for Nick,
12 who also participates in the group practice demo.

13 Looking at that model, and you've had some experience with
14 it now, based on that experience, any suggestions for change
15 in the model that would make it more powerful from your
16 perspective?

17 DR. SCHNEIDER: Again, I think it depends on what's the
18 outcome you're looking for. So this kind of unlinkage of
19 the savings piece with the quality piece where, in fact, we
20 could score 100 percent on all of the quality measures and
21 go to extreme lengths to not only collect all of the data
22 but make improvements and not get anything financially at

1 the end of the day because you have to jump through the
2 savings hoop first. That's kind of a difficult thing to
3 explain to the physicians.

4 I think the delay in the feedback, I don't know anything
5 around that. Our baseline year was 2004, we've been talking
6 about this since 2002. We won't know how we did in year one
7 until some time in the middle of 2007. It's almost old news
8 at that point. So I don't know a way around that, just with
9 the way that these models are so heavily reliant on claims
10 data when you're looking at the economic impact.

11 There were some things that were disappointing to me
12 personally along the way. Hospice was just carved right out
13 of it, which was not our expectation at the beginning. I
14 think the feeling was the physicians have less control once
15 someone is enrolled in hospice. But one reason the program
16 appealed to us is we have a wonderful hospice program that's
17 been in the community for decades and we think we do a good
18 job at end of life care.

19 In fact, if you look at that Dartmouth Atlas data that came
20 out a couple of months ago we're an extreme outlier to the
21 good side in terms of end of life care. So the fact that it
22 just gets taken out of our denominator doesn't make any

1 sense to us. But I'll defer to Dr. Wolter.

2 DR. WOLTER: The data lag is a huge issue. In fact, we
3 didn't see the bas year data, the data from the year before
4 the program kicked off until almost one year into the
5 program, something like that. So that really makes it hard
6 to respond well.

7 I think the financial model is very flawed also because you
8 have to achieve 2 percent savings relative to the comparator
9 group to even share in any savings. But then you only share
10 in the savings beyond the 2 percent. And so by design, I
11 think, when you consider the cost of investment in
12 infrastructure to manage care differently, there's really
13 almost no way to break even on this program. And so I think
14 the financial modeling over time has to be different.

15 But I think all the groups feel that there is tremendous
16 value in participating. There's going to be a lot learned.
17 And I think our capability at managing care differently will
18 improve.

19 I just have to take every opportunity I can to say this: I
20 think all the groups are creating focus in terms of what
21 they're tackling. I couldn't agree more with Dr. Casalino.
22 There's a huge danger right in front of us in terms of how

1 P4P is being unfolded for physicians. It's likely not to be
2 effective and there's likely to be a huge backlash. There
3 isn't focus. It's too mixed in with the issues around
4 fixing the SGR.

5 I know that wasn't the question you asked, Glenn, but I
6 think when you look at what's going on in the PGP demo,
7 there's really focus on how to manage care differently in
8 sort of that low-hanging fruit way. And we're not seeing
9 that same thing in the physician P4P that's now unfolding.

10 DR. MILSTEIN: In the Crossing the Quality Chasm Report, the
11 IOM offered the opinion that we weren't going to get major
12 improvements in either affordability or quality without -- I
13 think their wording was fundamental changes in the basic
14 methods of clinical work.

15 I'd be interested in any of your comments on Katherine's
16 observation that the most radical changes that she saw
17 within her organization were within the smallest, not the
18 larger physician practices.

19 DR. BURNS: I've seen the same thing. I remember we spent
20 time out at Intermountain Health Care. They have a very
21 large salaried group of physicians. But they also have a
22 lot of satellite clinics outside of Salt Lake City. I

1 remember interviewing the top physicians leader there and
2 that's where all of the changes came there, as well. It
3 wasn't in the core group. It was in the satellite clinics
4 where a lot of the experimentation takes place. Then over a
5 period of time if they can accumulate the results and
6 demonstrate the benefits, then they can perhaps persuade
7 other parts of that delivery system to make it. But it's
8 again, changing coming from the periphery, smaller groups
9 being willing to experiment and doing some different kinds
10 of things.

11 Basically, I think you're banking on finding some maverick
12 physicians who don't mind doing this differently.

13 DR. SCHNEIDER: If I could just add to that, I think some of
14 it depends on how does the internal payment system work
15 within some of the larger groups, because if they're
16 strictly a productivity-based model then they have the same
17 discussion that you're having but on a smaller scale. Where
18 I've seen it work is where a physicians says wow, group
19 visits for diabetics, wow, that's a great idea. I think my
20 patients will like it. I think it will be more fun for me,
21 but I don't have to go through some bureaucracy of internal
22 politics to get a nurse assigned to this task in a very

1 different model.

2 So I think what are the incentives within a group? How much
3 bureaucracy do you need to get through internally to make
4 change? And how does that all fit together?

5 DR. CASALINO: Arnie, this is a slight tangent to your
6 question, but I think again to unleash those energies you
7 have to recognize it's not talked about enough, I don't
8 think, that most of the patients who are seen in any given
9 day by most physicians do not need should be seen in person.
10 And many of the patients who do need to be seen should be
11 seen for a lot longer than they're seen.

12 So a very high percentage of physician and patient time is
13 paid for but wasted. The patient's time isn't paid for.

14 And again, we want to incent the systems that will allow
15 groups of whatever size to not do that and have physicians
16 have some time to actually use their brains.

17 MR. HACKBARTH: Okay, thank you very much. Terrific
18 presentations. It was a real pleasure to have you with us.

19 Thanks.

20 We need to dramatically switch gears here to a
21 congressionally mandated study on the impact of changes in
22 payment payments for Part B drugs.

1 ways to improve how ASP is calculated.

2 On the screen you see our congressional mandate. Last year
3 we completed a study on the effects of the payment changes
4 on chemotherapy services for Medicare beneficiaries. As you
5 may recall, we found that access to chemotherapy remained
6 good, but that some beneficiaries without supplemental
7 insurance were more likely to move for care to hospital
8 outpatient departments.

9 This year we have been asked to study the effects of the
10 changes on other specialties that provide physician-
11 administered drugs. We focused on the experiences of
12 urologists, rheumatologists and specialists in infectious
13 disease because these are specialties with some of the
14 highest Medicare expenditures for physician-administered
15 drugs, after oncologists. We have also continued to meet
16 with oncologists and beneficiary advocates to continue to
17 track access to care for beneficiaries receiving
18 chemotherapy.

19 Our analyses have combined claims analysis with interviews
20 with physicians, practice managers, hospital administrators,
21 specialty group associations, wholesalers, manufacturers and
22 other stakeholders.

1 Today we'll present some initial findings based on what we
2 heard from our interviewees. First, they suggested ways
3 that calculation of the average sales price, or ASP, could
4 be refined. Then, as we heard last year, they told us that
5 the payment system has had an effect on where some
6 beneficiaries receive care. We found that there were few
7 common measures to determine if quality of care has been
8 affected by the payment changes.

9 Next month, we'll present results from our analysis of 2005
10 claims data and discuss changes in physician practices.

11 Starting in 2005, Medicare began paying for physician-
12 administered drugs at a rate of 106 percent of the average
13 sales price. ASP is the weighted average of manufacturer's
14 sales prices for each drug that falls within a Medicare
15 billing code when you take into account rebates and
16 discounts. Manufacturers submit data quarterly and the
17 payment rate is set prospectively based on prices from two
18 quarters prior. CMS updates the payments quarterly.

19 In the first quarter of 2005, the new system produced
20 dramatic price decreases for many drugs as Medicare payments
21 came closer to purchase prices. By 2006 payment rates were
22 more stable. In cases where there was competition between

1 drugs, payment rates continued to fall. In other cases,
2 payments increased.

3 Overall CMS reported that the payment rate rose in the third
4 quarter of 2006, but significantly less than other
5 outpatient drug prices in general. Based on our interviews
6 and continuing studies by the Inspector General, most
7 physicians can buy most drugs at the payment rate, but all
8 report some drugs that they must pay more for than the
9 Medicare payment rate allows.

10 Since ASP is an average price, we would expect some
11 purchasers to pay more and some to pay less for any given
12 product. For example, larger purchasers often get better
13 prices than small purchasers. The payment rate takes this
14 into account since Medicare pays more than the average sales
15 price. However in interviews physicians and other
16 stakeholders identified some structural issues with the way
17 ASP is calculated that can lead to a difference between the
18 data reported by manufacturers that goes into the
19 calculations of ASP and the average price that physicians
20 pay.

21 We can classify these issues into three categories. First,
22 there's a lag between when data is reported and when the

1 Medicare payment rate changes. Secondly, there can be a gap
2 between the average price the manufacturer receives for a
3 drug and the average price physicians pay. And third, the
4 way discounts for bundled products are allocated in the
5 calculations of ASP may create a dislocation in the system.
6 Remember, ASP is based on prices for two quarters prior. If
7 manufacturers raise prices in the succeeding quarters,
8 purchasers may have difficulty buying the drug at the
9 Medicare payment rate until the ASP catches up. On the
10 other hand, if the price goes down, either because of
11 competition between branded drugs or because a generic
12 product enters the market, purchasers may buy the drug at a
13 rate well below the payment rate, again until ASP catches
14 up.

15 Here you see an illustration of this. In this illustration,
16 the average price in quarter one, you can see the blue dot
17 there, becomes the payment rate for quarter three, which
18 would be the ASP plus 6 percent. Say that the average price
19 goes up 1 percent each quarter in the succeeding quarters.

20 Since the payment rate is ASP plus 6, and that's based on
21 the first quarter price, most purchasers will still pay less
22 for the drug than they receive from Medicare but not an

1 additional 6 percent.

2 Medicare could require manufacturers to provide data more
3 quickly and update the payment rates more frequently. On
4 the one hand, this would allow Medicare to pay more
5 accurately for the drugs. But on the other hand, more
6 frequent updates could have an inflationary effect and lead
7 to more price increases.

8 I'll come to the second issue. ASP is based on payments
9 manufacturers get for their products. When manufacturers
10 sell directly to physicians the average amount they receive
11 should be the average price physicians pay. However, drugs
12 often pass through a larger distribution chain. For
13 example, wholesalers and GPOs may be involved in drug
14 shipping, storing, handling, and price negotiations. Each
15 link in the distribution chain receives a payment. If there
16 is a gap between the price manufacturers receive and report,
17 and the physician purchase price, ASP may be lower than the
18 average price that physicians pay. This can happen in two
19 ways. ASP may include discounts that are not passed on to
20 physicians or ASP may not include charges that physicians
21 pay.

22 Here we see three hypothetical examples, and I stress that

1 these numbers are made up. In the first case, you can see
2 the yellow highlight, the purchaser buys the drug directly
3 from the manufacturer, the manufacturer charges an average
4 of \$100, the physician pays an average of \$100, and Medicare
5 pays ASP plus 6 or \$106.

6 In the second case, when the drug passes through a
7 wholesaler, the drug is still priced at \$100, but the
8 manufacturer may give a 10 percent prompt pay discount to
9 the wholesaler if the wholesaler pays for the drug within a
10 particular time frame. Since the manufacturer only receives
11 \$90 for the drug, the payment rate of ASP plus 6 will equal
12 somewhat over \$95. In this case, the physician pays an
13 average of \$100 but receives \$95 back, although it is true
14 that the wholesaler could pass on and does pass on some part
15 of the discount they receive.

16 Finally, the third case, the drug again is sold for \$100,
17 the payment rate is \$106, but in some parts of the country
18 the physician is charged some sort of sales tax or gross
19 receipts tax. Say the tax was 2 percent, so the physician
20 would pay \$102. Here the payment is still higher than the
21 purchase price, but again not 6 percent higher.

22 Some manufacturers make discounts for one of their products

1 contingent on the purchase of one or more other products.

2 Many oncologists spoke about a particular example of this
3 kind of bundling that they said created particular problems
4 for them. Let me give you an example. Say we have two
5 drugs, drug A and drug B that are very similar products and
6 they compete for market share. The manufacture of drug A
7 also makes drug C, which is a lifesaving product that has no
8 competition. All oncologists must provide this drug to at
9 least some of their patients.

10 Now it's very unusual to get a large discount on a drug that
11 has no competition. But in this case, the manufacturer may
12 provide a significant discount on drug C to those purchasers
13 who choose to buy drug A instead of its competitor, drug B.
14 These bundled discounts result in a lower ASP for drug C and
15 a lower payment rate. Let's see how this looks.

16 Let's say that the list price for drug A is \$100 and the
17 list price for drug B is also \$100. The list price for drug
18 C is \$300. This is the drug without competition. If the
19 physician gets the bundled discount, which in this case is
20 10 percent for A and 30 percent for C, there's no trouble
21 purchasing either drug at the Medicare payment rate. As you
22 can see on the left side, the bottom left of your screen.

1 However, many practices reported that they were sending
2 certain patients to hospital settings. Most practices said
3 they were sending the same proportion as last year but some
4 indicated that this year had increased. For example, one
5 practice last year said that they had sent only patients
6 needing IVIG to hospitals but this year they were sending
7 all beneficiaries without supplemental insurance.

8 Less frequently, beneficiaries had been sent to other
9 settings besides hospital outpatient infusion centers or
10 were considering it. For example, infectious disease
11 physicians told us that they had sent some patients to
12 inpatient acute hospitals, skilled nursing facilities, and
13 long term care hospitals. I should note that these settings
14 have always been used to treat some of these patients.

15 The beneficiaries most likely to be shifted included those
16 without supplemental insurance and those who required
17 expensive drugs or biologicals such as Remacade or IVIG.

18 Depending on the level of Medicaid reimbursement, dual
19 eligibles were also more likely to be sent to the hospital.

20 Interviewees did not agree on how the care furnished in
21 physicians' offices compared to that in hospital outpatient
22 centers. Physicians generally thought that the setting

1 where they practice had the higher quality of care.

2 Physicians who preferred the office setting gave the
3 following reasons: there was more continuity to the care
4 because fewer different clinicians saw the patient. This
5 might mean, for example, that a nurse would detect the
6 beginning signs of an adverse drug reaction.

7 They also thought they had more control over the care
8 actually delivered. Hospitals do not always stock the drug
9 that was prescribed. In these cases, the patient will be
10 treated with a clinically equivalent alternative, which may
11 not work as well for that particular patient. They also
12 thought the staffs in their offices were more specialized.
13 Another concern was the greater risk of infection posed by
14 hospital settings, particularly for immune compromised
15 patients. Hospital outpatient infusion centers do not
16 always have separate areas to infuse these patients and so
17 they will be infused alongside other patients or end up
18 being admitted as inpatients to ensure a sterile environment
19 for the infusion.

20 Physicians also noted that registration and waiting times
21 were shorter in their offices.

22 In contrast, clinicians who practiced in hospital outpatient

1 settings had very different views about the quality of care
2 in their settings. These practitioners considered the care
3 they provided as comparable to that furnished in physicians'
4 offices. Last year we found similar differences in views
5 among oncologists. Differences appeared subjective and
6 dictated by where the physician practiced.

7 Finally, many physicians thought that hospitals are better
8 able to handle serious adverse drug reactions.

9 The mandate asked that we examine the effects of the payment
10 changes on quality of care. For each specialty, we looked
11 at the most common condition that requires physician-
12 administered drugs and found, not surprisingly, that there's
13 not a uniform set of quality or outcome measures across
14 them. There's just too wide a range in the diseases
15 treated, the treatments pursued, and the risks associated
16 with each. For example, the measures appropriate for a
17 chronic condition such as rheumatoid arthritis vary from
18 those that are relevant to an acute episode such as a bone
19 infection.

20 Further complicating the evaluation of quality of care is
21 the lack of convincing evidence about the most effective
22 treatment for some conditions such as prostate cancer. The

1 uncertainty about the best course of treatment will result
2 in wide variation in practice patterns. When evidence is
3 mixed, patient attitudes towards the risks associated with
4 each treatment option may play a larger role in their
5 decision making.

6 For each condition, we found that appropriate quality
7 measures are available but that Medicare does not collect
8 information to track many of them. There are large private
9 datasets that include these conditions but the data are
10 collected at only selected sites. Thus, while the data may
11 include a mix of practice types, they will not be
12 representative. For databases that track patients over
13 time, and many of them are longitudinal, we would also need
14 to understand the patient follow up techniques and drop out
15 rates so we can assess potential biases.

16 For each condition, we did examine the measures that might
17 be used to evaluate the quality and outcomes of care. For
18 urologists the most common conditions treated with
19 physician-administered drugs are prostate and bladder
20 cancers. Outcome measures for these conditions might
21 include things like survival rates and complications and
22 side effects from treatments.

1 In addition to these measures, Medicare might gather
2 information about the extent and aggressiveness of the
3 patient's disease. This information, which is used to guide
4 patients to the most appropriate treatments, will be very
5 helpful for risk adjustments so that valid comparisons could
6 be made across patients and the physicians that treat them.
7 For a chronic disease like rheumatoid arthritis, outcome
8 measures include changes in functional status and pain
9 management. A process measure could include whether the
10 patient exam included assessments of both of these.
11 Quality measures for infectious disease include whether the
12 infection was successfully treated and vascular access
13 complication rates. Other process measures might include
14 how well a practice or outpatient center screens out high
15 risk patients who are not suitable for outpatient care.
16 This concludes our presentation this morning. In future
17 presentations we will present results of claims analysis and
18 further findings from the structured interviews to see if
19 access to care has been affected by payment changes. This
20 morning, commissioners may want to discuss possible
21 recommendations for refining the ASP.
22 DR. SCANLON: Let me start with a little background because

1 ASP plus was actually a GAO recommendation in 2001. I don't
2 want to appear defensive about that, but let me tell you why
3 we got to that point.

4 We were studying the situation then which was average
5 wholesale price, which we talked about as neither an average
6 or a price, and just a number that Medicare was paying, and
7 that there was incredible profits that were associated with
8 supplying Part B drugs.

9 In looking at the provision of drugs, one of the things that
10 I think we don't appreciate, and it did not come across --
11 and this is not a criticism of anything that you did. But
12 the common sense of the drug market is it's relatively
13 straightforward. You've got a purchaser and a supplier.
14 And the reality is you've got middlemen all over the place,
15 some of whom touch the drugs and some of whom don't. And
16 there are financial flows that are sometimes called rebates,
17 sometimes called discounts, sometimes not really labeled but
18 there's money going back and forth. And they may be going
19 to people that touched the drugs or didn't touch the drugs.
20 So sorting all of that out is a very difficult thing to do.
21 One of the huge issues that we were facing in thinking about
22 how do you reform this AWP system is where can you get

1 information? Where can you get data?

2 And what we settled on was the leverage point that could
3 potentially be used was the manufacturer. We had experience
4 with the Medicaid rebate program to go to manufacturers and
5 get information on sales prices.

6 Thinking about some of the intermediaries that are involved
7 in this process, Medicare doesn't have a relationship with
8 them. It's not impossible for the Congress to say you have
9 to do this. I mean, we used to have a military draft. But
10 it was unlikely that they were going to do this. The other
11 potential source of information was the physicians, which
12 would also be unprecedented in terms of the Medicare
13 program, to say to physicians -- unlike other providers --
14 to say we want some information about your costs. And in
15 this case, it also wouldn't be all physicians. It would
16 have to be certain specialties that would have to do this.
17 So those are the reasons why we settled on the manufacturer
18 as the best source of information for this.

19 The plus 6, and we actually did not come up with the 6. Our
20 idea was plus, that you needed to do something beyond the
21 average sales price at the manufacturer level to reflect the
22 fact that physicians were not buying from manufacturers in

1 all cases, that there were going to be additional costs for
2 different purchasers, that an average is an average, there's
3 a distribution, some people pay more, some people pay less.

4 You needed a cushion that was going to assure access for
5 Medicare beneficiaries.

6 It was not meant to be a profit. We knew that the average
7 sales price at the manufacturer level was not going to equal
8 the average purchase price at the physician level. We
9 weren't trying to say that there should be sort of a profit
10 margin that physicians got for administering Part B drugs.

11 In fact, what we argued was you should pay for the drugs
12 appropriately and you should pay for the administration
13 appropriately and suggested that the administration fees be
14 looked at, which has been done.

15 So that was the logic of it. And that, I think, deals with
16 one of the three problems that you identified, which was
17 that the average sales price is not equal to the average
18 physician purchase price.

19 The plus 6 is the issue, I think in part, to deal with the
20 second problem, which is the lag. You have two choices.

21 You can either try and shorten the lag, as you've talked
22 about, or you can say is the six enough to deal with the

1 lag? Or does the six actually, in keeping it where it is,
2 create some incentive for there not to be as rapid an
3 increase over time. And that's going to vary by drug. So
4 that's a real issue.

5 The third issue that you raised about bundling --
6 MS. BURKE: Bill, can you pause on that issue for just a
7 second? Help me understand. In the normal course, when
8 you're trying to neither encourage escalation nor ignore
9 reality, does developing some kind of a rolling average
10 rather than updating every month so that you did it over a
11 period of time, does that help soften the sort of bumps up,
12 but -- does that help in that second instance?

13 DR. SCANLON: I would argue or respond that I think that it
14 can, in many circumstances. But again, one of the problems
15 -- and actually it comes up in the bundling example, one of
16 the issues in the drug area is that we're dealing, in some
17 cases, with considerable market power on the part of a
18 particular drug.

19 MS. BURKE: No question, of particular unique drugs.

20 DR. SCANLON: What's the dynamic there? I think I, at
21 least, don't know what the dynamic there is going to be
22 like.

1 MS. BURKE: I'd like to separate out the bundling thing for
2 a second because I think there is a real substantive and a
3 real quality issue there which concerns me.
4 But just on the pricing issue, like you, I am concerned with
5 something that would essentially basically create the
6 incentive for escalations to occur if they're going to be
7 tracked immediately. This is probably one of the few places
8 in Medicare where we actually are relatively on time in
9 terms of pricing, as compared to working off three-year-old
10 data.

11 But having said that, the question is is there a way to do
12 that, deal with that lag issue, by moderating it with some
13 kind of a rolling average rather than simply just accepting
14 what the bump up is in that time frame.

15 I don't know. It would be something to think about that
16 would discourage the full escalation or the full acceptance
17 of whatever the increase is.

18 DR. SCANLON: For me, your question falls into a similar
19 category as the bundling in the sense, not the substance of
20 the question, but the fact that I think we need to model, at
21 least conceptually, in more detail what would be the
22 potential outcomes of a change in policy and actually have

1 more data to inform the model. How many times are we
2 experiencing a problem where the lag that we currently have
3 is creating a situation where physicians are not able to
4 purchase at a price.

5 MR. HACKBARTH: Bill, this issue of the timing of the
6 updates interests me in the sense that I'm not sure that
7 frequent updating is as much a problem as some people fear.
8 Certainly, if you were reimbursing fully for whatever price
9 increases occur, then frequent updates create a powerful
10 inflationary incentive.

11 This is a prospective system, though. The purchasers each
12 have the incentive to get it below the ASP plus 6 and get
13 the best bargain that they can. So as in any competitive
14 market, there's downward pressure on this price. The
15 payment system isn't constantly pushing it upwards.

16 MS. BURKE: But it is. In fact, the suggestion is that it -
17 - I think that's the question. A, I think Bill is exactly
18 right. Is it a problem? To what extent, in fact, are we
19 seeing people confronted with this against a cap essentially
20 because the prices haven't kept current? And is the
21 solution to make the payment more current? Which then leads
22 into the inflationary incentive, I think. Even though

1 [Simultaneous discussion.]

2 DR. SCANLON: A very important part of this market is not
3 generics. They are brands.

4 I think if you're a business in doing this, that you've got
5 certain relationships with your suppliers and that you may
6 be willing to incur a short-term loss because over time
7 you're going to be fine. And your interest in negotiating
8 stronger with your supplier is muted by the fact that the
9 rebasing is occurring.

10 I think we've said in the past that gee, prospective is so
11 much better than retrospective, and it's true, but on a
12 relative basis. Only when it's trended and truly
13 independent of costs does it become as effective as we've
14 given it credit for.

15 I wanted to say something about the issue about the
16 complexity of the bundling question, which I think is
17 another thing that needs to be sorted out, which is because
18 again we've got these multiple flows going among different
19 parties. And we're also going to have, I think, a fair
20 number of situations where we may not only be talking about
21 Part B drugs that are involved in bundles. That adds to the
22 complexity of how do we think about the right allocation of

1 discounts? That's the challenge that we may face. I don't
2 have an answer to this at all. This is not something GAO
3 looked into.

4 DR. HOLTZ-EAKIN: Can I ask a detail question? What
5 constitutes a sale? This is an average sales price. What
6 is the sale? Delivery? Sign a contract? I don't know the
7 answer to this question. What goes into that calculation?

8 And when does it occur?

9 DR. CASTELLANOS: Can I answer that from a practicing
10 physician's viewpoint? It's really easy, it's direct when
11 you're buying it from the manufacturer. He's asking the
12 question on the cost of the drug. And the way it's done is
13 when you're buying it from the manufacturer and the
14 manufacturer is directly delivering it to the physician,
15 there's no intermediary. There's no wholesale, there's no
16 update, there's no that.

17 In my field, most manufacturers do not do any kind of
18 problems like you're talking about. We do get some bulk
19 discounts if we buy in large amounts.
20 Where the problem comes in is when you're buying it through
21 a wholesaler. That's the real problem. And another real
22 problem is when the volume of the drug really isn't very

1 much so there's no incentive for the drug company to really
2 use market prices or let market forces develop. And we'll
3 get into that when I talk about bladder drugs.

4 MS. BURKE: I'm sorry, Ron. That's not the question. He's
5 asking a very specific question. [Inaudible.]

6 DR. CASTELLANOS: Can I answer that then? They do it by the
7 average sale price and they go back for two quarters. In
8 other words, every quarter of the year each of the
9 manufacturers provide a cost basis to the drug. And that's
10 given to CMS. And they go back two quarters. And the
11 average of the sale prices, that's how they determine the
12 price of the drug for that quarter.

13 Now subsequent quarters, if the prices go up, the price will
14 go up. If it goes down, it will go down.

15 DR. KANE: But sale to whom and how final is the sale is the
16 question?

17 MS. BURKE: What constitutes the sale?

18 DR. SCANLON: It might be better to phrase it instead of a
19 sale, what is a completed transaction? There's an issue --
20 and I don't know the answer to this, maybe you can help us.

21 There's an issue in terms of the ASP regulation. A
22 completed transaction may occur a year later because there's

1 accumulation of how many purchases did someone make? And
2 there's some type of rebate for the total volume that you
3 made over that whole period of time. How that gets factored
4 into something where, in some respects, Medicare has already
5 closed the books, is an issue. Because Medicare may make an
6 approximation -- again, I'm operating not on knowledge --
7 make a decision as to here's what ASP is based upon all the
8 information we have to this point. That rebate, even though
9 it's due to something that occurred prior to the next time
10 period, may get applied to the next time period.

11 It's those kinds of things that make -- I guess this is the
12 issue with respect to the bundling. There's a whole can of
13 worms here.

14 DR. SOKOLOVSKY: Let me try to answer what sounds like a
15 really easy question and, in fact, is really difficult.
16 In some cases, it is when the drug manufacturer sells it to
17 the wholesaler. In some cases the purchase price has been
18 negotiated with a GPO or a PBM who never takes possession of
19 the drug but there is a charge back mechanism. So it still
20 may be going from the wholesaler but the manufacturer is
21 counting what they got from it from the basis of what they
22 have negotiated.

1 The new regulations, and these regulations have changed in
2 the course of a year-and-a-half, says we know that your
3 rebates and your discounts you really don't know at the end
4 of every quarter because of a lot of it is prospective. We
5 want you to estimate them and divide it by 12 so that we
6 don't have sharp rises and falls in ASP as they had in the
7 first couple of quarters.

8 So some of it is an estimate that has to be reconciled later
9 on when they actually pay.

10 DR. HOLTZ-EAKIN: So those are the prices. When they do the
11 weighted average what volume of sale goes into each quarter?

12 Actual deliveries or ...

13 DR. SOKOLOVSKY: It's actual deliveries but with estimated
14 rebates that may not have actually been paid that quarter.

15 DR. SCANLON: I'll stop by saying I really think that in
16 order to feel comfortable about making changes here we need
17 a lot more information. The idea that all physicians are
18 reporting some problem I find a little difficult to
19 understand because we are supposed to be paying this
20 average. We're supposed to be having a 6 percent markup.

21 That's supposed to be a sufficient cushion.

22 When we were dealing back in 2000 with some of the

1 intermediaries, the idea was that most wholesalers were only
2 marking up 1 or 2 percent, and that may have been in an AWP
3 world and things may be different. But I think we really
4 need some better information to guide whether there's a need
5 to make a significant change.

6 DR. REISCHAUER: I didn't get the notion that all physicians
7 were complaining. You said some.

8 DR. SCANLON: All said they had some problems.

9 MR. HACKBARTH: Some drugs. Most physicians can buy most
10 drugs at the payment rate but all report some drugs that
11 they cannot purchase at the payment rate.

12 DR. KANE: Are they reporting the ones that they can buy for
13 a lot less than the payment rate? What's the bundle? How
14 does it come out as a whole? I think that's why we can't
15 really -- some are above, some are below. But what is the
16 net profit on their drug business? Or is it a break even?
17 I don't think -- are they reporting what they're paying
18 below the sales price, too?

19 DR. SOKOLOVSKY: This is not an area where we have good
20 information. Particularly, we have no information on
21 discounts and rebates. The IG does periodic investigations.
22 We wish they'd do more because they're the only ones who can

1 get at those discounts and rebates.

2 But in general what I hear is that this has become much more
3 of a grocery type business. All the margins are slim. And
4 there's some evidence, for example, that people buy much
5 fewer drugs. The inventory they keep on hand at any one
6 time is much smaller than it was.

7 And when we talk next month about changes in practice, you
8 can see that the margins are slimmer.

9 But again, most physicians can buy most drugs at the payment
10 rate. But sometimes the disadvantages, the ones who can't,
11 they may be cumulative. Each time we're talking about a 1
12 percent or 2 percent difference. But if you're on the
13 disadvantaged side each time, then you have problems.

14 DR. KANE: Unless it's offset by a 1 or 2 percent on the
15 other side. I just think you need to look at the whole
16 instead of the pieces.

17 DR. SOKOLOVSKY: We talked about do some drugs go down. In
18 2005, for example, two very popular chemotherapy drugs went
19 generic. There was a six month period then, nobody
20 particularly talked about it, but we saw that in the data
21 that we bought, that there were very big margins on those
22 drugs.

1 And then there are the cases of brand name drugs where
2 they're not the same but they do similar enough things that
3 they compete and those prices may be falling. For example,
4 many physicians told us that they choose a drug for treating
5 anti-nausea basically based on price. And that's driven
6 many of them down.
7 So it's definitely not that they're all going up. And nobody
8 is telling me that they're all going up. But the focus is
9 much more on -- of course, as you would imagine, if I'm
10 interviewing people, they're telling me about the ones
11 they're having problems with.

12 DR. KANE: Wouldn't it be an incentive for the manufacturers
13 to not keep increasing the price if people started saying I
14 can't buy it because of the price? Isn't that the essence
15 of what you want them to do?

16 DR. MILLER: I think that the lag does create a drag on the
17 manufacturer raising the price because you can't raise it so
18 fast that no one can purchase it. That's why, at least on
19 the lag issue, you've got to -- and you guys are all
20 touching on the issue. You've got to think really hard
21 about how much real time you want on this because you then,
22 I think, are incenting upward inflation in the price.

1 Joan, one other point to bring out in this. In some of the
2 discussions that I had with you, some of the places where it
3 was difficult to buy at this price had to do with the low
4 price generic drugs that were handled through a wholesaler,
5 where the fee would kind of outrank, almost in some
6 instances, literally the cost of the drug.

7 DR. SOKOLOVSKY: This is an issue I didn't have time to go
8 into but came up very, very frequently in the course of
9 conversations. Physicians are buying a lot of extremely
10 cheap generic drugs. They tend to buy them through the
11 wholesaler. The wholesaler may have a 2 percent markup plus
12 charging shipping and handling. In some cases, the drug
13 itself is so cheap that that shipping and handling and 1 or
14 2 percent increase really take is above the Medicare payment
15 rate. And they use a lot of those drugs.

16 It was striking to me, when I would ask for a list of drugs,
17 how often the list of drugs was dominated by these cheaper
18 old generic drugs.

19 DR. MILLER: And of course, these are not the big, expensive
20 cancer chemotherapy. This is the ones that have been around
21 for a long time.

22 DR. HOLTZ-EAKIN: I think this one is easier. We talk about

1 the average sales price but it's actually not for a single
2 drug. It's for all the drugs in a billing code; right? How
3 do you decide what goes in the code? Or how is that
4 decided? I realize you're not the...

5 DR. SOKOLOVSKY: As far as I understand it, CMS makes those
6 decisions. It usually takes a couple of years, or at least
7 a year after the drug comes on the market. There is a HCPC
8 code for unclassified drugs. And to get your own code takes
9 a certain amount of time.

10 If there are generic versions of a brand drug, they will all
11 be in the same billing code. There are some older
12 biologicals -- for example IVIG, it's not a generic drug but
13 a bunch of manufacturers make it. And up until this past
14 year they tended to all be bundled within one billing code.
15 This year CMS divided it into two different billing codes
16 because of a lot of issues about what was actually going
17 into each code.

18 DR. CASTELLANOS: First of all, just to remind you, this is
19 the non-oncology drugs that we're talking about. We're not
20 talking about the drugs that are distributed by the
21 oncologist or hematologist.

22 I would like to put my comments to the quality of care and

1 patient satisfaction area. First of all, from a physician
2 viewpoint, ASP, I think, is a much fairer way of paying for
3 the drug. You're actually paying a price that's very close
4 to the acquisition price. Prior to this we had AWP. I
5 didn't write those rules. I can tell you right away that
6 the physicians made a lot of money on that. And I think
7 today the ASP is a much fairer way of reimbursing the
8 physician for the cost. I certainly would not want that
9 changed. Maybe the percentage changed, but the concept I
10 think really, really, really works.

11 The quality of care issues, I think, are pretty good. I
12 think you mentioned some of them now. A big one is really
13 shift of setting or where you get the treatment. And
14 obviously this is based on cost or how -- in other words, if
15 I can't buy that drug for ASP plus 6 percent, or if that
16 patient doesn't have a coinsurance, or in some cases the
17 patient has Medicaid where I'm not reimbursed adequately, in
18 today's market I can't afford to take that loss anymore. So
19 that patient is then transferred to the hospital and is
20 being given medication in the OPD. I don't like it anymore
21 than anybody else. I think it disrupts care, the continuity
22 of care. It's a lot more expensive for the government,

1 market forces dictate the price. Unfortunately CMS, in
2 their wisdom, has kept LCA policy. It's not a national
3 policy. It's not a national directive. It's a local
4 carrier directive. And there's been such a wide variation
5 in how that's applied all over the United States and there's
6 a wide history of that.

7 As best as I can tell at this time, most states are LCA
8 states except Montana. We'll get back to that. But most
9 states come under that.

10 Now the issue here is very simple, is that what's happening
11 is that the treatment is tied to the cost. And you say
12 well, they're both the same. What's the difference? Well,
13 this is where we're going to get into patient satisfaction
14 and quality of care. One is administered intramuscularly in
15 the hip, and one is administered subcutaneously in the
16 abdominal wall. I don't have to ask any of you which you
17 would prefer. I don't have to do that. I think you would
18 all make a judgment that, from a patient viewpoint, I want
19 the least painful application.

20 But as I said, the treatment is tied to the cost, rather
21 than the benefit to the patient or the patient's individual
22 needs. As I said LCA policy is totally against MMA.

1 When I was on PPAC at CMS, we had a lot of disagreements
2 over this, a lot of contentions, a lot of discussion. And
3 CMS basically said it's not a national decisions, you have
4 to go to the local carrier.

5 Well, I have gone to the local carrier and the local
6 carriers, for the most part, have changed, gone back and
7 forth, changed. But Joan, I think -- and I hope you looked
8 it up. I think Montana still has an LCA policy.

9 What's so important about that? It's important in this
10 respect. As you know, Medicare is changing from carriers to
11 MACs and there are going to be 15 MACs. And the first MAC
12 is J3, which happens to include Montana.

13 So now what they've done, in May they had a meeting of all
14 the carriers, involving I think five or six states. And
15 they talked about what they can do about that. And they
16 made a policy that they're going to use, not just for this
17 drug but all local carrier decisions, they're going to use
18 the least restrictive or best care policy. And that's how
19 they're going determine whether they're going to use that
20 drug or not or any LCD, local carrier decision.

21 So my problem here is that in urology or in any drug for any
22 specialty, I really like a level playing field. I like the

1 physician to be able to one, buy the drug at the same price
2 anybody else is buying it or have it available at the same
3 price anybody else is available. And that's not happening
4 under LCA.

5 And two, I like the physician or the patient to decide which
6 forms of treatment they want. Quite honestly, I have had a
7 lot of patients that come down -- I live in Florida. We
8 have a lot of winter visitors and I have a lot of patients
9 that come down for treatment. And they've been on Zolodex,
10 which is the drug that's on the abdominal wall
11 subcutaneously and they want to continue that. Why?
12 Because that's what they've had and they don't know any
13 different and that's what they want.

14 I've had a lot of patients that have been on the other drug,
15 which is an intramuscular drug, and they like that. When I
16 tell them that I have to change their treatment based on
17 cost, they don't like it. And I can tell you, that happens
18 all over the United States.

19 And I can give you a very good example here in Washington,
20 D.C. where the professor of urology at a very prominent
21 university told a patient we're going to change you because
22 we don't lose any money and we make more money on it.

1 of a particular drug. And so you have to deal with them.
2 The course, as I understand it from the materials, you have
3 to deal with them on the purchase of this lifesaving drug.
4 The other drug, which is a marketplace drug and is available
5 by more than one provider, ought to compete in its own right
6 and they win or lose based on their competition and
7 essentially the experience with that particular drug.
8 I am wondering what it is, and I should say at the outset I
9 am not adverse to and, in fact, am generally quite positive
10 about the concept of bundling where we essentially use that
11 to our advantage in terms of looking at a range of services
12 that are provided for a particular condition.

13 But in this case it would appear to me that's really not
14 what this is about. This is really about using a
15 essentially sort of a predatory action to essentially
16 prevent a decision unrelated to the quality of the choice
17 being made.

18 It's raised, query whether or not there is something that we
19 ought to say or do about that? Query whether there are
20 other questions? I know I've mentioned briefly this to
21 Glenn in the past and agree with him that bundling in and of
22 itself, intervention into the market, is not something that

1 I generally am supportive of doing or of preventing
2 bundling. But in this case, it seems to me, it's not at all
3 about the kind of bundling that we fundamentally support.

4 So the question is what is it -- from the purposes of the
5 staff report, what is it that we might do or say that would
6 make clear that we believe this, in fact, ought not to be a
7 practice that's permitted.

8 DR. MILLER: If I could just say something here, Joan, and
9 this is to give you some time to get ready.

10 The first thing is I just want to be absolutely clear, Joan,
11 that this is correct. The statements that we make in the
12 paper that we put in front of the commissioners about the
13 quality issues are statements that you gathered from your
14 site visits in talking to the physicians; is that correct?

15 DR. SOKOLOVSKY: That's true. This is an issue that there's
16 no independent evidence about this. This is entirely --

17 DR. MILLER: That's true and I just want to be crystal clear
18 on that, that this is not a conclusion that we, the staff,
19 have drawn. This is something that physicians have said to
20 us.

21 Now to the second part of your question, what could be done?
22 You know how this process goes. Sometimes we kind of bring

1 problems and then collectively we start thinking about them
2 with you guys.

3 But I think what Joan was trying to say here is that we
4 could have a conversation that's very much about quality,
5 bundling philosophy, those types of things. And it could
6 get into some fairly complicated issues pretty fast.

7 Another way to think about it is really more from an
8 arithmetic point of view, and I think that's what Joan --
9 and I know you guys are getting this, but just to make sure
10 everybody is getting it. Another way is to think about it
11 just from an arithmetic point of view, which is we're not
12 going to make any judgment on bundling, per se. We're just
13 going to ask that the arithmetic of the ASP apply to the
14 drug that -- that's really more the question.

15 MS. BURKE: I don't disagree with that at all. Tell me
16 where we are, and I'm asking because I don't know the answer
17 to this question. Are there regs in draft that relate to
18 this issue that we ought to be apprised of?

19 DR. SOKOLOVSKY: In the current proposed physician fee
20 schedule, CMS mentions that they've heard that there is an
21 issue with bundling and they would like to hear more about
22 it. They don't propose any solutions.

1 MS. BURKE: So it's simply a reference to the fact they want
2 to know about it but no specific intention or suggested
3 solution to the question. Which raises then, I think again,
4 the solution that has been suggested, which is the
5 arithmetic solution for the time being until we get a better
6 understanding.

7 Like you, I don't want to pronounce on bundling as a general
8 matter. I don't think that's what this is about. The
9 question is whether to deal with what is essentially an
10 issue of inequity and then let the quality issue play out
11 and the broader bundling question play out.

12 MR. HACKBARTH: Doug had a question about the arithmetic.
13 Do you want to ask that or do you have it resolved? Do you
14 want to just do it offline?

15 DR. HOLTZ-EAKIN: We'll do it offline.

16 MS. DePARLE: I agree that my focus is on the bundling. We
17 talked about this briefly at our last meeting, and I think
18 it was in the context of the proposed rule at that point,
19 and several of us were concerned about it.

20 Now, Joan, that you've shown us the arithmetic of how it
21 works, I'm even more concerned. And based on what you
22 reported about the physicians you've interviewed saying that

1 this could be driving them to make decisions that weren't
2 based on clinical factors, it leads me to be more concerned.
3 And also, I think it could be impeding competition, which is
4 not what we want to do here.

5 So I would endorse making a recommendation that would at
6 least deal with the arithmetic on this, and then preserve
7 for a later day maybe the bigger question of bundling. In
8 general, I think how could MedPAC be against bundling;
9 right? We sort of like that idea from a payment policy
10 perspective. But this concerns me.

11 MR. HACKBARTH: Maybe we need to develop an alternative
12 terminology.

13 MS. DePARLE: Maybe so.

14 DR. REISCHAUER: This is not bundling.

15 MS. DePARLE: It's really not. This is what I think your
16 economist friends -- and since I'm a lawyer, Glenn and I
17 would say tying, using your market power and leverage in a
18 way that I think we would think may not be appropriate.

19 MS. BEHROOZI: Just briefly, I'm concerned about something
20 that you said, Joan, and it appears in the text. That we
21 seem to be disincenting the purchase of generic drugs.
22 Because if the physicians can't afford it, if they're not

1 going to be reimbursed for it, they're going to end up
2 having to pay more than the ASP plus 6. Doesn't that work
3 as a disincentive to purchase generic drugs, and may incent
4 them to buy the more expensive drugs where they're not going
5 to lose money, and then Medicare ends up paying more.

6 Am I understanding this correctly?

7 DR. SOKOLOVSKY: No, it's my fault. The kinds of generic
8 drugs that we're talking about are really very cheap drugs
9 and they're only part of a drug regimen. And nobody's going
10 to lose money -- even though they lose money on these
11 particular drugs, they don't lose money on the drug regimen.
12 When a new generic, not very inexpensive generic, enters --
13 a generic will be in the same code as the branded drug. So
14 in fact, the incentive is all to get the generic drug
15 because the branded drug will drive up the price within
16 that.

17 DR. REISCHAUER: Are there certain of these cheap generic
18 drugs that like 99 percent of them are gotten through
19 wholesalers? So you could say anything that's less than \$10
20 we don't give ASP plus 6 percent, we give ASP plus \$11 or
21 whatever the average markup and mailing costs are.

22 DR. SOKOLOVSKY: One of the things that came up most

1 frequently, which kind of amazed me, was saline solution.
2 That's the kind of thing we're talking about. Everybody has
3 to buy it. It's dirt cheap. But not so dirt cheap that you
4 don't have to have it shipped and sent. So yes, there are.

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

6 We will have a brief public comment period with the usual
7 rules. Comments no more than a couple of minutes. If
8 someone else is saying the same thing, don't say it.

9 MR. SCHUMACHER: Dale Schumacher. I'm the External Quality
10 Compliance Officer for the Long Island Health Network. And
11 I thought I'd cast a little bit of clinical integration
12 sunshine into today's gray meeting.

13 This is a 10 hospital group of clinically integrated,
14 relatively independent hospitals in Nassau and Suffolk
15 Counties in Long Island. We've tracking performance there
16 for almost five years. And clinical integration does seem
17 to work. We bench it versus the other Nassau-Suffolk
18 hospitals.

19 It's a combination of guidelines, conformance to guidelines,
20 both positive incentives and financial penalties. As the
21 External Compliance Officer, I can financially penalize
22 hospitals that don't hit guidelines after a year's time,

1 that are internal pay for performance initiatives and along
2 with pay for performance programs with insurers.

3 There is a single integrated quality committee across the 10
4 hospitals that seems to work, in essence the sharing of
5 trade secrets among the hospitals. Again, the program seems
6 to work.

7 The question about the Southwest Airlines alternative for
8 how can we do this better and quicker, that's a great
9 question. I would encourage any incentives for merging and
10 linking data and information systems. There are huge
11 numbers of data systems that exist there. On one side of
12 the aisle you could be struggling to find out data about
13 performance in the cardiac area. The other side of the
14 aisle, there will be a cardiologist that has money from a
15 drug company and is following these same patients over two
16 or three or four years and you just can't link or get
17 together. So you have to build those people -- I think it
18 was Davenport in the Harvard Business Review wrote an
19 article about competing on analytics about a year-and-a-half
20 ago. I think that speaks well to what we have to be able to
21 do.

22 So clinical integration, at least in this particular

1 situation in these hospitals, does work.

2 MR. HACKBARTH: We are adjourned. Thank you very much.

3 [Whereupon, at 12:07 p.m., the meeting was adjourned.]

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