

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, N.W.
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Monday, September 13, 2010
9:40 a.m.

COMMISSIONERS PRESENT:
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MICHAEL CHERNEW, PhD
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GEORGE N. MILLER, JR., MHSA
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BRUCE STUART, PhD
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1 P R O C E E D I N G S [9:40 a.m.]

2 MR. HACKBARTH: Would you take your seats, please?

3 Okay. Welcome to our guests for our first meeting
4 in our new cycle.

5 As always, we will have brief opportunities for
6 public comment at the end of the morning session and then at
7 the end of the day. I will remind you again that we invite
8 comments so people will take advantage of our brief public
9 comment periods, but they will be brief, and I urge you to
10 use other available avenues to communicate with the
11 Commission and its staff about our work, the most important
12 one being direct communication with the staff. They make an
13 extraordinary effort to seek out input for our work. We
14 also have a place in our web site where people can offer
15 comments on our work.

16 Our first session today is on the context for
17 Medicare payment policy, a regular feature of our March
18 report. It's a chapter that reviews some of the basic, but
19 still very important, information about program
20 expenditures, trends, the share of the budget, GDP, et
21 cetera, going to Medicare.

22 And, Kate, are you leading? Okay, Kate.

1 MS. BLONJARZ: Hi. I'm going to present on the
2 context for Medicare payment policy. In the beginning of
3 each March report, a chapter lays out the budget and
4 economic context for the Commission's Medicare
5 recommendations.

6 The principles of Medicare payment require us to
7 ensure beneficiary access to high quality care, give
8 providers an incentive to apply effective, appropriate care
9 and ensure the best use of taxpayer dollars. This
10 presentation will discuss the first and third components of
11 this mandate. First, I'll discuss the makeup of the health
12 sector and briefly touch on the factors that drive health
13 care cost growth at rates exceeding the growth in the
14 national economy. Then I will discuss one additional factor
15 affecting Medicare's financial outlook: the changes to
16 Medicare in the Patient Protection and Affordable Care Act.
17 Finally, I'll turn to Medicare's specific funding challenges
18 and the federal government's overall fiscal picture.

19 Currently, the health care sector makes up 16
20 percent of gross domestic product. Public sources
21 correspond to 47 percent of the spending, and private
22 sources correspond to 53 percent of the spending. Total

1 spending on health care is projected to grow by 6.1 percent
2 annually over the next 10 years, reaching 19 percent of GDP
3 by 2019.

4 Medicare is the largest single payer in the \$2.3
5 trillion health care sector, comprising 20 percent of
6 spending in 2008. As you can see from the table, Medicare
7 spending growth has exceeded GDP growth by 2.5 percent on
8 average over the prior 35 years.

9 Finally, what is also notable is that health care
10 spending growth in excess of GDP doesn't just affect public
11 payers; it affects all payers.

12 When comparing Medicare spending growth and growth
13 in the private sector, there are periods where Medicare per
14 capita spending grows faster than private per capita
15 spending, and vice versa. Between 2000 and 2009, Medicare
16 spending growth averaged 9.7 percent annually. Some of this
17 growth is due to the increase in the number of Medicare
18 beneficiaries. However, per beneficiary growth was still
19 8.5 percent over the same time period.

20 Again, in this graph, you can see the persistence
21 of spending growth in excess of GDP for public and private
22 payers.

1 The reasons that health care costs grow in excess
2 of GDP growth are likely familiar to you. Technology,
3 broadly categorized as new products, processes and
4 treatments, is identified as the largest single driver
5 affecting the growth in health care. Analysts have
6 estimated that technological improvement can explain between
7 25 and 50 percent of the growth in health care spending.

8 Health insurance coverage is also believed to have
9 an effect on health care cost growth by increasing the
10 amount of health care consumed at the individual level and
11 also shaping the market for new medical interventions at the
12 economy-wide level. Changes in health insurance are
13 estimated to contribute to between 10 and 13 percent of the
14 growth in health care spending.

15 I will just quickly touch on the next three
16 factors affecting health care cost growth. First, the
17 prices for health care services grow faster than non-health
18 care products and services. Second, provider consolidation
19 is also theorized to affect the growth in health care
20 spending. And finally, medical malpractice is thought to
21 affect the practice of defensive medicine; however, some
22 people have looked at the role of medical malpractice on

1 overall spending growth and found only a small effect.

2 Next, fee-for-service reimbursement used by most
3 public and private insurers results in an emphasis on
4 volume, not care coordination.

5 Aging has not played a substantial role in
6 explaining historical health care cost growth, between 2 and
7 3 percent, but it will play a large role in the future
8 growth of Medicare Medicaid, accounting for 45 percent of
9 the growth in the programs between 2010 and 2035. It will
10 then diminish in effect over the longer term.

11 Finally, higher household incomes increases the
12 demand for health care, with one recent study finding that
13 the income, or wealth, effect on health care consumption was
14 almost as large as the technology effect.

15 In 2009, Medicare spending was just over \$500
16 billion, corresponding to \$11,700 per beneficiary.

17 As you can see from the chart, Medicare's
18 financing is a mix of dedicated taxes, general revenues,
19 premiums and cost-sharing and other sources such as taxation
20 of Social Security benefits. Overall, approximately 23
21 percent of Medicare's revenue was from beneficiary
22 contributions, 33 percent from payroll taxes and 37 percent

1 from general revenue. The share that is paid by general
2 revenue is projected to rise to nearly 50 percent by 2030.
3 Currently, 18 percent of all revenues collected by the
4 federal government goes to Medicare.

5 The largest share of Medicare spending goes to
6 hospitals, 27 percent, and the second largest share, 22
7 percent, goes to Medicare Advantage plans. Spending for
8 physicians and prescription drugs account for 13 and 12
9 percent, respectively.

10 Before I discuss Medicare's long-term financing, I
11 want to touch on the Medicare provisions in the Patient
12 Protection and Affordable Care Act. The law specifies
13 yearly adjustments on varying schedules in the next 10 years
14 for most Medicare providers in addition to a yearly
15 reduction in the market basket equal to economy-wide
16 productivity. The Medicare trustees, in their 2010 report,
17 assumed that the productivity assumption would equal 1.1
18 percent a year.

19 The law will reset the benchmarks for Medicare
20 Advantage plans and introduce a bonus system based on
21 quality.

22 The law also establishes an Independent Payment

1 Advisory Board which is required by statute to make further
2 modifications to Medicare if per capita spending exceeds
3 thresholds set out in the law.

4 The law has three main provisions affecting
5 current Medicare beneficiaries. First, it phases out the
6 Medicare Part D coverage gap by 2020, it freezes the income
7 thresholds throughout the 10-year budget window for the
8 Medicare Part B income-related premium and establishes an
9 income-related premium for Medicare part D. And finally,
10 for current workers, it expands the hospital insurance
11 payroll tax by 0.9 percent for individuals making over
12 \$200,000 and couples making over \$250,000.

13 With respect to delivery system reform, the law
14 establishes a process for testing a number of interventions:
15 bundled payments for inpatient hospital care, accountable
16 care organizations, a shared savings program and value-based
17 purchasing for hospitals, among others. The Center for
18 Medicare and Medicaid Innovation is charged with conducting
19 pilots on changes to health care delivery systems that have
20 the potential to reduce spending or improve quality across
21 Medicare, Medicaid and private insurance.

22 Over the 10-year budget window, the provisions

1 affecting Medicare in the Patient Protection and Affordable
2 Care Act are estimated to reduce Medicare spending from
3 baseline by \$575 billion over 10 years, with the market
4 basket and productivity adjustments making up the largest
5 single share, the Medicare Advantage changes total \$145
6 billion over 10 years, and the other fee-for-service
7 provisions totaling \$135 billion over 10 years.

8 As seen from the table, Medicare's fiscal picture
9 is projected to be improved as a result of PPACA. Overall
10 growth in the next 10 years is projected to be 5.8 percent
11 annually, as compared with 7.1 percent as projected prior to
12 the passage of PPACA.

13 The current law assumptions are as follows:
14 First, current law assumes that the Medicare reimbursement
15 to physicians will be reduced by 30 percent over the next 3
16 years. Second, current law assumes that the productivity
17 adjustments to the provider payment updates in PPACA will be
18 implemented as scheduled and kept in place throughout the
19 projection period.

20 It is important for you to know that this year the
21 Medicare trustees also discussed an alternative scenario in
22 the 2010 report. This alternative scenario assumed that the

1 productivity adjustments are in effect through 2019 and
2 phased out thereafter over the subsequent 15 years, and that
3 physician payments will be updated by the Medicare Economic
4 Index. Under this scenario, Medicare's 10-year growth rate
5 would be 6.9 percent.

6 On this next slide, I just want to emphasize why
7 it is important to constrain Medicare's cost growth. Rising
8 Medicare spending directly affects beneficiary cost-sharing.
9 Currently, Medicare pays for approximately 55 percent of the
10 average beneficiary's current health costs. Out-of-pocket
11 spending and other sources such as Medigap or employer
12 coverage cover 19 percent apiece, and Medicaid covers 7
13 percent.

14 The growth in Medicare spending will result in
15 cost-sharing that consumes a larger share of beneficiary
16 resources. For example, the average beneficiary
17 contribution for Parts B and D, which is premiums and cost-
18 sharing, corresponds to 27 percent of the average Social
19 Security benefit in 2010. By 2030, the cost-sharing and
20 premiums for Parts B and D are projected to have grown to 50
21 percent of the average Social Security benefit.

22 Rachel and Carlos will present on beneficiary

1 cost-sharing more in their presentation after lunch.

2 Finally, a discussion of Medicare's fiscal picture
3 is incomplete without a discussion of the federal budget.
4 This last point is one that I will spend a little more time
5 on.

6 This chart shows debt held by the public under two
7 scenarios. As you can see here, public debt is projected to
8 be just around 60 percent of GDP in 2010. By 2019, it is
9 projected to reach nearly 70 percent, even under favorable
10 assumptions. I want to clarify that in these slides we are
11 not just talking about Medicare or health care; this is the
12 fiscal position of the entire federal budget.

13 The Congressional Budget Office also presents an
14 alternative fiscal scenario. The CBO's alternative scenario
15 assumes the following changes from current law, all of which
16 would increase spending or reduce revenue: The 2001 and
17 2003 tax cuts are extended. The thresholds for the
18 Alternative Minimum Tax are increased. Medicare payments to
19 physicians grow over time. And two provisions in PPACA are
20 modified -- first, that the Medicare productivity
21 adjustments are phased out after 2019 and the health
22 insurance subsidies are indexed to health care spending

1 after 2019. Under this scenario, the debt would exceed all
2 historical precedent by 2024.

3 So why are these debt levels important?

4 CBO and other observers have discussed a few
5 potential outcomes from high federal debt. First, it could
6 crowd out private investment. Second, it could lead to
7 inflation which would ultimately depress wage growth. And
8 third, it could limit the ability of the government to
9 respond to cyclical downturns. One final outcome is that
10 the credit markets could require higher interest rates on
11 federal debt which would dramatically increase the
12 government's interest payments.

13 Over time, interest payments on this level of debt
14 will start to dominate federal spending. In 2010, interest
15 payments on current debt will be approximately \$200 billion
16 or 5 percent of total federal spending, and approximately
17 \$1.3 trillion of federal spending will be deficit-financed.
18 By 2019 and 2035, under current law, the amount of debt-
19 financed government spending will have decreased from
20 current levels, but spending on interest payments will rise
21 to \$570 billion in 2019 and approximately \$1 trillion in
22 2035.

1 Under the alternative fiscal scenario, interest
2 payments by 2035 would be \$2 trillion, the yearly deficit
3 would exceed \$4 trillion and current revenues would be
4 sufficient to pay for only 44 percent of the government's
5 total spending that year.

6 You may be asking why this is important for
7 Medicare. These debt levels call into question the ability
8 of the government to pay all of its obligations including
9 Medicare, and, because of Medicare's increasing claim on
10 federal revenues, addressing the program's cost growth may
11 be one component in improving the government's overall
12 fiscal position.

13 I would like to conclude this presentation by
14 asking for your comments, questions or other topics of
15 discussion.

16 MR. HACKBARTH: Thank you, Kate. Well done.

17 Let me just provide a little bit more historical
18 context for why we have the context chapter.

19 Mark, maybe you can remember the exact year. I
20 can't. But a number of years, seven or eight years ago,
21 Congress amended the statute governing our activities, to
22 ask us to consider in our deliberations the budgetary impact

1 of our recommendations. And I think it was at the same time
2 they added the language about efficient provider, that we
3 should make our recommendations, update recommendations
4 based on what is adequate for an efficient provider of the
5 various types of services covered by Medicare as opposed to
6 the average provider. The point in each case was that the
7 Congress expected MedPAC, as an advisory body, to carefully
8 consider the fiscal impact of what we're doing.

9 So we initiated this context chapter as part of
10 the response to that. Another thing that we did was the
11 efficient provider analysis that those of you who have been
12 on the Commission have grown accustomed to, which we're
13 still, incidentally, expanding and developing. And then
14 also at the same time we started including estimates of the
15 budgetary impact of recommendations, not point estimates but
16 sort of, as we refer to it, in buckets and do that with some
17 consulting advice from CBO.

18 So that's the context of this. We are responding
19 to specific requests from Congress, now seven or eight years
20 ago.

21 Okay. So let's open this up for discussion among
22 the Commissioners. We will use our usual process. Round

1 one will be strictly clarifying questions: What did you
2 mean by Table 3, Line 4? That sort of thing. And then
3 we'll follow that with a second round of broader comments
4 and questions.

5 So let me start over here on this side. Let me
6 see hands for clarifying questions. I have Ron, Mary and
7 Peter to start.

8 DR. CASTELLANOS: Very nice presentation. Kate,
9 it wasn't in your discussion or your presentation, but in
10 the material, the briefing material sent to the Commission,
11 I see there's a pretty strong statement that says that
12 "Despite growth in health care spending as a share of GDP,
13 there's no significant evidence that this growth has
14 resulted in any commensurate improvements in quality or
15 outcomes."

16 You know, as a practicing physician, really that
17 kind of bothers me because I can show you a lot of
18 statistics with neonatology, cancer outcomes, et cetera,
19 where spending has increased outcomes and quality. So I'm
20 not opposed to your giving me a good example of why you put
21 that, but sometimes these statements carry on to the March
22 report, and I would like you to think about maybe toning

1 that down a little bit.

2 MS. BLONJARZ: Sure, we can absolutely do that.

3 MR. HACKBARTH: There's some literature on this
4 that I'm not nearly as well versed in as others are, but we
5 can come back to that if Mike has something he wants to
6 offer, or Kate or others. We'll come back to that in round
7 two. I think it's an important point that you've raised,
8 Ron.

9 Mary?

10 DR. NAYLOR: It was a terrific report. Thank you.

11 CBO, in the report that we had, estimates that the
12 aging of the population, as you mention, is going to
13 contribute significantly to the growth of Medicare and
14 Medicaid, at least in the short term, and I'm wondering if
15 you can help me understand. Did the CBO estimates take a
16 look at that growth in the context of people living longer
17 with multiple complex conditions? And was it taking a look
18 at it in the context of the current system design, or did it
19 take into consideration some of the estimated changes as a
20 result of the Affordable Care Act?

21 MS. BLONJARZ: With respect to your first
22 question, those are measured as per capita, and as the

1 population ages the risk profile will change. And so their
2 per capita measure does incorporate a little bit that people
3 may live longer and have longer, have higher costs over
4 their lifetime, but that's a pretty small effect. I mean
5 the bigger effect will be the number of people who are
6 receiving Medicare over the next -- Medicare and Medicaid
7 over the next 30 years.

8 DR. MARK MILLER: To the second part of your
9 question, yes, my sense about the way these estimates are
10 done is that there are sort of broad assumptions about how
11 much growth is above or below GDP as opposed to trying to
12 capture specific effects of this particular change in
13 policy. That's how they do the long-run projections.

14 DR. CHERNEW: They separate out the demographic
15 component and what you would call an excess cost component.
16 The demographic component takes into account explicitly
17 nothing. It's just there are more 85-year-olds, and then
18 they have a separate component which is an 85-year-old costs
19 this much more.

20 MR. HACKBARTH: Peter?

21 MR. BUTLER: Okay, on Slide 5. So I'm getting my
22 kind of accountant's hat on. I try to figure out how much

1 of the increase is due to each of these categories, and I'm
2 struggling more than usual on some of this.

3 We talk about technological. We always lead with
4 that, I think almost every year, and it used to be and it
5 says in here about half of the expense increase. Then
6 there's a more recent study that says maybe it's 27 to 48
7 percent of the growth is in technology. Then it also says
8 in prices it's somewhere between 5 and 19 percent of the
9 growth is due, but that's not -- but my math says that's as
10 much as 70 percent due to those factors.

11 I'm not sure that's true or not, but I think my
12 real question relates to the technology. I've never quite
13 understood the definition because I think of, well, you've
14 got a PET/CT scanner, and not only is it new, but it's used
15 a lot, and that's part of the technology. I'm not quite
16 sure how you categorize what.

17 I think it's a lot of the utilization. It's not
18 just the technology. It's buried in technology, and I'm
19 just not sure it's the right label.

20 MS. BLONJARZ: Yes, I think. So, on your first
21 point, definitely different studies have come up with
22 different ranges, and each study will add to 100 percent.

1 But if you try to break out all the components across
2 different studies you could definitely take the high end of
3 the range and get above that. The study that found a
4 slightly lower share of technology as a driver actually was
5 also the one that assigned a larger share to improvements in
6 income and wealth, household income and wealth, as a factor.

7 On your question about technology and how it's
8 defined, this is absolutely something that I've seen
9 discussed in the literature a lot because it isn't clear
10 whether a set of new procedures that are delivered to a new
11 category of patients, whether that is classified as
12 technological change or something else.

13 Most of the studies take the broadest possible
14 view that changes in procedures, processes and treatments
15 for a given condition is what they use for this bucket, but
16 I'm sure others could probably speak to this as well.

17 MR. BUTLER: Just my quick comment then, in the
18 chapter it makes it look like it's just new services as
19 opposed to the utilization of existing services as well, and
20 I think most definitions would at least include some of
21 that, I think.

22 MS. BLONJARZ: Right. Yes, we'll clarify that.

1 MR. HACKBARTH: Mike?

2 DR. CHERNEW: I'll wait until round two.

3 Okay.

4 MR. ARMSTRONG: Just very briefly on this point,
5 you, in the slides, refer to "technological improvement" and
6 in the report you talk about "technological advancement,"
7 and given the comments just made it seems like "advancement"
8 is the more appropriate label to give to this.

9 MR. HACKBARTH: Mike is, at the start of the new
10 year, being exemplar of round one etiquette.

11 [Laughter.]

12 MR. HACKBARTH: Jennie?

13 MS. HANSEN: Yes, this is round one on Slide 6,
14 and, you know, in looking at this, it is helpful to -- it
15 corresponds with the text about how much per beneficiary.
16 But in terms of the expenditure pie, the MA plans, you know,
17 assume 22 percent in terms of Medicare payment, but in
18 reality, they're paying also for physician services,
19 hospital services, and Part D coverage. So in some ways,
20 it's probably -- the percentages are then in actuality
21 different in terms of the actual use?

22 MS. BLONIARZ: That is right. We could take out

1 the MA piece of the pie and distribute it among all the
2 other categories.

3 MR. GEORGE MILLER: My question has to do with the
4 definition on Slide 5 of "industry consolidation." My
5 question is: Does it include also expansion of -- we have
6 seen growth in physician-owned hospitals as an example, so
7 does consolidation also include expansion just by
8 definition? Or is truly just industry consolidation?

9 MS. BLONIARZ: I believe that it does refer to --
10 you know, actually I'm not sure and I can get back to you on
11 that.

12 MR. HACKBARTH: So clarify for me, George, what
13 you mean by your reference to physician-owned hospitals and
14 how that plays in here.

15 MR. GEORGE MILLER: Well, 10 years ago we didn't
16 have physician-owned hospitals, and this question deals with
17 the health care cost growth as an example, and I just used
18 physician-owned hospitals. So if you have consolidation,
19 does it also include the growth of other providers over the
20 last years? And is that net of that effect, by definition?

21 MR. HACKBARTH: Yeah, so --

22 MR. GEORGE MILLER: Or is that a whole different

1 category that I may be missing --

2 MR. HACKBARTH: Yeah, so correct me, Kate, if I'm
3 not thinking properly about this, but I would think of
4 physician-owned hospitals as new entrants and competitors,
5 potential competitors, to existing providers. So it's sort
6 of the opposite of consolidation. Generally, consolidation
7 means you've got fewer purveyors of a particular service in
8 a given market, and so fewer hospitals, not more hospitals -
9 - or fewer whatever service we're talking about.

10 So your point about physician-owned hospitals
11 could be valid in terms of it being a cost-increasing force,
12 but it would fall under another category as opposed to
13 consolidation.

14 MR. GEORGE MILLER: Correct. And my question was
15 it in industry consolidation or is it in another category,
16 if I didn't put it correctly.

17 MR. HACKBARTH: You know, potentially that could
18 fit under a category like payment incentives in fee-for-
19 service. MedPAC's analysis was that at least part of the
20 physician-owned hospital development seemed motivated by
21 taking advantage of pricing anomalies and targeting
22 particularly profitable services. So, you know, this --

1 MR. GEORGE MILLER: [Off microphone]

2 MR. HACKBARTH: Yeah, yeah. Other clarifying
3 questions?

4 DR. DEAN: More on the technology issue. In the
5 written material, it talks about the fact that technology
6 expands in health care in a different way than it does in a
7 lot of other industries, and you say introduction of a new
8 product generally doesn't result in high levels of demand
9 until the price falls. I wonder the basis behind that. I'm
10 thinking of, for instance, robotic surgery, which has
11 expanded rapidly. And to my knowledge, there has been no
12 cut in price at all. In fact, prices, if anything, are more
13 expensive. And that seems to be more the typical experience
14 that I'm familiar with rather than the utilization being
15 controlled by price.

16 MS. BLONJARZ: I think there we were just trying
17 to make the point that, outside of health care, in consumer
18 products, generally the price starts out high, and it's when
19 the price decreases that demand will pick up. And that
20 doesn't -- kind of that story doesn't fit as much in health
21 care. So I think your point is consistent with that.

22 DR. DEAN: Okay. Maybe I misread that, because

1 that's exactly -- I mean, my experience is that is not what
2 happens in health care.

3 DR. MARK MILLER: We'll make sure that's clear. I
4 think there may be [off microphone].

5 DR. DEAN: Okay. Maybe so. And I think it is an
6 important point because it would seem that everywhere else,
7 technology increases efficiency and helps to control costs.
8 In health care it has done just the opposite, and we seem to
9 have accepted that, I guess, and I think that's unfortunate.

10 MR. HACKBARTH: Okay, round two comments.

11 MS. UCCELLO: I just have a quick comment. I
12 think this chapter does a great job setting the context for
13 things, and I was very pleased to see that the alternative
14 scenario was included in the discussion. I just think it
15 might even be moved up more, acknowledged sooner on, and
16 then I think it would also be appropriate for us to say that
17 the alternative scenario, and even the current-law scenario,
18 really emphasize the need to pursue aggressively these
19 health care payment and delivery system reforms.

20 DR. CHERNEW: First, in response to Ron's comment,
21 I think he's right. There's literature -- the cites I would
22 do would be like Cutler and McClellan -- on spending growth

1 over time and quality. And the issue is a lot of the stuff
2 in the chapter that shows we don't have good-quality sort of
3 cross-sectional comparisons, but not about the growth. So I
4 think that Ron -- there's a difference between sort of
5 inefficiency at the margin and saying we didn't get anything
6 because we spent more. And we could talk later, but I do
7 think, in response to Ron's comments, there's a lot of
8 academic research that says on average we've spent more and
9 we've got better. And there's also a lot of academic
10 research, much of which you show, which says we're still not
11 doing really very good at all in a number of ways.

12 With regards to the technology discussion that
13 we've had, I think it's important to say, to be clear, none
14 of these studies are as detailed as some of the questions
15 might imply that they were where they measure a whole series
16 of things, and there's a lot of interaction effects. And
17 despite the definition of technology, which they often will
18 give, which I think you correctly cited, it's really
19 everything else that's not in the things they measured, and
20 they often didn't measure a lot of stuff.

21 There are some very specific studies that look at,
22 like, revascularizations and what technology is. The

1 problem is the existing services often increase with the new
2 technology. So you have a new test for prostate cancer, and
3 that's the thing that's new. But the spending isn't just on
4 that test. The spending is on all the other related things
5 that were existing, and so separating that is hard. And
6 what you generally see in this literature is because of
7 these interaction effects -- the 27 to 48 percent thing, for
8 example, the question is you see people are wealthier and
9 then you get more services. If you count those more
10 services and the newest technologies as just technology, you
11 get closer to 48 percent. If you assume it was the
12 underlying wealth and industry spread that generated the
13 demand for all that stuff, then you take all of that stuff
14 and assign it to wealth.

15 So a lot of this is sort of an accounting exercise
16 trying to disentangle things which are inherently un-
17 disentagleable -- which isn't a word.

18 [Laughter.]

19 DR. CHERNEW: But in the spirit of that poor use
20 of words, technology is also a very complicated word that in
21 the general population has meaning and people think of it
22 like Jetson-esque -- which is also not a word -- Jetson-like

1 things of special equipment, and really it's a whole broad
2 set of practice pattern changes which would often include
3 specialty hospitals, which many people would say are really
4 made possible because of medical technology advances that
5 enable us to have them. Whether they're physician ownership
6 or not plays in as a separate question. But I think it's
7 useful to have the chapter written as clearly as possible,
8 but not to give the impression that these are that precisely
9 done.

10 MR. HACKBARTH: Mike, can I just ask you a
11 question about that? Your very first point that technology
12 is actually a residual --

13 DR. CHERNEW: In most of the studies.

14 MR. HACKBARTH: In most of these. So I have sort
15 of, as a lay person, looked at Joe Newhouse's stuff over the
16 years, and Joe I think is considered one of the people who -
17 -

18 DR. CHERNEW: And an author on that Smith one that
19 gave the --

20 MR. HACKBARTH: Yeah, that folks look to for this,
21 and it was his estimate, the 27 to 48 percent, and that's
22 lower than estimates that he did in the early 1990s. His

1 most recent work is still a residual. Technology is still a
2 residual.

3 DR. CHERNEW: That's right. But you could still
4 find -- you could find studies which we call affirmative
5 which could show you in a particular clinical area -- NICUs,
6 revascularization, advanced drugs, you can find a lot of
7 specific technologies in very specific clinical areas, but
8 the overall numbers that we're talking about here, when they
9 try and put it all together, tend to be residual studies,
10 including Joe's.

11 DR. BAICKER: And just to build on what Mike was
12 saying, the stacking order is really important. Analogous
13 to when you think about demographic changes versus spending
14 per person, the way you stack those things affects which
15 share you attribute to which. In some ways, I think the
16 stacking order might be chosen based on the policy levers
17 that are able to be deployed. You know, a policy lever that
18 affects health insurance coverage, if you think health
19 insurance coverage affects technological growth, that
20 certain health insurance characteristics drive technology
21 growth, maybe you want to put the health insurance coverage
22 first, and then look at the downstream implications.

1 Because there are -- you know, many -- two different ways
2 that you could stack those, and I would choose that stacking
3 order to maximize the ability to draw policy implications
4 from the policy levers that are on the table. And with
5 technology being a residual in all of the aggregate ones, I
6 think that's not so much the case with some of the
7 subcomponents where you can do a better aggregate breakdown
8 as opposed to technology, where you'll usually have to look
9 at very narrow cases to identify affirmatively technology,
10 and it can't be done across the board in the same way.

11 DR. CHERNEW: And these interactions, like
12 consolidation and price -- the chapter actually makes --
13 although it probably could be written more clearly,
14 consolidation leads to higher price. So if you treat them
15 as separate, price and consolidation, you miss the fact that
16 they're not really separate, and those interactions are --
17 these are all contributing things, and one should recognize
18 that you're not trying to take a bunch of additive things
19 and just add them up, because they all relate in very
20 complicated ways.

21 I just want to say I'll be -- I didn't do round
22 one. I just want to point that out.

1 [Laughter.]

2 DR. CHERNEW: Tom made a comment about technology
3 and other industries and stuff, and the only thing I'll say
4 about that is it's important to keep the difference between
5 cost, price, and spending. In most other industries where
6 there's technology advancement, we see unit prices go down,
7 but spending goes up. iPhone, you know, phones, information
8 technology, some of the highest spending growth industries
9 have been the high-tech industries, although the unit cost
10 goes down. And so I think we talk about spending, and it's
11 not a price we're talking about in general when we talk
12 about something. It's price times quantity, and those
13 things matter a lot.

14 Now my quick comment. I really do apologize. I
15 am in a short time window. You made a point in your
16 comments about that it might be important to address the
17 federal issue by controlling Medicare spending. That really
18 doesn't come out in the chapter, but I would have said it,
19 like Cori said, even more strongly. I don't see how we
20 solve that problem without addressing the projected -- I
21 don't see any scenario with reasonable tax rates that you
22 can finance this unless health care spending growth is on

1 the table. And I think it's really important to lead --
2 wherever you put it, to make that point that it is going to
3 be imperative to address this problem to include health
4 care. It's not just one of the things we might want to do.
5 I think for much of this budget debate, it's one of the
6 central things we have to come to grips with.

7 MR. HACKBARTH: Your gold star for round one has
8 been revoked.

9 [Laughter.]

10 DR. CHERNEW: I anticipated that.

11 MR. BUTLER: First of all, I would think we ought
12 to relax round one so he can get part of it out.

13 [Laughter.]

14 MR. BUTLER: Okay. He's talking like an
15 economist, and I'm a little lost. I'm a lay person on this.
16 I think what we miss in the chapter a little bit -- and tell
17 me if I'm wrong -- is that people want to know what the cost
18 -- and first you hear, well, of course, we have a growing
19 aging population. And I think the chapter says that's not
20 really it; that's part of it.

21 Second, we have prices that are going up. Yes,
22 that is a factor, but it's still not the big factor.

1 Then we have the third thing, what it is we're
2 buying and how much of it we're buying is the real issue,
3 whether it's new technology or new drugs or whatever. And I
4 don't know if we quite simply kind of say those themes --
5 and I may not have them exactly right, but if you weed
6 through this, I think the public thinks maybe a little
7 something, oh, we're all getting old and using more because
8 we're getting older and sicker, or we're paying a lot more
9 in prices. And I think it's more what we're buying, how
10 much of it.

11 MS. BEHROOZI: To take the entire context in which
12 Medicare operates and, you know, put it into a few pages is
13 a Herculean task, and you've done a great job of bringing a
14 lot of things together.

15 I'm going to express -- I guess it's a dissenting
16 voice a little bit or a different view on the issue of the
17 focus on what the bad consequences of federal debt are. I
18 think it's really important, what you said, Kate, that the
19 alternative scenario assumes two actions to be taken:
20 extending tax cuts that are also -- restore tax level -- or
21 not restore. I'm sorry. Create tax levels that are not
22 historically consistent with what we had seen in prior

1 decades in this country, and not addressing the AMT
2 inflation factor. Those are choices separate and apart, and
3 big choices, and they mean a lot -- have a big impact on the
4 balance of the federal budget and long-term debt, as do
5 other choices about how to spend the money.

6 So I think it's -- that doesn't mean to say I
7 think we should keep spending all the money that we want to
8 on health care and it should keep growing. I think it's
9 important to note that it can crowd out other priorities,
10 but to talk about the impact of the federal debt on the
11 interest rate that the federal government pays just seems
12 like going farther afield into other areas of economics and
13 federal financial policy, whatever -- that's not so much our
14 role.

15 I think that it's also important -- you know,
16 we've been talking about the impact of aging on cost growth.
17 While it's true that we can't sustain an ever growing share
18 of the federal pie going to health care, on the other hand,
19 it is an aging population, and not every additional health
20 care dollar that will be spent is a bad health care dollar
21 spent. Some of it will be necessary.

22 So I think to say 45 percent of cost growth you

1 can attribute to demographics, whatever that means, however
2 you break it down, and then say, oh, my God, the federal
3 government is going to have to pay much higher interest
4 rates because of this, you know, it's attributing too much
5 of all of our problems to Medicare.

6 But as I said, that doesn't mean I think that we
7 shouldn't emphasize the importance of controlling cost
8 growth. But I think that we then have to look at what are
9 the right ways to do it, and what separates out the good
10 dollars from the bad dollars that will be spent in addition.

11 Another broader context issue -- so there's the --
12 you know, broader context for federal spending, there's also
13 the broader context for Medicare beneficiaries, and that's
14 the economic collapse that many are still not, you know,
15 even seeing the surface of the water from, they're so far
16 underwater. On page 9 of the paper, you do talk about
17 people struggling and many people not having access to
18 adequate care. But I think that there's a more specific
19 recognition that can be made. There has been a lot of work
20 done on how people have changed their utilization of health
21 care. The National Bureau of Economic Research just came
22 out with a report showing that over a quarter of people --

1 this isn't Medicare beneficiary, but over a quarter of
2 people responding said that they had reduced their
3 utilization of routine health care because of their own
4 economic circumstances, the change in their own economic
5 circumstances. And, by the way, that was like more than
6 twice as much as in countries that have had universal health
7 care for a long time.

8 I think this kind of feeds into my last point.
9 This really is my last point, if we could maybe look a
10 little harder at the effective health insurance on growth of
11 health care spending relative to other factors. Again,
12 maybe because of the economic collapse, maybe because we've
13 reached a tipping point or something in terms of health care
14 cost growth crowding out wage increases. Workers -- the
15 Kaiser Foundation employer survey, employer benefit survey,
16 showed that workers are paying a higher share, somewhat
17 dramatically higher share last year than the year before.
18 You know, because of a combination of those factors,
19 employers are not paying more. They're paying more both in
20 terms of share of premium and cost sharing at the point of
21 service. And so in other countries where they've had more
22 insurance available for a longer period of time -- I know

1 there has also been dramatic cost growth, but, you know,
2 those are people who have been insulated, one would think,
3 from -- they've had the benefit of insurance, and maybe we
4 could look at cost growth here as compared to cost growth
5 there and get a little better handle on what insurance
6 contributes to it.

7 Just in terms of the statistic on page 13, or the
8 data point, health spending paid out-of-pocket by enrollees
9 in private insurance shrunk significantly, from 55 percent
10 in 1960 to 14 percent in 2007. As I said, I think we could
11 update that and maybe it might be a little bit higher now.
12 But also I'd be really interested to know what 55 percent of
13 the cost of health care in 1960 was as a share of the
14 average income as compared to 14 percent of health care
15 costs in 2007 given that health care cost increase has so
16 dramatically outpaced wage increases. So I think that kind
17 of as Kate said, you know, if you think health insurance has
18 a lot to do with it, you're going to find data that supports
19 that, if that's your starting point. But I think we could
20 unpack that a little bit more.

21 MR. ARMSTRONG: Two quick points. First, I do
22 think that the paper generally accomplishes the goal we have

1 for setting context for this report.

2 One issue I would raise is that we declare that
3 costs are high and we make an elaborate argument as to why
4 we would say that. We also declare that quality is low
5 relative to various comparitors and so forth. But we're
6 fairly indifferent as to whether there's a relationship
7 between the two, and I think that we could be stronger in
8 stating that we believe that there is a relationship between
9 the two, and that that will have policy implications --
10 actually, it already is having policy implications within
11 the Medicare program, and our belief is that as we make
12 improvements in one area, we should be able to make
13 improvements in the other, and I think we should be stronger
14 in that statement.

15 DR. BERENSON: Just on the reasons for health care
16 cost growth, I mean, obviously this is a -- I think it
17 depends on whether you're a lumper or a splitter as to
18 whether you have the eight or 25 or whatever. I tend to be
19 a splitter, not a lumper, so I would add one more,
20 consistent with Kate's notion of let's identify things that
21 have policy levers. I would throw fraud as a potential --
22 well, not as a potential, as a reason for cost growth,

1 anticipating some of the work we're going to be doing this
2 year.

3 MR. KUHN: I'd like to visit the issue where we
4 talk about in this paper about some of the work that Rick
5 Foster, the CMS Chief Actuary, some of the work that he did
6 and his projections of impact of ACA that's out there. And
7 I think we talk about the productivity adjustment that Rick
8 opined on, as well as the excise tax on high-cost employer
9 health plans, and the fact that both of those are going to
10 be critical that those are totally fulfilled if we're going
11 to be able to achieve the savings that are envisioned in
12 this legislation.

13 But Rick went on to opine a little bit, too, the
14 fact that he didn't believe that some of the productivity
15 adjustments were sustainable throughout the decade long of
16 ACA. And, you know, part of his thought process on there
17 was that the ability of providers to respond to the
18 incentives that are out there and whether the policy levers
19 were powerful enough. But we don't put that part of
20 activities that Rick opined on in this paper. And I'd just
21 like us to think a little bit more whether we want to be
22 more inclusive and talk a little bit more about some of

1 those downsides that Rick also put out there, that unless
2 the policy levers are strong enough, are we going to be able
3 to really achieve the savings that people envision that's
4 out there in terms of the productivity adjustments that
5 might be possible.

6 DR. KANE: So when I look at this list, I just get
7 depressed. I think I read that same list, you know, 30
8 years ago. I think it would be useful to maybe go at it as
9 where do we think the big opportunities are to reduce cost,
10 you know, or where's the low-value dollar as opposed to the
11 high-dollar value, and then attach to that some of the
12 things we could do to try to address them. I mean, frankly,
13 technological improvement could be almost anything to
14 anybody. Here it's a residual, you know, in economist
15 terms.

16 So I just think it would be interesting or maybe
17 more useful and maybe more relevant to the public audience
18 that we serve to describe more where do we think we're not
19 getting value and what are some of the tools that we would
20 like to work on to try to improve value.

21 One thing that's not on the list that I think
22 should be is individual health behavior, and especially when

1 we're talking about what's coming down the pike, the under-
2 65 population and what they're bringing into the Medicare
3 environment. I think there's a real need to talk about
4 what's coming down the pike in terms of individual health
5 behavior and what that might mean for Medicare if we just do
6 nothing or don't try to coordinate kind of more of a
7 population-based approach.

8 And then my last comment on the paper is -- and
9 it's got a lot of stuff I recognize. You know, we've been
10 talking about this for a while. But the little tag endnote
11 on page 30 about the need for coordination across payers I
12 think needs a lot more beefing up. I think the whole
13 fragmentation of policy efforts is a huge part of why we
14 have crazy costs and lack of value for the dollars spent.
15 And I think we really need to think much more seriously
16 about how we can have consistent across payer policies,
17 across insurer policies. Maybe we should be looking at what
18 Medicare can do to leverage what the private sector does
19 instead of always vice versa of how do we get the private
20 sector to kind of follow Medicare.

21 You know, there's just a lot of things that we
22 need to be, I think rather urgently, thinking about to get

1 the signals kind of all going in the same direction. As
2 long as we keep giving mixed signals -- some payers are fee-
3 for-service, some payers, you know, don't pay for preventive
4 care. As long as you keep giving those mixed signals,
5 you're not going to get the kind of push that we need to
6 really start to get a handle on the cost growth.

7 So I just would like to see the chapter be a
8 little more hopeful and oriented towards things that we
9 should be doing and focusing on rather than, ah, that
10 technology, ah, those agers, you know, what's the solution
11 to the aging population? I mean, poison the drinking water?
12 I don't know. But it doesn't give me a solution and a hope,
13 and so I'll stop there.

14 MS. HANSEN: Thanks. Well, I will just first
15 underscore the sense of urgency of possible action, you
16 know, as the tone for the chapter. I think it's been said
17 by several people here, but I think that is definitely one.

18 The second one is relative to page 23 in the text
19 that begins to identify, you know, what has some of the
20 impact of health care reform been, and it alludes to the
21 component of opportunity with people who are dually
22 eligible. And I just would like to see if we could enhance

1 that division a bit, because you mentioned how much cost
2 growth will come about, you know, between the two programs
3 that you mentioned orally, but having something to that
4 effect convey that since our June chapter likely will have
5 something that will follow the dual-eligible work.

6 And, in particular, one other piece that's in the
7 context chapter, that since the Medicaid program has been
8 expanded to 133 percent of poverty for the under-65
9 population, that portends a much larger number of people
10 coming down the pipeline who may be not the dual eligibles
11 of today but kind of the dual eligibles of the future. So
12 our ability to get that model more effectively correct and
13 understood as to how big of a piece it already is and that
14 conveys a sense of further urgency to really understand how
15 important the care delivery system needs some changing as
16 well as the incentives.

17 DR. BAICKER: I thought all the pieces that were
18 laid out here were incredibly helpful, and in trying to knit
19 together these issues that have come up, I didn't know
20 whether it might be helpful to frame things focusing on
21 spending growth, where those two words are very important --
22 spending is price times quantity, and some of these seem to

1 push on price, and some seem to push closer to -- can you
2 hear me now? Some seem to push more on quantity, and that
3 goes back to the stacking issue. Prices charged by
4 providers may be affected by industry consolidation, et
5 cetera. But framing it in that way and for the spending and
6 then thinking about the growth, we're talking about
7 increases at the margin, not average, and the issue that
8 Mike alluded to as well is that we might think that on the
9 margin we're not getting a lot of health for the spending or
10 we're getting less health than we were getting on average.
11 So thinking about price times quantity and defining quantity
12 as either services consumed or as health produced then might
13 help drive an analysis of how the dollar allocation maps to
14 the outcomes that we care about, which then pushes us
15 towards certain policy levers that are going to affect the
16 channels differentially.

17 DR. DEAN: Maybe to just follow up on some of the
18 comments that have already been made, I think it is
19 important to somehow continue to try to convey the idea that
20 it is possible to reduce costs without hurting quality,
21 because that's a great fear and continues to be a big fear
22 in the public, and all the furor about cutting Medicare and

1 the fact that that is going to harm beneficiaries, and we
2 know that -- we believe at least that that's certainly
3 possible to cut expenditures and not harm anybody. I think
4 we need to try to clarify that a bit and expand that that is
5 possible and maybe explain that, in fact, we have put, for
6 instance, a huge amount of emphasis, in my mind too much
7 emphasis, as a society on the fact that you control costs by
8 shortening hospital stays. And we have to the point, I
9 think, driven down hospital stays where they almost don't
10 allow for the natural history of some of these conditions
11 that we deal with, especially as we're dealing with a more
12 elderly population that just simply don't recover as
13 quickly. And the fact is that if you look internationally,
14 Americans use hospital services significantly less than most
15 of the countries that we're compared with. The number of
16 hospital days per capita is significantly lower than most of
17 the countries that spend significantly less on health care.

18 So I guess what I'm getting at is I think it might
19 be helpful to lay out more specifically what exactly are the
20 drivers of the cost increase, and you've done that. But I
21 think another area that hasn't been mentioned that I think
22 is of concern, and that's just the overall amount that we

1 spend on administration and the cost of managing the system
2 and shuffling the papers, which is substantial compared,
3 again, to a lot of the other systems around the world.

4 Finally, just a comment. I've been uncomfortable
5 for some time about the productivity adjustment and using
6 the term "productivity," which I, first of all, don't know
7 how you measure productivity in this context and, second of
8 all, as I understand it, how it's applied, it really is just
9 an across-the-board fee cut -- which may be appropriate.
10 I'm not arguing that part. But I think it isn't really
11 entirely accurate to call it a productivity adjustment when
12 it's an across-the-board adjustment. Given the fact that
13 many of us believe we have an underlying pretty seriously
14 distorted fee structure, it has a lot of -- it's a very
15 blunt tool, and I think it has some unfortunate
16 implications. I know it's something that's been in place
17 for a long time, but I guess it's something that has made me
18 uncomfortable for quite some time.

19 DR. BORMAN: Being a plain Jane general surgeon,
20 I'm going to try and come back to some pretty simple
21 concepts, I think, about this chapter.

22 First, I'd like to say I think it's a really -- in

1 the main, it's a wonderfully done chapter. I think it comes
2 across as quite fresh. I think many of the references are
3 quite current, and I really think it's extraordinarily well
4 done.

5 I think when we step back -- and I've heard from,
6 you know, different folks here that we need to be more
7 aggressive or we need to stay away from areas where we don't
8 belong, which are somewhat, you know, conflicting views. I
9 think maybe the answer to that is to remind ourselves who's
10 the audience here, and our first audience is to advise the
11 Congress. And so I think that -- frankly, I think that the
12 tone here has been pretty well balanced in terms of some
13 things that try and get at things that are within the
14 purview of the Congress to do without stepping into --
15 trying to or appearing to tell the Congress what to do. On
16 the other hand, I think to ignore the place that health care
17 first in the federal budget would be a huge mistake and
18 clearly misleading. But I think it's very important to
19 remember, you know, who is our primary audience and to
20 tailor it. And I thought the tone of this was very well
21 done and that I really liked the tone on the section that
22 relates to the OECD comparisons, which I personally have had

1 some difficulty with over time because I'm not sure it's the
2 right comparison group for some of the reasons that Tom Dean
3 has mentioned, and also because in this whole quality thing
4 -- and, Scott, I guess I would take a little bit of issue
5 with your blanket statement that quality is low, because I
6 think that depends on how you define quality. And to some
7 degree as a society we've defined quality as a moving target
8 over time. Originally, anything we did that just made
9 people live longer we said was as good thing, was a good
10 outcome in health care; and now we're kind of into things of
11 can we get the error level to zero, can we get ventilator-
12 associated pneumonia to zero, whatever. I think we've had
13 some shift in what quality really means. Quality isn't
14 where we want it to be, but low implies we have a clear
15 standard against which to judge it, and other than some
16 really clear things like mammography, Pap smear, prenatal
17 care, some of those kinds of things, I think that that level
18 of absolute value is perhaps lacking in the health care
19 quality arena.

20 One of the things that I would consider adding in
21 some place here because it's consistent with our prior work
22 is the absence of good quality comparative effectiveness

1 data. Really, that limits our ability to make intelligent
2 choices that really then rolls into the prices and the
3 volume and the use of technology and everything else.
4 There's this fundamental absence of good information by
5 which to at least compare therapies and at least engage the
6 patient and their family in making good choices and enable
7 us as a society and stewards of money to make better
8 priorities about our investment.

9 And then I would echo the comment that the end
10 there, the coordination of care part, seems to just kind of
11 dangle out there at the end and not yet reach its full
12 potential. And I think that might be a place to reiterate
13 that some of the benefits of the coordination that you
14 envision would relate to potentially reducing disparities;
15 more patient-centered and patient-directed care, and better
16 understood care by patients, more streamlined care for
17 patients, less complexity, particularly for the vulnerable
18 and the frail. I think it's an opportunity there at the end
19 to just sort of roll up some of the themes that could all be
20 benefits of better coordination of care and kind of bring it
21 back to it's a contextual big-picture chapter, because right
22 now it just kind of hangs on there as a little end thing,

1 and I'm just not sure what we want to do with it. But that
2 might be one way to make it contribute to the value of the
3 chapter.

4 Then, finally, just one last comment. We allude
5 in there to our ability to sustain people to later ages with
6 more complex conditions. And in some ways, you might regard
7 that as a success of our medical climate, but it has also
8 created all these challenges. And I think that just
9 heightens the importance of considering comparative
10 effectiveness and end-of-life and palliative issues, you
11 know, which we'll be going into further.

12 But I would kind of try and keep this at a
13 relatively general level as it is a context chapter. We
14 have other methodologies for getting to specifically this,
15 that, dah, dah, dah, or the menu of options, and I think at
16 least for me you've struck a nice balance in addressing many
17 of the issues.

18 MR. HACKBARTH: Okay. I'm not off to a very good
19 start this year. I never even got a gold star that I can
20 have revoked, so I am even behind Mike.

21 I had asked -- this is something I should have
22 said at the outset and failed to, and that's why I'm off to

1 a bad start. I asked the staff to try to shorten this
2 chapter. Over the years that we've been doing it, five,
3 six, seven years, it sort of keeps growing every year, and
4 in ways that add useful information. I don't disagree with
5 any of the points that have been made here. But if the
6 context chapter becomes where we comprehensively address
7 everything, it becomes unworkable, and it becomes a real
8 struggle for the staff to write. It drains from other
9 activities that they're doing to try to square up the work.

10 So I had asked Mark to shorten it up, and let's
11 focus more on a descriptive chapter, which is, I think most
12 responsive to what Congress asked us to do seven or eight
13 years ago, and say, you know, we get it, we understand the
14 budgetary context in which these decisions need to be made.
15 So focus on a description of the trends, in particular the
16 Medicare trends and the federal budgetary trends and the
17 context that that creates for Medicare policymaking; perhaps
18 a little bit about the causes, but really stay out of the
19 solutions. The solutions is what we address when we have
20 our various chapters, whether they be on update
21 recommendations or other policies. And so I've tried to
22 define a smaller and somewhat clearer box for Kate and Evan

1 to work in here.

2 Again, that's not to say that I disagree with --
3 there wasn't a single comment that I would disagree with,
4 but if we try to put it all in this package, I think it's a
5 big diversion of resources.

6 So we will take this input, and we will try to
7 strike an appropriate balance in the next chapter and get
8 back to you, but I did want to make it clear that that's the
9 direction that I had given Mark and the staff. I still
10 think generally it's the right direction, but we'll try to
11 include some of this as we can fit it within that framework.

12 Thank you, Kate and Even.

13 MR. HACKBARTH: Let's move on to our second topic
14 for today, which is the Medicare Shared Savings Program for
15 ACOs.

16 DR. MARK MILLER: Can I just say something here?

17 MR. HACKBARTH: Yes.

18 DR. MARK MILLER: For those of you who are
19 standing, I'm sorry, there are not enough seats, but there
20 are a few open. I see four here at the front, and if there
21 is anything in the midst that I can't see, maybe people who
22 have an empty seat next to them can raise their hand for a

1 second. I apologize, but we don't have -- we didn't
2 anticipate this many people.

3 DR. STENSLAND: All right. This spring, as part
4 of the Patient Protection and Affordable Care Act, Congress
5 enacted a new Medicare program for Accountable Care
6 Organizations, known as ACOs. The ACO is a group of health
7 care providers that take responsibility for the costs and
8 quality of care delivered to fee-for-service Medicare
9 beneficiaries. If the providers score well on quality and
10 cost metrics, they receive higher payments from CMS, and the
11 program will start on January 1, 2012.

12 Today, we will describe what Medicare ACOs are and
13 outline their mechanisms for controlling costs. Then we
14 will talk about four issues that CMS will have to decide in
15 regulation, and the proposed regulation, we are hopeful it
16 might come out in the fall. It might take until January or
17 February. There are a lot of complex issues for CMS to work
18 through.

19 But my objective here today is to give you all the
20 background on the ACOs to set the stage so you can discuss
21 some of these regulatory issues that CMS ought to grapple
22 with.

1 So ACOs are health care organizations formed
2 around a core group of primary care physicians. The primary
3 care physicians could be part of an integrated delivery
4 system, a large group practice, or a Physician Hospital
5 Organization. The ACOs can take many forms, but the common
6 element is they have a core group of primary care physicians
7 that serve at least 5,000 fee-for-service Medicare
8 beneficiaries. While an ACO must have these primary care
9 providers, having a hospital or a specialist is optional.

10 In addition to primary care capacity, the ACO must
11 also show CMS that it has certain capabilities. These
12 capabilities include distributing bonuses, defining
13 processes to promote evidence-based medicine, reporting on
14 quality and cost metrics, and being patient centered.
15 Obviously, CMS is going to have to make a judgment call as
16 to whether an ACO applicant meets these criteria.

17 One important characteristic of Medicare ACOs is
18 that the ACO's patients are still free to use providers
19 outside of the ACO, and if they choose to use a specialist
20 or a hospital that is outside the ACO, the ACO remains
21 responsible for their spending. The net effect of this
22 incentive is to convince the patients -- is that the ACO has

1 an incentive to convince its patients that it's delivering
2 the highest quality care. If the patients don't believe the
3 ACO physicians are providing the best care, they will use
4 physicians outside the ACO and the ACO physicians will then
5 lose their control over the patient's resource use.

6 This is just an illustration of how an ACO could
7 work. At the center of the ACO is some administrative
8 system that will distribute bonuses and collect quality
9 data. These administrative functions could be housed within
10 a group practice or a hospital or even an IPA. The ACO must
11 have some primary care physicians. These are the light
12 green circles. After CMS is told these physicians are part
13 of the ACO, CMS will then assign patients that use these
14 primary care providers to the ACO. The ACO is then
15 responsible for the quality and cost of care provided to
16 these patients. There could also be hospitals and
17 specialists, as you see in this picture with the little
18 dotted lines. However, adding these providers to the ACO is
19 optional.

20 The basic thrust of an ACO design is to give
21 physicians and possibly a hospital joint responsibility for
22 the quality and cost of care delivered to the population of

1 patients. They get a bonus if they keep cost growth below a
2 fixed dollar target. For example, if the growth in spending
3 target was \$500 per beneficiary per year in an area with an
4 average input cost index, that would mean that the ACO would
5 get a bonus if it keeps quality high and restrains cost
6 growth to less than \$500 per beneficiary per year.

7 And the ACOs are also required to coordinate care.
8 They should coordinate care with all providers in the local
9 delivery system, even if those physicians are not in the
10 ACO. For example, the ACO should coordinate care between
11 primary care, specialty care, hospitalists, and skilled
12 nursing facilities. It could also be argued that the ACO
13 should have some system in place with the local hospitals
14 and know when their primary care doctors' patients are
15 admitted and when those patients are discharged.

16 So we have talked about the ACOs' incentives to
17 constrain Medicare spending growth, but exactly how could
18 they do it? First, we often hear about plans to constrain
19 volume growth. ACOs could expect to reduce spending if they
20 prevent unnecessary admissions, prevent readmissions or
21 other services. However, reducing volume growth is not the
22 only option for reducing spending growth. The ACO providers

1 could reduce the price of a surgery by directing a patient
2 to an ASC rather than a hospital if that level of care was
3 appropriate, as long as the referral to the ASC does not
4 result in additional induced demand by the ASC owners.
5 Switching to this lower-priced sector could end up reducing
6 spending. Finally, even within a sector, such as within the
7 hospital center, there are different Medicare rates. ACOs
8 could reduce spending by recommending a lower-priced
9 hospital when that hospital is appropriate for the patient.

10 So the whole point of this slide is to say that
11 ACOs could save money by eliminating unnecessary services,
12 but they could also save money by reducing the price
13 Medicare pays for some of those services.

14 And that is the brief overview of what ACOs are
15 and how they can save money. Now we are going to shift to
16 talking about issues that were not settled in the
17 legislation. These are issues that could be addressed in
18 regulation.

19 The first issue we will talk about is random
20 variation in cost metrics. Then we will talk about a bonus
21 penalty model as an alternative to the bonus only model.
22 Third, we will talk about random variation in quality

1 metrics. And then, fourth, we will discuss how to inform
2 patients about ACOs.

3 Before we discuss the potential regulatory issues,
4 let us just review how a bonus-only model would work.
5 First, remember the ACO would continue to receive fee-for-
6 service payments at current fee-for-service rates. They get
7 a bonus if they meet the quality and cost targets. The cost
8 target is set equal to the prior year's spending, or based
9 on the prior three years' spending plus a national growth
10 amount, such as the \$500 I discussed, minus a threshold.
11 The threshold is the amount of savings that must be
12 generated before CMS starts to distribute savings as
13 bonuses. For example, CMS could keep the first two percent
14 of savings itself and then start distributing savings to the
15 ACO once the two percent threshold is met.

16 Note that Medicare needs the threshold to prevent
17 the system from costing Medicare money. Recall in the
18 bonus-only model, there is no penalty for exceeding the
19 spending target, so there will be some bonuses distributed
20 due to random variation, and these won't be offset by random
21 penalties. The idea that random bonuses are paid by CMS
22 makes CMS come up with some alternative offsetting revenue

1 and the offsetting revenue would be keeping that first two
2 percent of savings. And, of course, they could set a
3 different threshold than two percent.

4 So how will CMS address this random variation
5 issue and set the size of the threshold? In the PGP
6 demonstration, which was a test of the ACO concept, CMS
7 required that the first two percent of estimated savings
8 stay with CMS and then they would share the rest with the
9 providers and CMS. This was what was known as the two
10 percent threshold. However, the PGP demonstration sites had
11 an average of 20,000 beneficiaries. The new Medicare ACO
12 program will allow smaller ACOs, as small as 5,000
13 beneficiaries. This will result in more random variation
14 than we saw in the PGP demo.

15 So how could CMS deal with this greater random
16 variation in Medicare spending? One potential solution is
17 to have a bigger threshold for the smaller ACOs, meaning a
18 bigger amount of the savings is going to go to CMS before
19 they start distributing any savings, and the reason being
20 they are not sure if that savings is real or just a function
21 of random variation.

22 A second potential solution is to pool the

1 performance data of small ACOs over several years.
2 Basically, they would receive a bonus based on a rolling
3 average of their performance. And this raises the question
4 of how much variation is there in these 5,000 pools of
5 beneficiaries and how does that compare to, say, a 20,000-
6 beneficiary pool.

7 Here we show that the smallest ACOs have much more
8 variation than the larger ACOs. To create this table, we
9 looked at 2006 and 2007 Medicare A plus B spending for
10 randomly selected pools of Medicare beneficiaries. We then
11 examined whether spending growth from 2006 to 2007 is more
12 or less than the average.

13 In the first column, we show that ten percent of
14 the pools of beneficiaries with pools of 5,000 beneficiaries
15 had spending that was 3.6 percent or more below the expected
16 level, and ten percent of the pools of 5,000 beneficiaries
17 had spending that was four percent or more above the
18 expected level. As we move to the right-hand column, we
19 start to look at larger pools. At the farthest right-hand
20 column, we show random variation for pools of 20,000
21 Medicare beneficiaries. We see the variation is lower, with
22 about ten percent of these pools having spending that was

1 2.1 percent or more below the expected level and about ten
2 percent having spending that was 2.1 percent or more above
3 the expected level.

4 The point of this slide is to show that smaller
5 pools of beneficiaries will have more volatility. To limit
6 payments due to random variation, CMS will either need
7 larger thresholds than the two percent that it used in the
8 PGP demo or some pooling of data across years.

9 And I want to be clear that this is just an
10 illustrative example up here. We aren't saying that for
11 pools of 5,000 beneficiaries you necessarily need a four
12 percent threshold because there is a judgment call involved
13 here and there is some data involved here. What this shows
14 is that with a four percent threshold, roughly about ten
15 percent of the ACOs, even if they did nothing, would still
16 get a bonus. People may say that is not reasonable. Maybe
17 we only want to give bonuses to five percent of people who
18 aren't doing anything. And if that is the most -- if they
19 are going to have that more stringent criteria, then you
20 would need more than a four percent threshold because there
21 would be more people getting -- or you would want fewer
22 people getting random bonuses, if you didn't like the ten

1 percent threshold.

2 So there are two types of incentives to reduce
3 Medicare spending. First, there is the rather strong
4 incentive to reduce other providers' Medicare revenue, and
5 then there is a rather weak incentive to reduce your own
6 Medicare revenue. In the mailing, we went into a detailed
7 discussion of why the incentives under the bonus-only model
8 to reduce the ACO's own Medicare revenues are limited by two
9 factors. These are the threshold and random variation.

10 First, let us talk about the threshold. The ACO
11 may be reluctant to reduce their own fee-for-service revenue
12 if they are not sure they will be able to reduce the
13 spending by enough to get it by the threshold. For example,
14 even if an ACO reduced its spending by one or two percent,
15 they would not receive a bonus. They would lose their
16 revenue but get nothing in return. That is one mechanism to
17 reduce their incentive to control spending.

18 There is also the issue of random variation. For
19 example, if they had a particularly bad flu year and had a
20 significant uptick in pneumonia admissions, they may not get
21 a bonus, even if they were successful in cutting other
22 Medicare spending by more than the two percent threshold.

1 The bottom line is that even if an ACO reduces some
2 unnecessary services, it cannot be guaranteed to receive a
3 bonus due to random variation and the threshold.

4 So given the relatively weak incentives in the
5 bonus-only model, is there a model with stronger incentives?
6 And an alternative to the bonus-only model is a bonus
7 penalty model, and this has greater incentives to control
8 spending for two reasons. First, there would be no need for
9 a threshold. And second, the addition of a penalty creates
10 a second incentive. Together, the incentive of getting a
11 bonus coupled with the incentive of avoiding a penalty is
12 greater than the bonus incentive alone. The downside is
13 that the providers have to take on more risk, but they may
14 be willing to take on risk of a penalty if CMS gave them
15 some downside protection, perhaps in the form of a risk
16 corridor, and if CMS removed the threshold in the bonus
17 penalty model and let providers share in the first dollars
18 of savings that they can generate.

19 Now we just want to compare three types of payment
20 models. The first is the bonus-only ACO, which is in the
21 first column. The second column has the bonus and penalty
22 ACO. And for comparison, in the third column we have the MA

1 model.

2 In the first row, we compare responsibilities. In
3 the bonus-only model, the ACO takes no risk, but it gets
4 bonuses for good quality and cost performance. Then in the
5 bonus and penalty model, the ACO takes on partial insurance
6 risk. So in this sense, the ACO with penalties is more like
7 an MA plan in terms of its incentives.

8 In the second row, we compare operational
9 responsibilities. The two ACO columns have to distribute
10 bonuses and coordinate care. Now, this is very different
11 from the MA plan column, where the MA plans have to
12 negotiate prices and pay claims, and we have talked to
13 organizations that are interested in managing care, but they
14 have no interest in engaging in paying claims or negotiating
15 prices with providers. That is why some of these groups
16 want to be an ACO but not an MA plan.

17 Finally, in the bottom row, we show that
18 incentives are limited in the ACO bonus-only model. They
19 earn stronger incentives in the bonus penalty model and the
20 MA plan.

21 Now, David will talk about quality.

22 MR. GLASS: So how quality is measured and

1 evaluated will be crucial to the ACO concept. The quality
2 metrics chosen should reflect the outcomes the ACO program
3 is designed to achieve. Ideally, ACOs would improve the
4 health of the population they care for, so you might want to
5 measure the average risk score of the population and see how
6 that changes over time. Also, care coordination between,
7 for example, hospitals and physicians could be important, so
8 you might want to look at care-sensitive admission rates and
9 readmission. Finally, the patient experience of care is
10 something the ACOs should also improve, so you might want to
11 look at patient safety as well as self-reported measures.

12 After deciding what to measure, the CMS will have
13 to set quality targets and assess if those targets are being
14 met or not. An initial issue will be does every measure
15 have to be met? Some of the measures, or maybe a composite?
16 Remember, if the target is not met, no bonus will be paid.

17 CMS will face a similar problem assessing
18 achievement of quality as it does with costs, the same issue
19 of uncertainty and how to deal with random variation, and
20 how much certainty should CMS demand. CMS could require
21 that the ACO show with 90 percent certainty that its
22 outcomes are above average, or at least average, or maybe

1 not worse than average. Or it could set some other measure
2 of confidence.

3 The measures chosen by CMS as indicators of
4 quality, how the target is set, and how achievement is
5 assessed could influence how big of a sample of patients are
6 needed to accurately measure quality and may indirectly
7 affect which types of organizations choose to become ACOs.
8 For example, including hospital safety measures could
9 encourage including hospitals or hospitalists to be members
10 of an ACO. All these could be issues CMS addresses in
11 regulation.

12 We now want to turn to the beneficiary and how
13 they should be informed of their physician's choice to join
14 an ACO. Remember, unlike MA plans, patients do not enroll.
15 They are assigned to an ACO by CMS based on which physicians
16 they use. So first, the physician chooses to be in an ACO,
17 and then second, CMS assigns patients to the physician and
18 thus to the ACO.

19 The assignment could be retrospective. That is,
20 after the end of 2012, for example, CMS could use 2012
21 claims and tell the physician, these were your patients and
22 tell the beneficiary, you were in an ACO last year. The PGP

1 demo used retrospective assignment. Or the assignment could
2 be prospective. For example, under prospective assignment
3 to evaluate the ACO on 2012 performance, CMS would have to
4 look at 2010 claims to assign patients.

5 If we want the patient to know in advance that
6 their physician is in an ACO, then assignment has to be
7 prospective and use the older claims information. Why would
8 we want to tell the patient in advance that their physician
9 is in an ACO? It could be that one feels a patient has a
10 right to know what incentives his or her physician is
11 responding to. Following this logic, presumably, then, the
12 patient should have some choice to make knowing this new
13 information.

14 So the patient could stay with her physician and
15 her data would be used in the evaluation of the ACO over the
16 coming year. That would be the default option. Or if the
17 patient had some strong objection to ACOs, the patient could
18 choose to switch to a different physician who is not in an
19 ACO, and perhaps inform CMS of that choice. Or a third
20 option might be to let the patient stay with their
21 physician, but opt out of the ACO and not have her data
22 count in the ACO's evaluation. This last option might give

1 the beneficiary the greatest choice, but it could also be an
2 administrative complication for CMS and raise selection
3 issues. Of course, selection will be an issue for any ACO
4 design. The strategies will have to be chosen to deal with
5 it.

6 DR. MARK MILLER: Hey, David, I thought also when
7 we were talking about this, another reason that you might
8 want to have the patient informed is so some people make a
9 fairly strong argument if you want these things to work, you
10 have to engage the patient and kind of talk to them about
11 what the plan of care is and that type of thing --

12 MR. GLASS: Right, you can make the patient an
13 active --

14 DR. MARK MILLER: -- so it is beyond just the
15 patient rights issue. It is also sort of if the model has
16 that component.

17 MR. GLASS: Right. So we have outlined several
18 issues that CMS will eventually have to address in
19 regulation and that you may want to discuss during the
20 session.

21 The first issue is the random variation that
22 occurs in Medicare costs per beneficiary. Should CMS set

1 high thresholds before bonuses are distributed? And the
2 related issue is, if thresholds are large, will they
3 discourage small ACOs?

4 Second, should CMS be encouraged to create an
5 alternative model with bonuses and penalties? If small ACOs
6 have big thresholds in the bonus-only model, they may be
7 interested in the bonus penalty model without a threshold.

8 Third, what quality measures should CMS collect?
9 How should it set quality targets? And what degree of
10 confidence should CMS require with respect to assessing
11 achievement? These choices on qualities may have
12 implications for what entities are in ACOs and how large ACO
13 patient panels need to be.

14 Fourth, when should the beneficiary be informed?
15 Should this be done prior to the start of the patient's
16 expenditures and quality metrics counting toward the ACO
17 scores? And what should patients' choices be?

18 We would be happy to answer your questions and
19 look forward to your discussion.

20 MR. HACKBARTH: Okay. Thank you. Let's start on
21 this side this time with round one clarifying questions,
22 Kate, Jennie, Bruce, and Herb.

1 DR. BAICKER: In thinking about how to deal with
2 the problem of random variation in smaller ACOs, is it
3 within our choice set to think about different lengths of
4 moving averages depending on the size of the panel, or does
5 it have to be sort of a one rule independent of the size of
6 the panel?

7 DR. STENSLAND: I think in the -- that would be
8 under alternative models that the CMS could implement, and
9 the first look that we have in terms of the way the law is
10 written is the broad ability to implement alternative
11 models. So I don't think there is anything necessarily that
12 is off the table in terms of whether you have one common
13 number of years or a smaller number of years for larger
14 ACOs.

15 MS. HANSEN: Yes. Thank you very much. On page
16 14, when you spoke about -- excuse me, Slide 14, the
17 difference of prospective and retrospective, and I think
18 bearing in mind what, Mark, you brought up about the
19 consumer participation, with the PGP demos, was there the
20 experience that people opted out for any reason, since, you
21 know -- or was it really not significant?

22 MR. GLASS: Well, in PGP, it was retrospective

1 assignment --

2 MS. HANSEN: Right.

3 MR. GLASS: -- so no one could opt out because
4 they didn't know --

5 MS. HANSEN: Right. I'm sorry.

6 MR. GLASS: -- in advance that they were in there.

7 MS. HANSEN: Okay. So then this is more
8 theoretical at this point that they could opt out, but --

9 MR. GLASS: If you did it prospectively, then they
10 could have perhaps a choice to opt out.

11 MS. HANSEN: Right. Okay. But in the third
12 little bullet there, it says, say in the PGP, they stayed
13 with the physician, so that is how the model was? Once they
14 were already in, yes --

15 MR. GLASS: Well, the PGP -- so it was
16 retrospective, so at the end of the year they said, this
17 patient was indeed in your PGP for that year.

18 MS. HANSEN: Okay. Understood. Thank you very
19 much.

20 DR. STUART: Thank you. I really enjoyed reading
21 this chapter, but I think there is a framing issue that
22 bothers me, and it was brought up by Kate, and that is what

1 do we define as random. And rather than talking about
2 random, I would like to flip it on its head and suggest that
3 this really should be focused on the goal of having
4 persistent savings, cost savings, and persistent improvement
5 in quality, and then we can think of random variation as
6 impersistent. And the reason I say that is I think that the
7 difference between a benefit only, bonus only, and a penalty
8 only is really kind of artifactual, and I will just give you
9 one example, and in the spirit of round one and round two, I
10 will stop at the end of that.

11 Here is an example of a benefit, what I would call
12 bonus-only program. You have an ACO, doesn't matter what
13 size it is, and they meet the quality target and they reduce
14 the cost target, and so you credit them with this bonus
15 payment. But you also tell them that they're going to have
16 to have some evidence of persistency in this over time.
17 Otherwise, there's going to be a clawback and we're going to
18 take it away from you next year. Or we could say, well,
19 we're not going to give it to you this year, but we're going
20 to give it to you in your account for next year and if
21 you're persistent, then you get to keep it.

22 And I think that's important from a framing

1 standpoint, because I think, frankly, this idea of having
2 high thresholds for small plans is a killer. I just don't
3 see how that is going to bring in plans. So the framing is
4 the point that I'd like to emphasize here.

5 MR. KUHN: Just a quick question on page nine, and
6 if I can go back, just one quick thought on here, Jeff, is
7 that I understand the graph and understood when I read the
8 materials about the fact that you could have some of these
9 plans, at least in the top decile or the top ten percent
10 could just achieve a bonus for doing essentially nothing.
11 But I just want to make sure I understand, is that they
12 also, in order to achieve a bonus, would have to meet
13 certain quality thresholds, as well. So they're not
14 mutually exclusive. There are some interdependencies here
15 between the two. So this was just for illustrative purposes
16 on the random variation, but also to achieve a bonus, you're
17 going to have to hit quality metrics and other things that
18 are out there, is that correct?

19 DR. STENSLAND: Quality metrics still have to be
20 defined, but there will be something there.

21 MR. KUHN: Thank you.

22 DR. KANE: Just a quick question on Slide 14 about

1 the beneficiaries being assigned retrospectively. Can the
2 physician then say, I never saw this person or heard of this
3 person? I mean, is there some way for the physician to say,
4 even though whatever metric you've assigned them to me, I've
5 never heard of the person? I mean --

6 MR. GLASS: Well, they would be assigned based on
7 -- in retrospective, they would be assigned based on the
8 claims in that year. So if the physician never saw the
9 patient yet had put in a claim that they had seen the
10 patient --

11 DR. KANE: Well, I guess it gets to where it's
12 only a very small, you know, like if it's a very small --
13 they might have gotten a claim, but it might have been for a
14 small thing relative to a larger thing going on with that
15 patient. I mean, I guess it has to do with being assigned
16 in models --

17 MR. GLASS: It's usually a plurality --

18 DR. KANE: -- and how good they are and whether or
19 not people can say that --

20 MR. GLASS: Yes. It's usually a plurality of E&M
21 visits or something like that would be the assignment
22 algorithm. And it could be to any physician in the ACO,

1 perhaps, will be how they do it, as opposed to a particular
2 physician.

3 DR. MARK MILLER: So you catch that, that there's
4 usually some critical mass that you have to clear before the
5 patient gets counted as yours.

6 DR. KANE: And what I think I just heard him say
7 is it can be to an ACO rather than a specific physician if
8 there's a group of physicians --

9 MR. GLASS: That will have to be determined by CMS
10 and regulation --

11 DR. KANE: That would make more sense.

12 MR. HACKBARTH: Bob and Scott, and everybody else?

13 DR. BERENSON: On Page 11 -- this, I guess, is for
14 Jeff -- in talking about risk corridors to protect the ACO
15 from large swings, you've established here it looks like
16 sort of an aggregate, what I would -- not being an actuary
17 and I'll defer to Cori here -- sort of an aggregate
18 protection. In the paper, you talk about an individual
19 level corridor.

20 I mean, in fact, should we think of this the way
21 actuaries do reinsurance with individual and aggregate sto-
22 loss? I mean, both of them could be on the table as the way

1 to approach this.

2 DR. STENSLAND: It's wide open so they both could
3 be on the table.

4 MR. ARMSTRONG: I just wanted to clarify. We say
5 in a couple of places that -- same slide, actually -- that
6 CMS may have the authority to create alternative models. Do
7 we know whether they do or not, first?

8 And then second, the alternative model that we've
9 evaluated here, the two-sided bonus penalty model, is that
10 ours or is that proposed from somewhere else? And is there
11 a reason why subcapitation or other variations on a similar
12 theme might not also be a possibility?

13 DR. STENSLAND: First, we try to put it in quotes,
14 you know, because we're not going to make a legal judgment
15 as to whether CMS actually has this authority. At first
16 reading of the sentence, it looks like broad authority, but
17 maybe that's up for the general counsel at CMS to decide.
18 So I think there's a couple sentences where we give you the
19 sentence in the mailing materials where it appears to give
20 broad authority.

21 The reason we put the bonus penalty in there is
22 just to show the most simple example we could come up with

1 where they have both upside and downside risks, and there
2 certainly is all these other options on the table such as
3 partial capitation, and people have different ideas what
4 they think partial capitation is. And those are all
5 potentially on the table.

6 MS. BEHROOZI: On behalf of everyone else, I
7 should know the answer to this question. So you're talking
8 about staying within the fee-for-service payment system.
9 Does a provider have the option of varying the beneficiary's
10 co-insurance amount? Can they decide to accept less,
11 because you talk about keeping people in the ACO has to be
12 through persuasion of one kind or another. Can they use
13 economic persuasion or incentives in any way?

14 DR. STENSLAND: There's nothing specifically about
15 that in the law. I guess this would be under, if CMS
16 decided to do something, under the alternative models option
17 or under their demo capacity. They could do something in
18 that range. But there's nothing specifically stated in the
19 law.

20 MR. GLASS: And they'd probably have to waive
21 certain provisions about kick back and that sort of thing.
22 I'm not sure which provisions exactly would apply, but I

1 don't think you can just unilaterally say, no, we're not
2 going to charge you cost-sharing on something.

3 MR. BUTLER: So Slide 9 is truly around one
4 question. So again, this says that if you had a pool of
5 20,000 or more, it's likely about 10 percent of the
6 participants may get money for doing essentially nothing,
7 irrespective of the quality issues at measurement. Is that
8 right?

9 DR. STENSLAND: Basically.

10 MR. BUTLER: With the 2 percent threshold that had
11 been shown in the model, right?

12 DR. STENSLAND: If you did nothing, you would have
13 about a 10 percent chance of getting a bonus.

14 MR. BUTLER: Okay. So then on the far left-hand
15 side, because the pool's minimum is 5,000, if that were not
16 -- I'm going to back into the number. Instead of 3.6, if
17 that were 2 percent, how many, do you think -- what's your
18 guess at the percent that might receive a bonus with the
19 smaller pool? Because right now that's what's on the table,
20 the 5,000. You don't know?

21 DR. STENSLAND: I don't know. If you moved it up
22 to 5 percent, it goes up to about 5 percent. So if you want

1 like something stuck in your head that's kind of a ballpark,
2 about 5 percent of the pools of 5,000 people have spending
3 that's 5 percent below expected.

4 MR. GLASS: But you're asking for the 2 -- if it
5 was a 2 percent threshold --

6 MR. BUTLER: Yeah, a 2 percent threshold for the
7 5,000 group, would it get a third of the people, a third of,
8 you know --

9 DR. STENSLAND: I don't know. I wouldn't
10 speculate.

11 DR. NAYLOR: So this is really a great description
12 of an effort to promote shared accountability and shared
13 savings through care coordination.

14 In the actual provision, I think that the section
15 talks about groups of providers, talks about health
16 professionals, and defines that as physicians and other
17 practitioners. In your sense of this, and consistent with
18 other provisions in the Affordable Care Act to really grow
19 access to primary care, period, through nurse-managed
20 clinics and others, do these providers go beyond physicians
21 in terms of who can be a part of these accountable care
22 organizations?

1 DR. STENSLAND: In terms of -- they don't label it
2 just as physicians in the Act. It is ACO providers, I
3 believe, is the phrase, and there is physicians and other
4 providers.

5 DR. NAYLOR: So, I guess explicitly then, this
6 will allow nurse practitioners, others, to play a major role
7 in these accountable care organizations?

8 DR. STENSLAND: I believe so. It refers to a
9 certain subset of the law that I'd have to get into to see
10 exactly who is under that subsection of the law, but I
11 believe that's it.

12 DR. NAYLOR: I think so.

13 DR. CHERNEW: I have a question about Slide 7. It
14 says, "The target equals prior year spending plus fixed
15 growth amount minus the threshold." In the chapter it
16 actually says three years prior, but apart from that, is
17 that done on an individual basis? So if you save 10 percent
18 of spending for an individual, the next year your target
19 goes down by 10 percent because the prior year is now lower?
20 If you keep someone in the ACO for five years, or however
21 long it is, the more success you have, the lower you get
22 paid as the prior year spending drops?

1 DR. STENSLAND: That's the way it looks like from
2 the law, except I think I did say one year, but it should be
3 the prior three years. So because you have this little
4 rolling average thing, you don't get completely dropped down
5 --

6 DR. MARK MILLER: Mike, you said individual in
7 your sentence, but you meant the ACO?

8 DR. CHERNEW: It wasn't like an area-specific
9 average like they do this for MA and stuff. It's the person
10 who's there. The person in your ACO, they look at that
11 individual person's spending and all the people who are
12 assigned to you in their previous three years, as opposed to
13 the spending in your HRR or something like.

14 MR. GLASS: Right, correct, the people assigned to
15 the ACO.

16 DR. CHERNEW: That are counted like ACO.

17 MR. GLASS: Right.

18 DR. CHERNEW: It's not an MA version.

19 DR. CASTELLANOS: Part of our discussion last year
20 and the years before on this, there's a very practical
21 point. I live in Florida, I'm a physician, and we see a lot
22 of snowbirds, people going and coming, and that's what

1 society is today. We discussed accountability at that time.
2 Has there been any follow-up on that, how you're going to
3 account for that?

4 MR. GLASS: I mean, that is another issue, how do
5 you deal with people coming in and out of the ACO? And if
6 that number ends up being a really high percentage, then it
7 will make it difficult.

8 DR. CASTELLANOS: I would suggest that there's
9 going to be tremendous geographic variation on that in the
10 United States.

11 MS. UCCELLO: I think it's really important to
12 differentiate different types of random variation, because
13 that's going to have implications for what kind of risk-
14 sharing mechanism makes the most sense.

15 And so, here I think we need to distinguish
16 between variation that's specific to an ACO and variation
17 that's systemwide. And so, I think I got stuck on this flu
18 reference in the text because that seems to be more of a
19 systemwide variation.

20 I'll follow up in Round 2 about this, but in terms
21 of Slide 9, this is showing really more of the ACO-specific
22 type of variation, perhaps. But is there any way we can

1 kind of figure out more of a systemwide variation from year
2 to year?

3 MR. GLASS: Is your question then, if spending
4 went up -- the way the ACO would work, as we understand it,
5 is that CMS will estimate an increase in the fee-for-service
6 spending average cross-nation. And you're saying, well, if
7 there's a bad flu epidemic across the nation, that will go
8 up versus the expectation and try to capture that sort of
9 thing as well?

10 MS. UCCELLO: Well, that's the way I'm thinking,
11 again for more of the Round 2 stuff, but I guess I'm just
12 wondering, you know, how much does this truly capture the
13 total variation?

14 DR. STENSLAND: I think this is definitely over-
15 simplified because there are those two components. For
16 example, I was thinking of the flu in your particular
17 community and that would affect kind of your ACO, but not
18 the whole nation.

19 But if there was something else that affected the
20 whole nation, maybe a great new drug came out and it cost a
21 gazillion dollars. It would also create some random
22 variation that would be nationwide and it would affect your

1 odds of getting bonuses because it's all based on a
2 projection of what spending will be.

3 So there's kind of this national projection
4 number, and there's some variation around that. And then
5 there's your individual characteristics and there's some
6 variation around that. So you've got both of those two
7 things taking place, which would add more variation.

8 MS. UCCELLO: I guess my question for this is, do
9 we have any sense of the relative size with those two
10 sources?

11 DR. STENSLAND: We could do it. We haven't done
12 that.

13 DR. MARK MILLER: But I hear two things coming out
14 of that question. One, can we quantify at all -- if there's
15 going to be a national target, what kind of variation do you
16 see around that. But two, in the exchange, in the exchange
17 back and forth, my first reaction to your question is, as
18 you think about issues like that that affect systemwide in
19 setting the benchmark, and I'm wondering if that's kind of
20 the way you're thinking about it.

21 MS. UCCELLO: I think that's one way to address
22 that.

1 DR. MARK MILLER: And you're just saying that
2 there may be some variation in that benchmark that needs to
3 be considered?

4 MS. UCCELLO: [Nodding affirmatively.]

5 MR. HACKBARTH: So my question, I think, is
6 related to Mike's. Mike said that to the extent that a
7 provider is successful in reducing costs, it looks like they
8 get evermore difficult targets if it's based on their
9 historic costs.

10 Set aside that problem for a second, the law is
11 quite specific in saying that the foundation for the target
12 is provider-specific costs. So if you have historically
13 efficient providers, they're going to get more challenging
14 targets than providers who have historically been wasteful
15 in their spending.

16 MR. GLASS: But the growth amount could
17 conceivably be a higher percentage of their spending.

18 MR. HACKBARTH: Yeah, so --

19 MR. GLASS: So their target in that sense would be
20 --

21 MR. HACKBARTH: So you're anticipating --

22 MR. GLASS: Sorry.

1 MR. HACKBARTH: -- what my real question was. So
2 the language in the statute is national average growth,
3 increased by national average growth. And the way you're
4 interpreting that is the idea that we actually had in our
5 ACO chapter, that it would be a dollar amount, a national
6 average dollar amount, as opposed to a national average
7 percentage amount.

8 MR. GLASS: That's correct.

9 MR. HACKBARTH: And if you calculate it as a
10 dollar amount, that would be a higher percentage increase
11 for the historically low cost providers and a smaller
12 percentage increase for the high cost. That's the way you
13 interpret the statute?

14 MR. GLASS: Yeah. Well, we're saying that because
15 it says the projected absolute amount of growth in national
16 per capita expenditures for Parts A and B services. It says
17 that. That's how we were interpreting absolute.

18 MR. HACKBARTH: Yeah. I didn't think that
19 absolute was the way I would phrase it. I would have said a
20 dollar-specific national average dollar amount. Absolute
21 doesn't make clear whether you're talking about absolute
22 percentage changes or dollars, to me. So that was the --

1 MR. GLASS: Right. We're interpreting absolute as
2 meaning not percentage, but rather, dollars.

3 MR. HACKBARTH: Okay. Let's go to Round 2. Again
4 on this side, Kate and George, Jennie and Bruce, and Herb.

5 DR. BAICKER: So part of the reason I asked my
6 original question and building on what Cori was saying, it
7 seems like you have a classic signal extraction problem.
8 You've got signal and noise and you're trying to figure out
9 what tools to draw the signal about the provider inputs, and
10 it seems like there are a number of different statistical
11 tools in your toolkit and I don't know what the tolerance
12 would be for doing something that seems non-transparent or
13 fancy relative to some of the more basic measures.

14 But I know this has come up in other policy
15 contexts, for example, in looking at teacher quality and
16 doing teacher bonuses or retention decisions based on
17 performance. They've had very similar signal extraction
18 problems and I don't know how much we're drawing on that
19 literature.

20 You've mentioned using longer look-backs for
21 smaller ACOs to try to build up a big enough sample size so
22 that sampling variation is less of a problem. You can also

1 try to net out national or regional trends using some co-
2 variants or fixed effect so you could try to draw down
3 common shocks across ACOs by controlling for other stuff.

4 And then you can also look at levels versus
5 changes, and I don't know how that fits in with the
6 statutory constraints, especially for smaller entities. If
7 you do a mix, a weighted average of absolute performance
8 this year versus changes over last year or changes over a
9 moving window, then you may be able to net out more noise.
10 That's going to result in some very different looking
11 formulas for different ACOs, and maybe that's not
12 acceptable.

13 But if I were purely just trying to extract signal
14 from the noise, I would want to use all three of those
15 statistical tools.

16 MR. GEORGE MILLER: My question deals with the
17 smaller ACOs as well, particularly in rural areas. Do you
18 have a sense if the variation for rural providers would have
19 the same impact as a larger group? And just by the
20 demographic, that they had longer distances to travel?

21 And particularly a concern for me is where they
22 are on EMR and if that would help to effect some of the

1 savings by not having that infrastructure or not having EMR
2 in place. Would you have a system that said to be an ACO,
3 you need to have EMR in place, as an example? Have you
4 thought about that and what the impact could be?

5 DR. STENSLAND: Well, I would kind of divide these
6 rurals groups into two different groups. The independent,
7 small rural provider. I think it's going to be a tough haul
8 for the ACO to have 5,000 beneficiaries if you're a small,
9 little six group practice. But if you are part of a big
10 system, then I could see it happening, where you could have
11 an ACO covering all the physicians in the system. Say you
12 may even have an urban system that has some satellite
13 clinics and hospitals and all of those people could be part
14 of the same ACO.

15 MR. GEORGE MILLER: But wouldn't the problem be
16 with EMR to get the same data and the data and the same
17 information there if they all are not on the same platform?
18 I mean, you're talking about a wide geographic area.

19 DR. MARK MILLER: I mean, just to pick up, you
20 could think of something like a Geisinger which operates out
21 and has a system that reaches out.

22 MR. GEORGE MILLER: I think more like Tom.

1 DR. MARK MILLER: I was coming to Tom. Actually,
2 not, in all seriousness. Tom-like.

3 But what I would urge you to perhaps take that
4 comment in just a slightly different direction. We've
5 identified a couple of issues here that are kind of in-play,
6 fairly large, maybe we have something to say about. But it
7 doesn't mean you can't say anything about anything else.

8 One of the things that is going to be in play are,
9 we talked about this a little bit, conditions of
10 participation. What do you expect these groups to be able
11 to do? For example, CMS's ability to bring data in in a
12 real time has been shown to be somewhat difficult, okay,
13 just to put it diplomatically. And I think some of the
14 thinking for these groups is that they have the ability to
15 track the patient and know when the patient goes to the
16 hospital on their own. So some of your comments about
17 electronic medical record or these types of conditions, if
18 the commissioners feel strongly about these types of things,
19 you should articulate it and it can be something that we can
20 talk about as the process moves forward.

21 I know that didn't quite get to your rural issue,
22 but I would use that comment to make a broader point.

1 MR. GLASS: And I would just add that if you're
2 going to set quality measures that are going to require EMRs
3 to report them, then that will also constrain who can become
4 an ACO.

5 MS. HANSEN: Since it's right now quite open, one
6 of the conditions of participation or considerations of
7 participation and reporting is the population that presents
8 with multiple morbidities and all.

9 It's an area that, many of you know, I
10 consistently kind of have concern about to make sure that
11 populations like this don't get left out, you know, when you
12 try to gather an N of a population to have a slightly more
13 hugely skewed well population, as we've had some experiences
14 in the MA world and all, but the ability to at least elevate
15 and focus some -- shine some light on this population -- but
16 on the concomitant side, to make sure that the risk
17 adjusters are there on the fee-for-service side, if this is
18 the way it's going to be paid, so that the incentives would
19 be there to probably maximize the best care coordination and
20 show some impact, frankly, over a high utilizing population.

21 But I would just like to somehow convey an
22 emphasis to elevate a focus on this because this is the

1 growing population. This is where, frankly, the Medicare
2 and Medicaid, for that matter, money gets spent. So I just
3 would like that elevation to be constantly visible. Thank
4 you.

5 DR. STENSLAND: I think --

6 MR. HACKBARTH: Can I just make one thing before
7 we get too far away from this exchange about conditions of
8 participation? This is very tricky ground in that it's
9 tempting to be very specific in terms of what these
10 organizations need to look like and what sort of
11 infrastructure and capabilities.

12 But there's a risk of sort of over-engineering the
13 product. Frankly, I think some of that may have happened
14 with Medical Home, where lots of very specific requirements
15 are loaded on thinking, "Well, these things sound good,"
16 without a clear understanding of what really is essential to
17 producing the product that we want.

18 You make it so that the cost of doing it is
19 prohibitively expensive and that becomes a barrier to
20 participation. So at one level, I think there have to be
21 some minimum conditions of participation, but you need to be
22 very deft in how you do it. Bruce?

1 DR. STUART: I'd like to follow up on my Round 1
2 point about persistency of the outcome, whether it's cost
3 reduction or whether it's quality improvement, because I
4 think this is important in terms of trying to get the
5 incentives right. I used the example that I gave of a
6 system that was set up with a clawback so that whatever your
7 size is, you're given -- let's take the cost reduction and
8 the quality stays the same.

9 You're given your bonus. It goes into the bank
10 account. Now, you as an ACO are going to have to figure out
11 what you're going to do with that bonus. So if you thought
12 that you actually had earned that bonus, that you had taken
13 activities which, in fact, internally you think can explain
14 the difference, then you might well say, okay, well, we're
15 going to distribute that bonus to the individual physicians
16 within the group.

17 But what if you said, well, you know, I don't know
18 whether we earned that. Then a prudent organization would
19 say, well, at least some of that bonus ought to stay in the
20 organization, in the account, until we figure out whether
21 that reduction is a persistent reduction. Now, the
22 persistent reduction could be varied. It could be last

1 year, it could be a moving average, it could be some
2 combination of this, and I'm not suggesting that this is
3 necessarily straight-forward, but at least in principle, it
4 would put the onus on the organization to make a
5 determination of whether it's earned it or not. Frankly, it
6 seems to me that's where it ought to be.

7 And I think from just a language standpoint, you
8 could say a bonus payment with a potential for a clawback is
9 just a bonus only. It's not a penalty, because if it gets
10 taken back, you just didn't earn it in the first place. So
11 it's not there and you didn't deserve it. And so, it's not
12 there.

13 Having said that, I think that once you put that
14 onus on the accountable care organization, then I'm
15 wondering, are state insurance commissioners going to say,
16 well, you know, you're acting like an insurance company and
17 so you've got to behave like an insurance company, you've
18 got to meet reserve requirements, and I worry about that.

19 And then last, but certainly not least, this idea
20 of persistency in behavior, in performance, rather, on the
21 quality side strikes me as being fundamentally the same as
22 on the cost side. But from a measurement standpoint, as you

1 note in the chapter, it's different because quality
2 standards apply to specific patients with specific services
3 that they should have received. Whereas, the cost standard
4 presumably is across the whole panel.

5 But the idea would be the same, that you really do
6 want to have persistency in these changes over time before
7 you set up a system so that additional funds were going to
8 go to these organizations.

9 MR. HACKBARTH: Bruce's point about running afoul
10 of insurance regulations is, I think, an important one. It
11 seems to me that would be an issue. If you go to not the
12 shared savings, but a risk corridor model, that now you have
13 a risk-bearing entity, albeit with the risk constrained by
14 the risk corridors.

15 My recollection was that was one of the issues
16 with the provider-sponsored organization option under MA.
17 Your table listed, well, they didn't want to be in the
18 claims business and all that insurance stuff, but I think
19 there was also a question about whether they would then
20 become regulated as insurance companies and have to deal
21 with that. Do I remember that correctly?

22 MR. GLASS: It does ring a bell, right.

1 MR. HACKBARTH: Do you know, Bob?

2 DR. BERENSON: For better or for worse, I was at
3 CMS when the PSO option came in. The point is that the PSO
4 option was for entities that, for whatever reason, did not
5 get qualified as an insurance entity. They had to
6 demonstrate a reason why they were not an insurer, and
7 essentially gave CMS the option of designating them in lieu
8 of being regulated by the insurance.

9 But it was all in the context of solvency
10 requirements and giving appeal rights and essentially
11 treating them as insured entities, but permitting Medicare
12 to do it rather than the states. That's what that was
13 about. But I think it's definitely relevant here.

14 DR. KANE: The whole discussion about conditions
15 of participation, I think, made me think more about not so
16 much what the individual ACO might have to have in sort of
17 structurally and processes, but also what conditions in the
18 environment of the ACO we may want to consider, and that
19 would include things like are there other payers willing to
20 go along with this in the environment?

21 And also, is there some type of inter-operability
22 in the electronic medical record so that when you do a

1 multiple -- if a physician group practice admits to three
2 systems or two systems, that there's some way for them to
3 actually build an information system so they can manage the
4 care.

5 So I don't think it's necessarily conditions of
6 participation for the ACO itself, but it's that there are
7 some environment contexts in which we should talk about what
8 fosters their success and how can Medicare help foster the
9 success of an ACO, and then maybe choose ACOs that already
10 are in those kinds of better oriented environments, and what
11 are those conditions looking like.

12 MR. KUHN: This is a good list of questions that
13 we have, and I agree with Glenn, I don't think we want to
14 over-engineer what an ACO is. At the same time, I don't
15 want us to try to boil the ocean. I think that's just too
16 much for us to kind of reach out and get a hold of.

17 Having said that, I would like to just talk about
18 one area on the issues up there, and that's the area of
19 quality and the measurements in the quality area. I think
20 the areas that we have in the paper dealing with population
21 health, care coordination, patient experience, and hospital
22 care were all appropriate measures and ought to be explored.

1 I think there's other things that we can perhaps look at as
2 well in terms of efforts to really improve health in terms
3 of smoking reduction, maybe obesity measures that might be
4 out there. Other areas in terms of patient engagement
5 measures might be useful to look at as well as we go
6 forward.

7 But at the same time, I think there needs to be a
8 trade-off and there needs to be kind of a value proposition
9 of those who want to go into the ACO, and that again gets
10 back a little bit to the COPs. But, for example, you know,
11 if you're going to be doing all this additional quality
12 reporting as a result of your engagement in the ACO, do you
13 really need to continue to report on the PQRI measures or
14 the RHQDAPU measures that are out there? Is that a
15 redundancy in the system? Is that asking providers to do
16 too much?

17 Another thing that you might want to think about,
18 if you're in the ACO, do you really need to be participating
19 in the readmission policies that are coming forth as a
20 result of ACA?

21 Again, I think it's a redundancy and probably
22 doesn't need to be there.

1 So, you know, to the extent that we can -- like I
2 said, I don't want us to boil the ocean, but I do think we
3 need to think about some of these interdependencies here of
4 some of the parts of fee-for-service, how that's out there,
5 so that ACOs, you know, on the quality side and some of
6 these other areas, you know, get the maximum potential and
7 make it as attractive an opportunity for providers to want
8 to engage in these new efforts as we go forward.

9 My final comment would be just making sure that it
10 is attractive for providers to look at. I know we're
11 looking at some of the different payment models here beyond
12 the bonus only, and I think you called it, Jeff, a
13 bonus/penalty model. I think nothing sends shivers down the
14 spine of providers more than calling something a penalty.
15 So if we can eliminate that from our future conversation, I
16 think that would be --

17 DR. STUART: [Off microphone.]

18 MR. KUHN: Yeah, an earned bonus or something
19 else. I don't know what the term would be, but I think just
20 branding these that there's a penalty out there somewhere I
21 think creates some perception problems that I don't think
22 we'd want to perpetuate.

1 MR. GLASS: One awkward thing might be that a
2 physician or a hospital, if it were part of an ACO, could
3 also still have fee-for-service patients who weren't
4 assigned to it. And so if they didn't report measures for
5 their ACO patients, would they still have to for their non-
6 ACO patients? And complications would ensue.

7 MR. KUHN: Yeah, and that's going to be part of
8 the complications as a result of the new things in reform as
9 we get into these transitional modes on a lot of different
10 payment and delivery models that are out there. But to the
11 extent we can think of ways to help streamline the process
12 to make it as attractive a model as possible would be the
13 goal.

14 DR. BERENSON: Yeah, I want to just address the
15 5,000 threshold number. I have a concern about that being
16 much too low. My understanding is that it first came about
17 related to an analysis about statistical validity of quality
18 metrics and you needed 5,000. But there's sort of a
19 disconnect in the law. On the one hand, they identify
20 organizations that include ACO professionals and group
21 practices, networks of individual practices of ACO
22 professionals, which I interpret as IPAs; partnerships or

1 joint venture arrangements between hospitals and ACO
2 professionals, and hospitals employing ACO professionals.
3 So PHOs, integrated delivery systems, large multi-specialty
4 group practices, IPAs -- to me those are the correct
5 organizations, and yet you can do 5,000 patients with -- an
6 eight- or ten-member primary care practice can have 5,000.
7 I don't think we want to -- in my mind, the ACO concept is
8 not to do shared savings with a practice of ten docs. The
9 medical home is there. I'm not concerned about putting --
10 making the threshold such that small practices or little
11 tiny aggregates, you know, a tiny IPA, would not be able to
12 participate.

13 I really think we need, practically speaking -- I
14 know the law says 5,000. But my own view is that the design
15 should be encouraging larger organizations that are capable
16 of taking over, providing the continuum of care, and have
17 the opportunity to either directly provide or arrange for
18 the whole range of services. And so I would be looking at,
19 you know, practically speaking, around a 20,000 threshold,
20 and that's what I understand the PGP groups are talking
21 about, that below that there's just no sort of efficiencies.
22 So that would be my view on that one.

1 MR. ARMSTRONG: I didn't know I would be doing
2 this, but I guess I'm building a bit on Bob's points.

3 First, like many of us, I come to this with a
4 mind-set that sustainable lower medical expense insurance,
5 which is what we're trying to achieve, comes from care
6 systems that have certain elements, and we're trying to use
7 policy to advance those elements. With that in mind, I
8 would first affirm in my experience 5,000 seems like a
9 number that is difficult to work with and creates risks that
10 I don't think are worth. And I'm very glad to see that we
11 are looking at alternatives to the bonus-only model. I
12 don't think we've gone very far yet in exploring what those
13 alternatives might look like, and I think that will be good
14 work for us going forward.

15 I don't see how this could work if there isn't
16 prospective identification of patients. One element in a
17 care system that drives lower expense trends sustainably is
18 a patient's relationship to the care system and a kind of
19 engagement. And so my view on that question would be that
20 we do need to be prospective in identifying patients.

21 Finally, I would just say that I would expect that
22 piloting ACO-type models of care systems will be taking

1 place in markets all across our country, independent of this
2 regulation. And my advice to CMS would be to look for ways
3 in which, whether it's through their own innovation funds or
4 through what will be hundreds if not thousands of other
5 pilots, you know, coming to life in markets around the
6 country, I would encourage CMS to look for ways to
7 understand what the lessons are from all of those as well as
8 it applies its own thinking to developing its requirements
9 for these pilots.

10 MS. BEHROOZI: I just want to weigh in on the
11 informing-the-patient factor. I don't see how you can not
12 inform the patient and provide for prospective enrollment,
13 or at least an opportunity to opt out. I mean, I think you
14 can do both. You can look at retrospectively -- because I
15 think the statute actually is pretty directive about that,
16 look at utilization retrospectively and assign people to
17 providers. But then from the point going forward where the
18 provider is subject to the bonus or the other thing that
19 we're not going to call a penalty -- which I think you do
20 need to have -- then at that point I think the patient needs
21 to know it up front, and I think other people need to have
22 the opportunity to decide they want to be part of a system,

1 partly because of what Scott says about engagement, but
2 partly because of something you clued me into, Glenn, the
3 messaging. The messaging has got to be affirmative. You've
4 got to talk about how these accountable care organizations
5 will be accountable for quality and overall cost so that
6 it's not somewhere down the line that a beneficiary says,
7 Oh, wait a minute, they save money if I go to those cheapo
8 whatever provider down the street, that cheapo lab, as
9 opposed to the glamour lab with, you know, the nice curtains
10 and everything. Oh, wait a minute, this is on my back that
11 they're going to save money.

12 It's got to be affirmative messaging. It's got to
13 be positive. It's got to be about accountability for
14 quality and it's all good for the patient. And so the
15 question that I raised in the first round about whether
16 there's any way to build in economic incentives to patients,
17 I think, you know, may be a little farther down the line,
18 but I think it's an important one because, again, in the
19 context where people are finding it harder and harder to pay
20 for health care, they would say, hey, if the doctor and the
21 hospital and whatever stand to save money by improving the
22 quality of my health, well, maybe I should, too. And that

1 would also help drive more business to the better organized
2 systems.

3 MR. BUTLER: I'll start with agreeing with Bob and
4 Scott on the threshold participation number. First of all,
5 we don't really want really small groups, even if -- that's
6 not the intent, and if it's a bigger group, you need more
7 than 5,000 to convert a culture anyway. So I would agree
8 that -- I don't know whether 10,000 is the right number, but
9 more than 5,000.

10 Now I'll step back a little bit on philosophy. Of
11 the things we've talked about in the last couple of years
12 when I've been here, this has been -- and we've always said
13 how are we going to, you know, manage the continuum, what
14 tools do we have available. I've always thought this one
15 had maybe the most promise because it wasn't as invasive,
16 did not require you to accept and hand out capitation, and
17 had the opportunity of getting the mainstream in a different
18 mind-set. And paired with Medical MA plans, I said maybe
19 this could be kind of the broader longer-term solution.

20 So if you start with that and you say a majority
21 over time you're trying to move into either an MA plan or
22 something like this, then I draw the conclusion you want to

1 make the ease of entry easy if you want to try it
2 nationally, because you're not going to get a lot of
3 traction doing pilots that not many participate in because
4 we've shown that that doesn't move too fast.

5 So, philosophically then, I would favor having
6 ease of -- you know, which it steers away from penalties. I
7 mean, people that take this on are going to put a lot of
8 their dollars, a lot of their energy, a lot of their
9 leadership behind it to get it started, which by itself is a
10 fair amount of time and effort to get going, I think. And
11 the reason I say to make it easy -- which means I'm not even
12 for the penalties at all. I understand the math. But I
13 think you want people in markets to feel that if they're not
14 in it, somebody's going to get their patients. That's one
15 way to think about it, because that would be an incentive:
16 I better get in this, or I'm not going to be part of an
17 organized system. And, therefore, that would get somebody
18 to get off the dime, which requires a pretty significant
19 participation in a given market.

20 The alternative is maybe don't make it so easy to
21 entry, and at the risk of adding some of the regulatory
22 burden that you talked about, have a statewide waiver, get

1 all payers into it, really try to do something along those
2 lines that would really accelerate and intensify the effort
3 in a given market so that you could really test it would be
4 another way to go, or you could do both in some fashion.
5 But consistent with my ease of entry, I would not spend a
6 lot of energy -- I know this sounds wrong, but on the
7 quality measures and letting people, patients know
8 prospectively. I understand all the benefits of doing those
9 things. We've already struggled with quality measurement in
10 MA plans as we demonstrated last year. What makes us think
11 we can just lop them onto these efforts when we really
12 haven't had a lot of success in the MA plans?

13 So ease of entry, make it simple, and cast the net
14 wide and far, you might get a lot of takers, as demonstrated
15 by the interest in the room. If you add a lot of regulatory
16 things and expenses and look at just the short-term
17 incentives, as Bruce has pointed out, you're not going to
18 get the sustainable commitment that we're trying to
19 encourage.

20 MR. HACKBARTH: Just a clarification, Peter. So
21 you are emphasizing ease of entry in terms of not a lot of
22 detailed requirements and no risk bearing -- is the two

1 themes I heard most -- but then deal with the threat of
2 bonuses based on random performance by escalating the
3 minimum size requirement. Is that the combination? Do I --

4 MR. BUTLER: Yeah, there may be ways, though, that
5 you can get at the -- I understand the math. If it's
6 random, you may be spending more than you had thought you
7 would spend. There may be ways to handle that. Maybe some
8 of Bruce's longer-term pull it back or whatever is a way to
9 do it.

10 I think that -- believe me, the penalties and some
11 of those things are worth pursuing, but I would view the
12 innovation -- I would use that home that the Secretary has
13 to really push some of the more aggressive models as opposed
14 to doing it in the voluntary model that the regulations are
15 supposed to address this fall.

16 MR. HACKBARTH: Okay.

17 DR. NAYLOR: Just briefly, because I agree with
18 many of the comments. I think the great opportunity here is
19 around a chance to take accountability for a population and
20 focus on the population as well as the individuals within
21 it. And it does -- we haven't paid a lot of attention to
22 what it's going to take for systems to build the capacity to

1 do that. The thing I like about the act is it places
2 emphasis on evidence and using what we know and what we
3 don't know and creating the right kind of network of
4 providers.

5 I think there's where there's also an opportunity
6 to focus not so much on individuals within this group, but
7 the team of providers. How are we going to maximize on the
8 contributions of all team members? So in terms of models,
9 alternative payment models, one that we might want to
10 explore is not just shared savings to the individual typical
11 providers, physicians or hospitals, but to the team who
12 shares accountability for the outcomes here.

13 On outcomes, I think that this is as really great
14 opportunity to focus on a simplified set of outcomes that
15 really focus on people and what they want. So they do want
16 to be engaged in their plan of care. Their families do,
17 too. They want shared decisionmaking. They want something
18 that's going to work in terms of improving the way they get
19 up every day and function and quality of life.

20 So I think we pretty much know where we should be
21 focusing our energy on performance measures, and I do think
22 we should be encouraging that. What we do know is

1 interoperability isn't going to work unless we have the
2 right data elements in there. And right now the meaningful
3 use criteria pay little attention to the data elements that
4 are going to allow providers to function efficiently and
5 effectively as a team. So I think we should be pushing for
6 the next generation of the high-tech meaningful use act to
7 really focus its attention on those elements that are going
8 to make it work better for people.

9 DR. CHERNEW: So first I'd like to say that my
10 general preference would be for a smaller program that's
11 better designed than a program we make bigger so we get more
12 people in but don't design very well. And that said, I
13 would generally be supportive of having some downside risk,
14 whatever you term it. I think that's going to end up being
15 important. If we see this is the wave of the future, I
16 think we're going to need a program that has some of that.

17 I'm very worried about the current proposed
18 payment rate process. I think it's not very tenable to have
19 this heterogeneity across ACOs based on how they've done,
20 particularly a system in which the better you do means
21 there's a growing gap between what you're getting paid and
22 other people are getting.

1 It sort of penalizes you by capturing all your
2 efficiency gains in ways that I don't think are useful. In
3 the same spirit, I would generally support a process that's
4 a little bit more like a MedPAC process for the update as
5 opposed to some sort of national spending growth update,
6 because that just seems to raise the target based on what
7 everybody else is doing as opposed to where we want to
8 actually get to.

9 So I think in designing a sort of ACO model which
10 many people talk about as being the wave of the future, the
11 solution to a lot of our problems, we really should think
12 about a design in which that's likely to come to pass. And
13 at least in some of the things that Jeff and David
14 presented, I don't see it quite there yet on some crucial
15 points.

16 DR. CASTELLANOS: I'd like to make two points.
17 Carrying on what Mitra said, I look at it from the
18 beneficiary's viewpoint. What is the benefit for the
19 beneficiary? Every beneficiary expects that doctor to
20 provide the best quality, and if they go into this ACO
21 model, especially prospectively, he or she expects excellent
22 quality. If she or he doesn't go into that model and has

1 that chance of outgoing, he or she is still going to get the
2 same quality.

3 So you got to look at it from the perspective of
4 the beneficiary. What is the benefit and what can that
5 person get by going into a system that may -- and I didn't
6 say it will provide a lower-priced provider and a lower-
7 priced sector. I don't see the benefit unless you give some
8 economical benefit to the beneficiary.

9 The same with the physician. As a physician, and
10 as a businessman, because I'm running a business, I say,
11 What's the advantage of myself going into a bonus-only
12 model? Well, one of the things I remember Nick Wolter
13 saying when he went into the PGP model was there was no
14 upfront costs. And I know he mentioned that to me, and we
15 had a lot of discussions that it was expensive for the
16 Billings Clinic to go into this model, and they never got
17 that reimbursed.

18 So I think if you're going to look at this, you
19 got to understand why would a physician go into this, or a
20 business, especially a primary care doctor who really
21 doesn't have a lot of excess income, and why would a
22 beneficiary, the patient, go into it.

1 The other issue -- and, again, Bruce, you kind of
2 mentioned it earlier this morning about resolving some of
3 the regulation issues. If you expect the primary care --
4 and this is going to be a primary care model. If you expect
5 him to take care of a lot of the urologic issues, a lot of
6 the general surgical issues, and as long as that person
7 follows evidence-based medicine and guidelines and clinical
8 pathways, et cetera, he's going to be okay. But he's going
9 to need some protection from defensive medicine. He's going
10 to need that to cut down on his costs.

11 Now, I know there was an earlier discussion today,
12 and I know Bob Berenson and myself had some brief talk about
13 this. This is a big cost for the physician, and there's a
14 good study now in Health Affairs that shows that it probably
15 accounts for 2.4 percent of annual expenses for health care.
16 So we need to get some protection under regulatory issues on
17 defensive medicine.

18 MS. UCCELLO: Okay, I'm just going to circle back
19 to the risk sharing.

20 I think the text provides some pretty compelling
21 case for a two-sided risk-sharing mechanism. But, again,
22 just to restate that it's not going to be truly symmetric if

1 there can't be some kind of adjustment to the threshold to
2 reflect this national variation.

3 To do that, however, you know, by definition
4 that's going to have to be retrospective. So does that make
5 -- so the target is not necessarily going to be known in
6 advance to the ACO. Is that going to be problematic? I
7 don't know. But I think we have to recognize some trade-
8 offs with that.

9 In terms of Bob's questions about reinsurance, I
10 think aggregate reinsurance is pretty much akin to a risk
11 corridor. But an individual reinsurance is really just
12 looking at specific outliers. And that could be
13 incorporated into either this one-sided or two-sided
14 approach in that if you have an outlier, they could be top-
15 coded at a certain amount; they could be -- but I don't
16 think you'd want to do that because you want to hold that
17 ACO responsible for at least some share. You want to
18 encourage care management above that level so you can have
19 some kind of cautionary, in a sense, accounting for that.
20 But either way I think that could be incorporated into this.
21 But, again, you're making the target more fuzzy. Does that
22 make it difficult to achieve or to know how to get to?

1 MR. HACKBARTH: I continue to have concerns about
2 non-enrollment models. I agree with some of the points that
3 Scott and Mitra made about the desirability of engaging the
4 patients actively, and that can only happen when they're
5 exercising a choice to participate. But there's also -- so
6 that's a positive reason for favoring an enrollment model.
7 I have some negative reasons as well, and they relate to
8 what happened in the 1990s with the managed care backlash,
9 which I still have nightmares about. At the time I worked
10 for Harvard Community Health Plan, a very good organization
11 that got tarred with a lot of nonsense in sort of a national
12 reaction to managed care. So it was a traumatic experience
13 for me. And so I've thought a lot about what were the
14 lessons that we could have, should have learned, and one of
15 the lessons that I think I came away with is that the
16 explosive combination was patients feeling like their care
17 had been changed without their making an active choice to
18 choose that new style of care. And often that happened
19 because an employer eliminated options for them; they were
20 forced into some model of managed care as opposed to making
21 an active choice to enroll. And so they felt herded,
22 compelled. They didn't like what they got. And what I

1 think was the match that set off that potentially explosive
2 gas was there were providers who didn't like it, and they
3 had every incentive to foment unhappiness among their
4 patients. And as we move into the ACO world, there will be
5 providers who are losing, or the ACOs aren't working,
6 frankly. And they will have an incentive to raise doubts in
7 the minds of their patients about what's happening to them.
8 And if those conversations go like, Oh, do you know that you
9 are now participating, getting your care from an
10 organization where people have an incentive to withhold care
11 from you? Oh, you didn't even know that, did you? That is
12 just the road back to where we were in the 1990s, and it
13 wasn't a happy place.

14 So I really feel that -- and there are a number of
15 different ways that it might be accomplished, but I think
16 there needs to be serious thought given to how to engage
17 patients in this in a positive, constructive way, and if the
18 patient doesn't want to participate, they need to somehow be
19 protected.

20 Now, I know that's more questions than answers,
21 but I think we could end up having a very bad experience
22 again. And I know all the reasons for the non-enrollment

1 models, you know, that, Oh, what we want to do is get as
2 many patients into this, and it's only if a lot of patients
3 are involved that there are economic incentives and rewards
4 are going to be strong enough. But to skip over that step
5 of getting the patients involved I think is just very, very
6 risky.

7 Unfortunately, as I listened to the conversation,
8 I did not hear unanimity on a number of key issues, so I
9 think we've got some work to do to identify issues and see
10 if we can bring ourselves to resolution for purposes of
11 providing advice to CMS and the Congress. I think it was a
12 very good discussion. I think it was very focused and
13 substantive. But I think we're in different places on some
14 important issues that we'll need to work through.

15 Thank you, Jeff and David, for your good work in
16 framing the issues, and obviously there will be more on this
17 soon.

18 Now we'll have our public comment period.

19 [No response.]

20 MR. HACKBARTH: And it looks like nobody's racing
21 to the microphone, in which case we will adjourn for lunch
22 and return at 1:15.

1 [Whereupon, at 12:13 p.m., the meeting was
2 recessed for lunch, to reconvene at 1:15 p.m. this same
3 day.]

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1 to keep patients somewhat sensitive to the costs of care,
2 particularly in situations where care may be more
3 discretionary in nature. So one issue to consider is
4 whether changes to Medicare cost-sharing are moving in a
5 direction that gets to that balance.

6 In past meetings, we have examined the question of
7 ways to redesign the cost-sharing structure of fee-for-
8 service Medicare. Later, in our current cycle of meetings,
9 we will return to the issue of innovative benefit design and
10 whether there are models in the private sector that can be
11 applied to Medicare. Within the Medicare program itself,
12 through Medicare Advantage, private plans can modify the
13 cost-sharing structure of fee-for-service Medicare within
14 certain limits. Some of the features found in MA plans may
15 be applicable to fee-for-service Medicare in achieving the
16 balance that we have talked about.

17 With regard to MA, as you are aware, there have
18 been major changes in MA payment policy. Later this fall,
19 we will provide an overview of those changes and their
20 possible impact.

21 In terms of learning from the experience of MA
22 plans, in the March 2010 report to the Congress, the

1 Commission recommended that MA encounter data be collected
2 in such a way as to allow quality comparisons between fee-
3 for-service and Medicare Advantage. The encounter data,
4 which CMS expects to begin collecting in 2012, will also
5 enable researchers and others to evaluate the effect of MA
6 plans' cost-sharing structure on utilization of care and
7 whether the quality of care is affected by different cost-
8 sharing structures. When encounter data or aggregate
9 utilization data become available to us, we anticipate
10 undertaking such an analysis.

11 And now, moving on to the gory details of our
12 presentation, Rachel will discuss the situation in fee-for-
13 service Medicare and recent changes.

14 DR. SCHMIDT: Thanks so much, Carlos. I get the
15 gory details, yes.

16 So let's start with changes to cost-sharing in
17 fee-for-service Medicare.

18 The biggest thing to note here is there are few
19 direct changes to it, with the exception of preventive care.
20 Most of the cost-sharing requirements for Part A and Part B
21 services remain the same as they've been, and much of it
22 takes the form of percentage co-insurance on Medicare-

1 approved amounts or is otherwise tied to rates of growth in
2 Medicare spending.

3 Fee-for-service Medicare has no cap on
4 beneficiaries' out-of-pocket spending, unlike Medicare
5 Advantage, which Carlos will tell you about in a minute.
6 The relationship between many of the changes in PPACA and
7 fee-for-service Medicare's cost-sharing is more indirect.
8 If the new law's measures are able to slow growth in
9 Medicare spending, then they will also slow growth in fee-
10 for-service cost-sharing and premiums over time.

11 One direct change in the new law that affects fee-
12 for-service cost-sharing relates to preventive care.
13 Beginning in 2011, beneficiaries will not have to pay any
14 cost-sharing for preventive services covered by Medicare
15 that have been recommended by the U.S. Preventive Services
16 Task Force with a grade of A or B. The law also gives the
17 Secretary authority to modify Medicare's coverage of
18 preventive services based on Task Force recommendations.

19 Turning to the Part B premium, what I'm about to
20 tell you is not a change in law but is a projection of how
21 the Part B premium will look to different categories of
22 beneficiaries. Under law, Part B premiums are set each year

1 to equal 25 percent of the average cost of Part B services
2 for elderly beneficiaries. However, the law also contains a
3 hold harmless provision in which the annual increase in the
4 Part B premium for a beneficiary cannot be larger than the
5 dollar amount of the annual cost of living adjustment in
6 their Social Security benefit.

7 In 2010, there was no Social Security COLA and
8 about three-fourths of Medicare beneficiaries were protected
9 by this hold harmless clause, keeping their Part B premium
10 flat at \$96.40 a month. However, under law, Medicare still
11 needed to recoup the aggregate amount of premium dollars it
12 would have received. So that aggregate dollar amount was
13 spread out only among the remaining one-fourth of
14 beneficiaries who are not protected by the hold harmless
15 provision. They faced a Part B premium of \$110.50 a month.
16 The four categories of people who face the higher premium
17 are shown on this slide. The Medicare trustees expect a
18 similar situation for 2011.

19 There is one particular change in PPACA that
20 relates to the Part B premium that Kate mentioned this
21 morning in terms of the context chapter. Remember that in
22 2007 Medicare began using an income-related premium. In

1 other words, beneficiaries with higher incomes receive less
2 of a subsidy than everyone else.

3 In 2010, the highest income earners with modified
4 adjusted gross incomes of \$214,000 for an individual, or
5 double that for a couple, paid \$353.60 per person per month
6 for Part B. Under the new law, the income threshold at
7 which people start to face the income-related premium will
8 stay at 2010 levels over 2011 to 2019.

9 CMS's Office of the Actuary projects that the
10 number of beneficiaries who face higher premiums will
11 increase from about 4 percent in 2010 to more than 10
12 percent by 2019. An open question is how many of these
13 individuals will choose to drop out of Part B as a result.
14 The Office of the Actuary thinks it will be small, but no
15 one really knows for sure yet.

16 There are a couple of other changes in PPACA that
17 do not affect fee-for-service cost-sharing per se but do
18 affect supplemental coverage. Last spring, we talked about
19 how PPACA includes a provision in which the Secretary will
20 request that the National Association of Insurance
21 Commissioners revise standards for the most popular types of
22 Medigap policies -- Plan C and Plan F -- to include nominal

1 co-pays in order to encourage appropriate use of physician
2 services in Part B. The new law doesn't say exactly what
3 those co-pays will be. It leaves that to NAIC, but directs
4 them to use peer-reviewed evidence or examples from
5 integrated delivery systems. The new standards are to be
6 ready by 2015 and will affect policies issued after that
7 date. So this effectively grandfathers current Medigap
8 policy holders.

9 While not part of PPACA, NAIC recently went
10 through a similar exercise for a new type of standard
11 Medigap policy called Plan N. This summer, insurers began
12 offering Plan N policies which include \$20 co-pays for
13 office visits and \$50 co-pays for emergency room visits.
14 These new policies will have somewhat lower premiums in
15 return for co-pays at the point of service. However, we may
16 want to watch to see whether Plan N will be used as the role
17 model for revisions to Plan C and Plan F. A concern in
18 doing this is that co-pays apply in a more narrow fashion
19 than may be desirable. Basically, in Plan N, they apply to
20 evaluation and management services but do not apply to other
21 types of services that may be more discretionary in nature.
22 For example, Plan N covers all of Medicare's cost-sharing

1 for durable medical equipment and imaging. The Commission
2 may want to keep future revisions to Medigap standards on
3 its agenda.

4 The new health reform law contains other
5 provisions that may affect retiree health coverage, such as
6 the introduction of state-based health insurance exchanges
7 and requirements that large employers offer coverage to their
8 workers. Many of these changes are aimed at individuals who
9 aren't yet Medicare beneficiaries, but the responses of
10 employers and workers to these changes will affect the
11 future distribution of secondary coverage to Medicare.

12 MR. ZARABOZO: Thank you.

13 On average, Medicare Advantage plans have cost-
14 sharing below Medicare fee-for-service levels for the
15 Medicare Part A and Part B services. In 2010, the monthly
16 dollar value of cost-sharing reductions for MA enrollees
17 was, across all MA plan types, about \$38 or about 30 percent
18 of the \$132 a month that is the average value of cost-
19 sharing in fee-for-service Medicare.

20 Plans use rebate dollars to finance cost-sharing
21 reductions. As you may recall, when a plan's bid to cover
22 the Medicare benefit package is below the MA benchmark for

1 the plan service area, a share of the difference goes back
2 to enrollees in the form of a rebate to provide extra
3 benefits and the remainder of the difference is retained by
4 the Treasury. The most common extra benefit for MA
5 enrollees is the reduction of Medicare A and B cost-sharing,
6 as we discuss in the mailing materials.

7 Looking at the differences among plan types in MA,
8 some of the rebate dollars that HMOs have are generated
9 because they are bidding below Medicare fee-for-service
10 payment levels in their market areas. However, on average,
11 it is only HMOs that are bidding below fee-for-service
12 levels. For all other plan types, rebates are possible
13 because MA payments exceed fee-for-service payment levels
14 across market areas.

15 Because of various changes in payment policy for
16 MA plans and because of provisions tying payments and rebate
17 levels to quality measures, the level and distribution of
18 rebate dollars is likely to change in the future. As I
19 mentioned, later in the fall, once we receive plan bid data
20 from CMS, we will have a presentation on the MA payment
21 changes and their impacts, including how quality measures
22 will be a factor in determining rebate levels.

1 In terms of the details of what cost-sharing for
2 Medicare services looks like in MA plans, the cost-sharing
3 structure can be quite different from cost-sharing in fee-
4 for-service Medicare. Two general statutory rules apply:

5 One rule that has been in place since the original
6 statute authorizing risk plans is the requirement that, on
7 average, the actual value of cost-sharing in MA cannot be
8 greater than the cost-sharing of fee-for-service Medicare
9 for Part A and Part B services.

10 The other general rule introduced in 2003 is that
11 cost-sharing provisions in MA plans cannot be discriminatory
12 in a way that would discourage enrollment of sicker
13 individuals or people with particular conditions. This non-
14 discrimination provision in the law has been the basis of a
15 number of rules that CMS has imposed with regard to cost-
16 sharing in MA plans. Recent legislation also imposed
17 additional rules for MA cost-sharing.

18 Before reviewing the specific rules that apply to
19 MA plans, here we show some of the ways in which a typical
20 MA plan will have cost-sharing that differs from fee-for-
21 service Medicare. For physician services, for example, MA
22 plans will typically have fixed dollar co-payments rather

1 than the 20 percent co-insurance that applies in fee-for-
2 service. Often co-payments will be higher for specialists
3 than for primary care physicians.

4 For inpatient hospital care, MA plans usually do
5 not have deductibles, but plans will often have daily co-
6 pays on the first few days or weeks of inpatient hospital
7 care with no limits on the number of days covered. This
8 compares to the fee-for-service approach of having a large
9 deductible, co-pays in the later days of the stay and a
10 limit on covered days.

11 I would also note that MA plans may cover as a
12 Medicare-covered service, skilled nursing facility care that
13 is not preceded by a three-day hospital stay. MA plans
14 often have cost-sharing for durable medical equipment as
15 does fee-for-service Medicare, and about 10 percent of plans
16 have cost-sharing for Medicare-covered home health care.
17 Fee-for-service has no home health care cost-sharing.

18 Finally, something we will talk about in more
19 detail is the MA feature of having an upper limit or cap on
20 a member's total out-of-pocket expenditures in a year.

21 I mentioned that CMS has used the general
22 statutory provision prohibiting discrimination to impose

1 certain rules on cost-sharing in MA. These include the
2 rules that limit cost-sharing for emergency room services to
3 \$50 and a rule that imposes a limit on cost-sharing for
4 certain services such as Part B drugs, so that cost-sharing
5 is not higher than fee-for-service Medicare. A new
6 regulatory requirement is that all plans must have yearly
7 out-of-pocket expenditure limits or caps, which I'll discuss
8 in more detail in the next slide.

9 The PPACA legislation included limits on cost-
10 sharing in MA for the specified services listed in the
11 slide; that is chemotherapy administration, dialysis and
12 skilled nursing facility care. PPACA also gave the
13 Secretary specific authority to limit cost-sharing to
14 Medicare fee-for-service levels on other services. At the
15 same time, the legislation reiterated that plans could
16 impose cost-sharing for services in which Medicare fee-for-
17 service did not have any cost-sharing, such as home health
18 care.

19 Earlier legislation provided protections to
20 Medicare/Medicaid duals in special needs plans, protections
21 that CMS extended to all duals through regulations,
22 regardless of the type of MA plan.

1 Beginning with the 2011 contract year, all MA
2 plans must have annual caps on members' out-of-pocket
3 expenditures for Medicare Part A and Part B services. The
4 required cap will be \$6,700 per year for all plans except
5 that regional preferred provider organizations set their own
6 limits under the prior law.

7 Now plans can also have a voluntary cap of \$3,400
8 or less. Plans that use the voluntary cap are granted
9 greater leeway in the amount of cost-sharing they can charge
10 for individual services at the point of service.

11 Local PPOs, like regional PPOs, must have caps for
12 in-network care at either the voluntary level or mandatory
13 level, but they also must have an overall cap that applies
14 to the combination of in-plan and out-of-plan services.
15 Since 2003, regional PPOs have been required by law to have
16 in-network and overall out-of-pocket expenditures.

17 Now Rachel will discuss cost-sharing under Part D.

18 DR. SCHMIDT: PPACA made several changes to Part
19 D, most of which broadened the Part D benefit and decreased
20 beneficiaries' cost-sharing obligations. The most notable
21 change is to phase out Part D's coverage gap -- the range of
22 drug spending where enrollees now pay 100 percent co-

1 insurance. That phase-out starts this year by giving
2 beneficiaries who reach the coverage gap and do not receive
3 Part D's low income subsidy a \$250 check. CMS estimates
4 that about one million of those have been mailed so far, and
5 they expect that number ultimately to be closer to about
6 four million.

7 Beginning in 2011, there will be a coverage gap
8 discount program provided by pharmaceutical manufacturers
9 that I'll describe more in a minute.

10 In addition, Part D's cost-sharing requirements in
11 the coverage gap will fall over time, from 100 percent today
12 to 25 percent by 2020. That reduced cost-sharing starts a
13 little earlier for generics than for brand name drugs, which
14 I'll show you on some slides in a second.

15 Also, today the parameters of the standard defined
16 Part D benefits -- the deductible, the start of the coverage
17 gap, the out-of-pocket limit -- change each year by the
18 average increase in Part D spending. Under PPACA, the out-
19 of-pocket threshold will increase more slowly between 2014
20 and 2019.

21 This chart is borrowed from Kaiser Family
22 Foundation because it nicely shows the overall difference in

1 the Part D defined standard benefit before and after changes
2 in the new law. You can see on the left that the standard
3 benefit has a deductible, then a period where the enrollee
4 pays 25 percent co-insurance.

5 Most Part D enrollees don't reach the coverage
6 gap, but if they do they pay 100 percent of their plan's
7 negotiated price for covered drugs. And then if that
8 enrollee has very high drug spending, they reach an out-of-
9 pocket threshold where their cost-sharing falls back to
10 about 5 percent co-insurance. So the beneficiaries' cost-
11 sharing is in the dark blue and covered benefits are in
12 light blue. On the right, you can see that the dark blue
13 section is much smaller.

14 So Part D's benefit will broaden under the new
15 law. Part of the benefit expansion is being picked up by
16 pharmaceutical manufacturers through their discount program.
17 Still, Part D will begin covering more of what has been
18 enrollee cost-sharing. That's good news for those enrollees
19 who have relatively high drug spending. However, it also
20 means that there will be upward pressure on monthly premiums
21 for Part D, and Medicare's program spending will increase
22 somewhat.

1 Briefly, the year-by-year decrease in cost-sharing
2 for brand name drugs is shown on this chart. The 50 percent
3 shown in light blue reflects the manufacturer's discounts
4 they'll be giving to non-low income subsidy enrollees who
5 reach the coverage gap, the medium blue portion shows how
6 the Part D benefit will expand over time, and the dark blue
7 shows how enrollee cost-sharing will decrease.

8 And here's the same slide for generic drugs.
9 There is no manufacturer discount program for generics, but
10 Part D's benefit will broaden over time to cover 75 percent
11 of the price of generics, with enrollees' cost-sharing
12 falling to 25 percent for those who are in the coverage gap.

13 Here is a little more about how the coverage gap
14 discount program will work. Pharmaceutical manufacturers
15 that want to continue offering their products through Part D
16 have signed agreements to participate in the discount
17 program. Beginning next year, they are to give non-low
18 income subsidy enrollees who reach the coverage gap a 50
19 percent discount on the price of their drugs. That is on
20 the price that the plan sponsor has negotiated as payment
21 with the pharmacies. So this is not considering
22 manufacturers' rebates. So when a beneficiary goes to the

1 pharmacy and has reached the coverage gap, they pay the
2 discounted price.

3 For purposes of figuring out when a beneficiary
4 has reached the out-of-pocket threshold, where they pay
5 about 5 percent co-insurance, the new law says that Medicare
6 should include both what the enrollee paid and also the
7 amount of the manufacturer discount. This has the effect of
8 increasing the number of enrollees who will reach the
9 catastrophic region of the benefit, where Medicare pays for
10 more of the coverage. So again, this is good news for
11 enrollees with high drug spending but will lead to upward
12 pressure on Part D premiums and Medicare program spending.

13 Finally, the PPACA also initiated income-related
14 premiums in Part D beginning in 2011, using the same income
15 thresholds as in Part B.

16 Also, like Part B, the income thresholds will not
17 increase between 2011 and 2019. The Medicare trustees
18 estimate that about 3 percent of Part D enrollees will pay
19 higher premiums in 2011 and this will grow to about 8
20 percent by 2019.

21 So here we are, concluding with the same slide
22 that Carlos showed you earlier as a launching point for your

1 discussion about Medicare cost-sharing and beneficiaries'
2 financial liability. We're happy to take your questions.

3 MR. HACKBARTH: Okay. Thank you, Carlos and
4 Rachel.

5 Let's begin with round one clarifying questions.
6 Cori?

7 MS. UCCELLO: Just a quick question, has the
8 Commission ever commented in the past about the hold
9 harmless provision?

10 DR. SCHMIDT: Not to my knowledge.

11 MS. UCCELLO: Has the Commission ever commented on
12 the hold harmless provision?

13 DR. SCHMIDT: The hold harmless provision in Part
14 B that we discussed earlier, not to my knowledge, no.

15 MR. HACKBARTH: Other clarifying questions?

16 MR. BUTLER: Two quick ones just on supplemental
17 or Medigap policies. What is it, like 85 percent or
18 something, of all enrollees have?

19 DR. SCHMIDT: It's 90 percent. There's only about
20 10 percent or so that have no supplemental coverage.

21 MR. BUTLER: Okay. Then the second question, I
22 think can be best answered by asking on Slide 14 or 13, but

1 this will work. So I guess what I didn't fully appreciate
2 is that the gap coverage that now is mandated, a lot of the
3 responsibility is the plan, not the federal government.

4 DR. SCHMIDT: You mean as it changes over time?

5 MR. BUTLER: Yes.

6 DR. SCHMIDT: Yes.

7 MR. BUTLER: And so isn't that just passed along
8 in premium increases to the individual then, in effect?

9 DR. SCHMIDT: Well, the premiums cover about 25.5
10 percent of the average value of the standard benefit. So
11 it's split between the Medicare program and beneficiary
12 premiums.

13 MR. HACKBARTH: Other clarifying questions?

14 DR. BERENSON: On Slide 4, I just want to
15 understand the hold harmless/non-hold harmless groups. If
16 in fact there was no hold harmless, would the premium have
17 been somewhere between those two numbers, like around 100 or
18 something?

19 DR. SCHMIDT: I should have done that calculation.
20 I didn't. I'd have to guess.

21 DR. BERENSON: But I mean basically the group
22 that's not held harmless has to make up for.

1 DR. SCHMIDT: Exactly.

2 DR. BERENSON: So what will happen in 2012? They
3 might actually see a decrease? Is that allowable in there?

4 DR. SCHMIDT: We actually asked the actuaries that
5 question, and no, it would not decrease.

6 DR. BERENSON: So they might be flat for a while
7 until the others caught up to them, okay.

8 Although if, just continuing the same question, if
9 we're in a low inflation era now or at least for the next
10 few years, and the COLAs are very small or nonexistent, that
11 means there's going to be more of a financing burden on the
12 people who are not covered by the hold harmless and more
13 pressure on their premiums, pushing them up.

14 DR. SCHMIDT: That's correct.

15 MR. HACKBARTH: So do I understand the system
16 correctly, so one category of beneficiaries that's not
17 protected by the hold harmless is the new enrollees? So
18 it's like each class of new enrollees will have their own
19 unique premium based on what's necessary to cover the
20 residual cost when they enter the Medicare group?

21 DR. SCHMIDT: I think yes, but the limiting factor
22 is how well economic growth is, and the economy as a whole.

1 So this is driven by a comparison of the Social Security
2 COLA to what would be the increase in the Part B premium,
3 those dollar amounts, and that's the constraint on it. So
4 usually, say an average monthly Social Security benefit is
5 on the order of \$1,000 and you get something on the order of
6 a 3 percent/4 percent COLA, that usually would be enough to
7 cover the average increase in the Part B premium.

8 So hopefully, if we get to a point where there's
9 more economic growth again, that will kick in again. But
10 yes, in years where there's flat growth as we're seeing and
11 no COLA increase, then yes, the new entrants, the people who
12 are duals, who are in the Medicare savings programs, plans
13 rather, those folks are going to be bearing for the
14 aggregate dollar amount of premiums that would otherwise be
15 paid.

16 MR. HACKBARTH: In the other cases, basically, the
17 government is picking it up.

18 DR. SCHMIDT: Through Medicaid, yes.

19 MR. HACKBARTH: For the duals and the savings
20 program people.

21 DR. SCHMIDT: There's the FMAP. So it's shared
22 between state and fed.

1 MR. HACKBARTH: And then there's the high income
2 people which is sort of a separate set of issues.

3 DR. SCHMIDT: Right.

4 MR. HACKBARTH: But the new enrollees are not
5 having it picked up by anybody else. They're, by
6 definition, not high income people, and this is getting
7 loaded onto them disproportionately right now.

8 And did I understand you correctly to say that
9 once their premium is set it doesn't go back down?

10 DR. SCHMIDT: Well, it's again this comparison of
11 whether the increase in the Part B premium is bigger or
12 smaller than the COLA. And my understanding, if I was
13 interpreting what the actuaries said correctly, is it
14 probably would not go down.

15 MR. HACKBARTH: Yes. Okay.

16 Clarifying? Bruce?

17 DR. STUART: I wonder what's going to happen to
18 the people who come, who are eligible for Medicare under the
19 new higher income limits for PPACA when they become
20 Medicare-entitled. Would they be under the same rules as
21 duals today because if they are then there's a
22 substantially, fairly large number of people who will be

1 Medicaid-entitled in the years before they come into
2 Medicare, who are not now and then they would be excused
3 from all of these cost-sharings? Is that correct?

4 DR. SCHMIDT: I would have to go research that. I
5 don't know the answer off the top of my head.

6 MR. HACKBARTH: Anyone else? Interesting
7 question.

8 DR. STUART: It strikes me that that could be
9 bigger in terms of the cost impact on Medicare than almost
10 anything else.

11 MR. HACKBARTH: Right. To be honest, I haven't
12 thought about that.

13 Jennie?

14 MS. HANSEN: I was just commenting earlier that I
15 do think that because of that higher level of qualification
16 we'll see a lot more duals. You know. Just by virtue of
17 their --

18 MR. HACKBARTH: Joan may have some information for
19 us.

20 MS. HANSEN: Joan has an answer?

21 DR. SOKOLOVSKY: Even at those higher income
22 limits, even if they don't become full duals, as the income

1 limits work right now, they would still be eligible for MSP.
2 So the government would still be picking them up.

3 MS. HANSEN: Sure, sure.

4 DR. SOKOLOVSKY: Without any changes.

5 MS. HANSEN: Right. So that does say that there
6 will be more people getting some federal subsidies as a
7 result. Right.

8 DR. MARK MILLER: Whether it's full dual or
9 whether it's MSP.

10 MS. HANSEN: Yes.

11 DR. MARK MILLER: We can look more carefully at
12 this question and get the specifics.

13 MS. HANSEN: My question is really relative to the
14 new groups, especially the ones who are paying out of
15 pocket.

16 I just wonder, between the Part B side and then
17 the increase in income relating under the Part D, just what
18 that co-payment trajectory is going to start happening for
19 middle income populations, kind of not on the Medicaid
20 qualified side and not on the \$214,000 and above side, just
21 what that's doing. It's kind of like the new Alternative
22 Minimum Tax on the Medicare side for people.

1 So just wondering about our just tracking what
2 happens there because that group seems to also once again
3 the middle income ends up paying that much more.

4 MR. HACKBARTH: Yes, and within that group you
5 could have greatly disparate premiums based on when you came
6 into the program. So you could have the same \$25,000 income
7 beneficiary who came in 10 years ago, say, and they'll have
8 1 premium. And somebody who came in, in 2010, would have a
9 markedly different premium. Right?

10 MS. HANSEN: Right.

11 MR. HACKBARTH: Same income level.

12 DR. CHERNEW: Higher.

13 MR. HACKBARTH: Higher, right.

14 DR. SCHMIDT: Income data are pretty difficult to
15 get, frankly. So it's hard to make predictions or
16 projections that we can feel very confident about, but they
17 do exist, and we'll try and bring you what we can.

18 MR. GEORGE MILLER: Slide 4 is up there. No,
19 Slide 3. I'm sorry. Slide 3. By removing all cost-sharing
20 for preventive services recommended by, with Grade A or B,
21 who pays that decrease in revenue for the providers with
22 this happening? I understand why it's happening.

1 DR. SCHMIDT: That's a good question. That's kind
2 of up in the air at this point.

3 MR. GEORGE MILLER: Thank you.

4 DR. SCHMIDT: I've seen some comments, I think, to
5 the physician rule that are along the same lines, and I
6 don't think we know the answer quite yet.

7 DR. BAICKER: You mentioned trying to draw lessons
8 from the Medicare Advantage experience. I know the
9 encounter data aren't available yet. I wonder what data are
10 available from Medicare-based administrative sources and
11 from surveys that may be non-comprehensive but informative,
12 like the MEPS or the HCAP or things like that, both on the
13 payment side and on the services utilization side.

14 MR. ZARABOZO: There are such data, like MCBS for
15 example. You can use that for this kind of analysis if you
16 wanted to do that.

17 DR. BAICKER: But you're missing a bunch of stuff
18 that you will get in the encounter data in terms of
19 utilization.

20 MR. ZARABOZO: Right.

21 DR. BAICKER: Is the only difference that from the
22 MCBS you just have a survey sample but the same richness of

1 information is there, or are you waiting on utilization
2 measures that aren't available anywhere else yet?

3 MR. ZARABOZO: I would think -- well, part of it
4 is the same size, and the other may be more utilization
5 information would be available from the encounter data. And
6 also, there may be an issue with knowing exactly what the
7 benefit package is for the individual.

8 DR. SCHMIDT: The MCBS's utilization is basically
9 self-reported.

10 MR. ZARABOZO: Yes, yes.

11 DR. SCHMIDT: So we don't really have the hard
12 data to know exactly what happened there.

13 DR. MARK MILLER: Possibly, but I may have
14 misunderstood the entire exchange. But MCBS, I mean there
15 are also versions of it in which they link the claims data.

16 DR. SCHMIDT: For the fee-for-service population.

17 DR. MARK MILLER: Right. And she's asking about
18 the MA piece. Okay, right. Now I'm back in the game.

19 MR. HACKBARTH: [Off microphone.] Let me ask one
20 other clarifying question about the hold harmless, now
21 focusing on the high-income people who are paying an income-
22 related premium, not protected by hold harmless so they have

1 to pick up a piece of this residual. So at the highest
2 income level, just for the sake of simplicity, they pay up
3 to 80 percent of the cost.

4 DR. SCHMIDT: Right, so --

5 MR. HACKBARTH: But the added piece attributable
6 to the hold harmless is in addition to that, correct?

7 DR. SCHMIDT: Yes, that's right.

8 MR. HACKBARTH: So if this goes on for some period
9 of time, they could actually start bumping up against 100
10 percent or more than 100 percent of the actual cost of their
11 Part B benefits.

12 DR. SCHMIDT: Yes -- well, it seems --

13 MR. HACKBARTH: Well, a negative subsidy, not a --

14 DR. SCHMIDT: Well, it's more of an individual
15 consideration in addition to that. That would be 100
16 percent of the average elderly beneficiary's utilization,
17 and for some people, you know, their usage may be higher and
18 for others, lower.

19 DR. SCHMIDT: So it's more of an individual level
20 consideration, I'd say.

21 MR. HACKBARTH: Good point. Okay. So to go back
22 to the original question, the hold harmless in a period of

1 low or no COLAs starts to have more meaningful implications
2 because you're basically asking a small group of people to
3 bear the whole cost of the Part B increases. And so this
4 may be a particularly good time to be thinking about the
5 hold harmless and its implications.

6 DR. SCHMIDT: And to pray for economic growth.

7 [Laughter.]

8 MR. HACKBARTH: And that's first, actually.

9 DR. BERENSON: I forgot to ask for Carlos, is
10 there any reason why an MA plan can't offer a value-based
11 benefit design with varying cost sharing? And do any?

12 MR. ZARABOZO: What is allowed is tiered cost
13 sharing, and I think that's by choice by provider. Now,
14 what was recently sent out by CMS is you cannot do tiered
15 cost sharing sort of by a base provider. So the California
16 situation where you pick a medical group within a plan and
17 you're assigned to that medical group, your cost sharing
18 cannot be based on the choice of that medical group. But,
19 for example, among different hospitals you could have
20 different cost sharing. They're trying to limit that tiered
21 cost sharing. But in terms of, for example, can a diabetic
22 have different cost sharing from a non-diabetic, that's not

1 possible. That's only possible under a plan design so that,
2 for example, special needs plans can say, Here's our cost-
3 sharing structure which is appropriate for this kind of
4 beneficiary, but not -- so to do that, you would have to set
5 up a plan that is for these people, and if it's disease-
6 based, it would have to be a special needs plan.

7 MR. HACKBARTH: Okay, let's proceed to round two.

8 MS. UCCELLO: I just have a follow-up
9 clarification for this hold harmless. So premium is 110 for
10 the people who have to pay the whole thing. Say next year
11 there's 3 percent or whatever COLA, that 110 stays 110 and
12 the 96 goes up? Or they both go up?

13 DR. SCHMIDT: Well, for the people who are paying
14 96/40 this year, if there's a zero COLA again, they will
15 still stay at the 96/40. The people at 110, if they're the
16 entering cohorts just turning 65, they paid 110.50 this
17 year, but they're not income-related or in any of the other
18 groups, then they continue to pay 110.

19 MS. UCCELLO: My question is: Once we start
20 getting positive COLAs again, what happens to that 110 and
21 the 96 -- yeah, do they -- so 110 is frozen until they catch
22 up?

1 DR. SCHMIDT: I'm not sure I'm following exactly.

2 Do you want to --

3 DR. MARK MILLER: All right. So here's what I
4 think, just to get you -- because I think you were speaking
5 to this --

6 DR. SCHMIDT: Earlier

7 DR. MARK MILLER: -- when some questions were
8 coming along here. So in the case where you start to get
9 increases, and the question was, you know, what happens to
10 the people who are paying the higher amount, you implied in
11 your answer that what happens is they don't come down, they
12 sort of stay there and people catch up over time. That's
13 what was the implication.

14 DR. SCHMIDT: Right.

15 DR. MARK MILLER: I think that's what she's
16 asking.

17 DR. SCHMIDT: Yes.

18 MS. UCCELLO: So they don't both move up.

19 DR. SCHMIDT: [Nodding affirmatively.]

20 MS. UCCELLO: Okay. Thank you.

21 Just in general, I'm troubled by the inequities of
22 this. I don't know -- I mean, hopefully this is just a

1 short-term issue, so I don't know how much of a priority we
2 need to make this. And I wouldn't want to freeze it for
3 everybody necessarily because that's just going to increase
4 federal spending on this. But I think it's something we
5 should think about.

6 DR. CHERNEW: I have first some follow-ups on
7 Bob's question, which might not be surprising, and then I
8 have one other.

9 The first one is: My understanding about the
10 value-based insurance design portion of it is they can't
11 charge a co-pay above what the Medicare co-pays would have
12 been. So say there's a cancer screening or treatment
13 service which Medicare's co-pay would have been 20 percent
14 of something, but it's decided by the plan that that's a
15 very low-value treatment, I don't think the plans even in an
16 actuarial sense are allowed to charge more than what the
17 Medicare fee-for-service co-pay would have been.

18 MR. ZARABOZO: Correct. On the specific services
19 where they're prohibited from doing so, and then they look -
20 - there are listed service and then they look at individual
21 services and say these are services at risk for attempting -
22 -

1 DR. CHERNEW: But there could be other services
2 like PET scanning. Say you thought PET scanning wasn't very
3 high value -- and I'm not saying it isn't. I'm just using
4 an example. I can pronounce "PET." That's the only reason
5 why I picked it.

6 [Laughter.]

7 DR. CHERNEW: If you thought it wasn't very high
8 value, they're limited as to how much they could charge
9 enrollees for PET by what the regular fee-for-service
10 benefit structure is, even though PET's not one of the
11 things that has been pulled out separately. I think that --
12 I could be wrong. That's why I'm asking the question.

13 MR. ZARABOZO: No, that's what the actuarial value
14 --

15 DR. CHERNEW: Oh, so they can as long as they keep
16 --

17 MR. ZARABOZO: Right.

18 DR. CHERNEW: -- actuarial value.

19 MR. ZARABOZO: Right, unless CMS says this appears
20 to be discriminatory.

21 DR. CHERNEW: My second question has to do with
22 the diabetes example, which is how you answered his

1 question. If you look at the Preventive Services Task Force
2 recommendations, there are many which are disease specific,
3 so, for example, it's Grade A evidence to get screened for
4 diabetes if you have high blood pressure, but not if you
5 have low blood pressure.

6 MR. ZARABOZO: Right.

7 DR. CHERNEW: So when they try to put those
8 services for -- no cost sharing for preventive services into
9 practice, are they accepting that's going to be disease
10 specific, or are they not?

11 MR. ZARABOZO: Well, I think that would be a
12 coverage -- that is what is or isn't covered. I think it's
13 more of a coverage issue.

14 DR. CHERNEW: But they would cover diabetes
15 screening even if you had low blood pressure.

16 MR. ZARABOZO: For 2012, then they're telling them
17 you have to adhere to the fee-for-service rules about here's
18 how cost sharing will be done on preventive services. So to
19 the extent that fee-for-service -- whatever fee-for-service
20 does, they will also have to.

21 DR. CHERNEW: And fee-for-service certainly can't
22 be disease specific because they won't know half the

1 information that you need to do the U.S. Preventive Services
2 Task Force stuff, correct?

3 DR. SCHMIDT: I think it's left to the physician
4 to determine whether they meet the criteria.

5 DR. CHERNEW: Right. And so my real question is:
6 You didn't mention at all -- just really a comment. You
7 didn't mention anything about employers. I think one of the
8 biggest issues about how beneficiary cost sharing will
9 change over the next however many years is going to have to
10 do with the change in employer-provided subsidies for
11 retiree coverage, both in terms of premium subsidies and in
12 terms of generosity of benefits and a whole series of
13 things, and I think that's an -- I think individuals will
14 feel that as much as some of these other program-specific
15 changes.

16 MR. ZARABOZO: One thing to mention about
17 employers, the out-of-pocket costs apply to the employer
18 group plans under Medicare Advantage, those limits.
19 However, when CMS announced its policy, it says that
20 employer group plans may come in under the waiver authority
21 to change that if they want to. So I don't know whether
22 they're inviting employer group plans to say we'd rather not

1 have these out-of-pocket -- or whatever the story is, but
2 they can be treated differently from other types of plans
3 with respect to that out-of-pocket cost limit.

4 DR. CHERNEW: [Off microphone.] Generally,
5 employers are going to tend to drop or make less generous
6 their provisions overall, and that will have big impacts for
7 all the other charts you show us about beneficiary out-of-
8 pocket --

9 DR. SCHMIDT: Let me take that point, and we tried
10 to put a little bit about that in the mailing materials and
11 didn't talk to it so much in the slides. There's a debate
12 how much of that was going on way before PPACA versus now,
13 and we weren't going to get into that.

14 MS. BEHROOZI: Thanks. This is a great place to
15 find all of the information about how the premiums will
16 change and co-payments change and things like that. But one
17 of the things that I was looking for was, you know, somewhat
18 similar to what Mike was saying, the impact on the average
19 beneficiary. And in the context chapter, there was a little
20 reference -- it's on page 25 of the context chapter -- to
21 the projected impact on -- you know, to the beneficiary,
22 like the co-insurance amounts that -- as I understand it,

1 what the long-term projection is of all the provisions of
2 PPACA taken together on, you know, aggregate spending,
3 because, you know, in this section, when we talk about
4 improved benefits, like particularly under Part D, then what
5 we refer to is the fact that, you know, the benefits are
6 more generous, that means the premiums are going to go up.
7 But taken together, we say in the context chapter,
8 everything seems to have -- somebody thinks there's going to
9 be a downward impact on what beneficiaries will pay. So I
10 think if we can stand, you know, in that -- you know, take
11 that perspective a little, what it means to the individual
12 beneficiary and what they can expect to see over the long
13 term.

14 And then on the preventive care actually, there
15 are two points. One is that -- or two points made in the
16 paper. One is that not charging people for preventive care
17 will mean, you know, more expenditures for the program,
18 which could have an upward impact on premiums, but that
19 maybe people won't know about it and won't use it. But
20 there's certainly a lot of publicity about the preventive
21 care being free -- quite a lot of publicity about it. So I
22 don't know how transferable the prior experience is that's

1 referred to here, and also the whole point of preventive
2 care is to reduce long-term costs, you know, acute costs and
3 the costs of chronic care. So that recognition of why the
4 decision was made to make these services free sort of seems
5 to be absent here. So I think we should note that.

6 DR. STUART: Following up on the preventive
7 services, have you had a chance to go through the book and
8 just see which services do get an A or a B? The last time I
9 did that, there weren't very many, and I think it might be
10 useful to have a table that just kind of listed them.

11 DR. SCHMIDT: I can't list them off the top of my
12 head, but I do have the book to -- or a PDF of it, anyway.
13 I'd be happy to.

14 MS. HANSEN: Yes, first of all, I just want to say
15 that I really appreciate the mailed materials. There is a
16 lot of detail there, an array of information that was very
17 helpful.

18 In the course of our discussion, however, as we
19 were talking about some of the various impacts to different
20 groups, it became a little bit more complex and byzantine to
21 me, and I wondered if we could array just what happens to
22 the beneficiaries that are certain income groups and be able

1 to kind of almost play out what that scenario would be, both
2 in this immediate term for -- whether it's the years until
3 2014 or 2019, I forget the year, and then what may happen
4 afterwards with or without inflation, just to see what this
5 whole out-of-pocket impact is going to be for, in many ways,
6 all income levels, so whether you're eventually a lower
7 income with Medicare savings plans to kind of this middle-
8 income group that has such great variability to the highest
9 income individuals, just so we can begin to understand what
10 that trajectory may end up being in terms of people's
11 financial impact in the long run. That would be helpful.

12 And then just a very quick question in terms of
13 how out-of-pocket expenses are perhaps calculated in MA
14 plans, so when we talk about \$6,700 or so, that might be a
15 max. There seems to be -- and I don't know if this is
16 accurate. There seems to have been some variability as to
17 how MA plans calculate out-of-pocket expenses. So is there
18 a more standardized way to look at that now?

19 MR. ZARABOZO: You mean in terms of what is
20 included or not?

21 That was a problem before, whether it was or was
22 not included in the -- when they had caps. And now it's

1 every -- all the Part A and Part B services must be included
2 under that cap.

3 MR. GEORGE MILLER: Yeah, just to follow up my
4 question also on the providers who had decreased revenue, do
5 we know what that number -- could you look and find out what
6 that number would be, if you could find out what those in
7 Grade A and Grade B, and I guess it would also have an
8 impact for providers with the out-of-pocket cap as well on
9 fee-for-service, what the financial impact would be and how
10 pays it. Is that going to -- do the providers eat it, or
11 will Medicare pick that up? I'd just be curious to know.

12 DR. BERENSON: I don't understand why they have
13 decreased revenue, I guess. Isn't it just you're relieving
14 the cost-sharing obligation from the beneficiary, so that
15 means Medicare's picking it up, isn't it?

16 DR. GEORGE MILLER: [off microphone.]

17 DR. SCHMIDT: That would an initial guess. The
18 reason I kind of hemmed and hawed in response to your
19 question is that I did see some comments to some of the
20 proposed rules out there where at least some providers
21 thought this was ambiguous, and I thought I needed to go
22 clarify that to be sure.

1 DR. BERENSON: Okay, that's fine. But I don't
2 think we should presume there's going to be decreased
3 revenue. We should find that out. Okay.

4 MR. GEORGE MILLER: [Off microphone.] That was my
5 question.

6 DR. BORMAN: Two things. Number one, like Cori,
7 I'm concerned, if I'm understanding the hold harmless piece,
8 a little bit about the way that things are shifting around
9 to different groups, and just sort of an idea about if I
10 entered the program this year versus if I enter it next year
11 or the year after, what would that look like under, you
12 know, a zero COLA, a 3-percent or 5-percent or something.
13 Just as a small comparison, not any huge undertaking table
14 that I won't understand, but something pretty basic I think
15 would help me a lot, because I'm troubled that there's
16 something fundamentally wrong here, but maybe seeing it play
17 out I'll have a better feeling about it.

18 The second piece is -- and it comes back to a
19 couple of comments that were made about trying to think
20 about as the income sources and amounts change, as people
21 enter the Medicare population who no longer have such
22 generous employer-sponsored benefits and who don't have a

1 defined benefit retirement plan but, in fact, are defined
2 contribution and will be somewhat victims of their timing of
3 retirement versus the market and some of those kinds of
4 things, I'm interested in that, but I think we could be
5 asking for very complex calculations and information that
6 may not be available. I kind of get that sense. So at
7 least for me, it might help. We talk about what percentage
8 of the typical SSI payment will be consumed by the premiums,
9 both the B and D premiums. Could we look at what will be
10 just the share of the typical retirement income that will be
11 consumed as opposed to trying to do fancy things for, you
12 know, employer this and duals and whatever, just kind of do
13 some simple contrast, or look at what percentage of people -
14 - just tell us what percentage of people will, in fact, be
15 projected to still have an employer contribution at all to
16 this. That would at least give us a very down and dirty
17 sense of how big the problem's going to be, how it's going
18 to change, because my guess would be, given the volatility
19 of the economy over the last couple of years, and that we
20 don't even have the data out of those, that being able to
21 project downstream what a typical retiree's income will look
22 like and what it will be and where their sources would come

1 from would just mire us in a huge speculative calculation
2 that I'm not sure is of value. If we can just get a couple
3 of benchmark kinds of things to help us think about, at
4 least that is for me how I would think through it a little
5 bit.

6 DR. CHERNEW: The Social Security people do -- the
7 Social Security actuaries go through all of that activity to
8 know that, and what they haven't done is merged that with
9 these things particularly well, which we have a small
10 project to try and do, but I think that income distribution
11 stuff, there's other people that [off microphone].

12 MR. HACKBARTH: Like Karen, I'm still struggling
13 trying to make sure I understand the implications, and so I
14 agree maybe some more examples along the lines of the ones
15 we've discussed here would be helpful in making sure that
16 we've got it.

17 I need you to elaborate on something you said
18 earlier, Rachel. A couple times you pointedly said, well,
19 economic growth is key here.

20 DR. SCHMIDT: Yeah.

21 MR. HACKBARTH: As opposed to just inflation. I'm
22 missing your point there. Part B premiums are determined by

1 Part B expenditure growth linked to that, and then we have
2 the Social Security COLA link. Where does the rate of
3 economic growth come into --

4 DR. SCHMIDT: That was my shorthand for speaking
5 about the COLA, I suppose you could say.

6 MR. HACKBARTH: Okay. So you're assuming a
7 correlation between growth and inflation.

8 DR. SCHMIDT: Right.

9 MR. HACKBARTH: Okay. And then I just wanted to
10 make sure I correctly understood one other thing. I think
11 it was an exchange with Cori.

12 So let's focus on the case of the 2010 new
13 Medicare beneficiary, not covered by the hold harmless, so
14 they've got the 110, whatever, dollar premium and they're
15 picking up that big item. Then let's assume in 2011 there's
16 a cost-of-living increase in Social Security that is high
17 enough to cover the Part B premium increase. So the
18 Medicare beneficiary who newly enrolled in the program in
19 2000 now is going to pay a higher Part B premium than they
20 did this year up to the max of the COLA. They can't go up
21 faster than that. The 2010 enrollee, they're held constant
22 until the others catch up, or do they pay the high number

1 that they paid in 2010 plus the COLA, up to the COLA
2 increase?

3 In other words, are they held flat --

4 DR. SCHMIDT: I believe --

5 MR. HACKBARTH: -- you have to close, or do they -
6 -

7 DR. SCHMIDT: Shinobu may want to jump in and help
8 me, but I believe it's the 110 -- how about I come back and
9 work out an example and bring it back to you rather than
10 misspeak, check with the actuaries --

11 MR. HACKBARTH: Okay. So the question is whether
12 the gap closes or whether they march up in sync and the gap
13 stays constant.

14 DR. SCHMIDT: Right. I could speculate, but I
15 could be wrong, too.

16 MS. UCCELLO: And I want to add a question to
17 that, too. What does the new entrant in 2011 pay? Are they
18 paying the 110, or are they paying the 96-plus?

19 DR. SCHMIDT: You know, I think the actuaries are
20 starting to work this out just now themselves, so I'll see
21 what answers I can get for you.

22 MR. HACKBARTH: Okay.

1 DR. MARK MILLER: Because you know how actuaries
2 are.

3 MR. HACKBARTH: Yeah, right.

4 [Laughter.]

5 DR. MARK MILLER: Sorry about that. It was just
6 right there. And what we'll probably do on --

7 MS. UCCELLO: I didn't --

8 DR. MARK MILLER: No, I know. Actually, we got
9 this far without one joke. Just the tension was killing me.
10 What we'll do with some of these technical ones is
11 put an e-mail together that everybody has looked hard at and
12 send it to all of you, because I'm not exactly sure whether
13 we'll have a session to follow up immediately on some of
14 this stuff, so we'll make sure that either -- we'll get it
15 to you one way or the other, either in a session or in an e-
16 mail to all of you.

17 DR. KANE: I'm just trying to wrap up what all
18 this means to me other than that the Greatest Generation is
19 screwing the Baby Boomer Generation.

20 [Laughter.]

21 DR. KANE: I'm trying to get over that. The
22 concern I think I'm taking away is that the healthier,

1 wealthier people -- and those tend to often go together --
2 you're going to start getting selection out of B and maybe
3 even D, I don't know, but B, anyway, of the healthier people
4 who have the higher -- you know, is that good or bad for the
5 program? And is there a way to mitigate that? So you're
6 going to actually -- you might actually start to make your
7 costs worse, spiral worse relative to your income because
8 you're going to lose the contribution of healthier,
9 wealthier people and start getting stuck with sicker, poorer
10 people. That's what I worry about. I don't know at what
11 point that starts to happen, but I'll leave it to our
12 actuaries to figure that out.

13 DR. SCHMIDT: Just to repeat something that Robert
14 Reischauer used to say when he was on the Commission, it
15 was: Even with the income-related premium, you're at least
16 getting something like a 20-percent subsidy from the
17 Medicare program of the average cost. So there still could
18 be some selection because if you're wealthier, healthier --

19 MR. HACKBARTH: Well, that used to be the case.
20 It's not clear to me that that will continue to be the case.
21 So, yeah, this is sort of confusing, and I think whenever
22 you say that certain people are exempted and the residual

1 are going to bear all of the costs, you're running a risk of
2 unintended consequences, and what we just need to do is sort
3 of sort through what those consequences might be.

4 Okay. Any concluding questions or comments?

5 MS. UCCELLO: Just one more question or comment.

6 Is it appropriate for us -- and maybe this was talked about.

7 Is it appropriate for the Commission to provide input to

8 NAIC on how they're going to define services for eligible

9 cost sharing for C and F?

10 DR. MARK MILLER: Yeah, I think the answer to that

11 is yes. We have ongoing conversations with them as a matter

12 of course. There's been discussions back and forth on

13 defining the new Medigap --

14 DR. SCHMIDT: They have reached out to us to have

15 some conversations about it, and we would like to. Their

16 deliberations, as I understand it, have been on hold until

17 next year, but there is room, I believe, for us to discuss -

18 -

19 MS. UCCELLO: And presumably one of our points

20 will be not to define it too narrowly, right?

21 DR. SCHMIDT: [Nodding affirmatively.]

22 MR. HACKBARTH: Thank you very much.

1 [Pause.]

2 And our next session is on retainer-based
3 physician practice. Go ahead [off microphone] whenever you
4 are ready, Cristina.

5 MS. BOCCUTTI: Okay. Given a sense that retainer-
6 based physician practice, otherwise known as concierge care,
7 has been growing, we on staff were thinking that it would be
8 very useful if we learned a little bit more about this type
9 of model of care. So we wanted to learn say, for instance,
10 what it is, its prevalence, and how it's affecting Medicare
11 beneficiaries' access to physicians.

12 To help us, we contracted with NORC at the
13 University of Chicago to help conduct a study examining
14 these questions. And so today I'd like to introduce
15 Elizabeth Hargrave from NORC, and she, along with her
16 colleagues from Georgetown University, conducted a study,
17 and she's here to present the findings. And I will help
18 push the slides for her, and I can answer other questions as
19 they come up, too.

20 MS. HARGRAVE: Okay. I'll start just by giving a
21 little background about what this is, retainer-based
22 physician practice. It's most commonly called in the press

1 concierge medicine, although some of the folks we talked to
2 actually really dislike that title, so we tried to pick a
3 more neutral title as we're talking about it.

4 The reason we call it retainer-based practice is
5 that the physicians that are using this model are generally
6 charging a monthly or annual fee to their patients -- it's
7 almost like a membership fee -- to be a part of the
8 physician's practice, so thus the retainer, that fee that
9 they're charging.

10 In exchange for patients paying this extra fee,
11 the physicians generally limit the number of patients in
12 their practice, which I'll talk about a little bit more
13 later. And they market themselves as offering greater
14 access and enhanced services to their patients. So they may
15 promise, you know, same-day or next-day appointments, longer
16 appointments. They may give out their cell phone number to
17 all of their patients. And most of them offer a very
18 extensive annual physical that may be, you know, 60 or 90
19 minutes with lots of tests and meeting about various issues.
20 Some make home visits; some will attend specialty
21 appointments with their patients. So a wide variety of
22 different extra services. Most are also charging insurance

1 for the office visits that they're providing in addition to
2 charging their patients this annual fee, and I'll talk a
3 little bit more about that later in this presentation.

4 So just a little bit of overview of what we did
5 for this project. We had three main goals, as Cristina
6 mentioned. One is we just wanted to get a sense of how many
7 physicians are using this model. There is sort of a
8 constant trickle of attention to it in the press, but no
9 real good source of how many physicians are doing this.

10 So to try and get a sense, we did a search of
11 various online directories that are either aimed at
12 marketing the physicians -- there's a professional
13 association. Several of the management organizations that
14 help physicians set up these practices have lists of the
15 physicians that they've worked with. And as we were doing
16 our literature review, we also sort of kept track of folks
17 that we came across.

18 And then once we had as big a list as we could
19 find of these physicians, we started to look at what are
20 some of their characteristics, where are they, how do their
21 fee structures work. And in addition to just looking at the
22 list of physicians that we had, we went out and interviewed

1 just 16 that are actually using this model, but tried to get
2 a little bit more richness to what's going on in their
3 practices. And we also spoke with a number of consultants
4 and management organizations that help physicians transition
5 into using this type of practice. So from them, we sort of
6 got more of an overview of the overall set of folks that are
7 doing this.

8 And then, third, we wanted to see if we could get
9 a sense of whether this is affecting Medicare beneficiaries'
10 access to care, and that's hard to measure because this is a
11 relatively small phenomenon and hard to find individual
12 beneficiaries. What we did is we went out and interviewed
13 several beneficiary counselors in areas that we thought
14 might be sort of hot spots to see if they were getting a
15 sense that within their particular market, whether this was
16 affecting access to care or not.

17 So we, as I said, went out and tried to find as
18 many of these practices as we could and found 756 of them --
19 or I should say 756 individual physicians that are using
20 this model. That has grown from -- you know, 1996 was when
21 the first practice opened. That was just two physicians.
22 In 2005, GAO did a report that used a pretty similar

1 methodology to ours, and they only found 146. And I should
2 say that both our count and GAO's are probably undercounts
3 because there are probably physicians using this model that
4 aren't listed in any of the directories that we used. But,
5 you know, growing but still a very small fraction of 1
6 percent of all the physicians in the country.

7 When we looked at some of the characteristics of
8 the physicians that were on our list, we found physicians
9 using this model in all but 11 states, so it's pretty
10 widespread across the country. This is a little bit of a
11 change from the GAO study which found that it was a pretty
12 coastal phenomenon. There are plenty of them in the middle
13 of the country now.

14 But almost all are in metropolitan areas, and
15 mostly in large metropolitan areas. There were three that
16 accounted for a quarter of our list: Los Angeles, Miami,
17 and the Washington, D.C., area, which may be why we keep
18 seeing stories about this in the press.

19 And there are a few that really jumped out at us
20 as having -- you know, smaller cities like Naples, Florida,
21 that have sort of a disproportionate number of physicians
22 doing this considering their populations size. Naples is a

1 town of 315,000 people, and they've got 16 physicians that
2 ended up on our list.

3 Most of the physicians on our list for whom we had
4 specialty information from, you know, one of the management
5 firms or any of the sources that listed specialties, most
6 were in primary care. We did find a few specialists, like
7 endocrinologists and cardiologists, that were doing this,
8 but overwhelmingly primary care.

9 And just looking at the addresses of the
10 physicians on our list, most of them seemed to be either on
11 their own or in a two-person practice. There are a few
12 larger retainer physicians where we found up to seven at one
13 address. So either they're completely solo practice, which
14 was the norm in the folks that we actually talked to, or
15 they're in a larger practice but the only retainer physician
16 on our list at that address.

17 When we talked to both the sort of big-picture
18 consultant folks and the individual physicians, we saw a
19 pattern of there's really three different models within this
20 retainer model. The first one we're calling fee for extra
21 services, and this is really the most common and was the
22 model used by the very first practice in Seattle. The

1 retainer fees explicitly paid for some extra services.

2 Often that annual physical is one thing that folks point to
3 as this is what your retainer fee is going to. And above
4 and beyond those extra services that are explicitly stated,
5 then the physician is continuing to bill insurance or
6 Medicare separately for all of their office visits, or the
7 patient directly if they're not accepting insurance.

8 The annual fee for this type of practice among the
9 physicians that we interviewed -- and this is a small sample
10 -- ranged from \$600 annually to \$4,200 annually. The GAO
11 study found an even wider spread. There are some that
12 charged tens of thousands of dollars. But the most common
13 is \$1,500.

14 So the second model -- this is less common, but
15 the word from some of our interviewees is that it's growing
16 -- is where this annual or monthly fee actually covers all
17 of your costs for your physician visits. So you pay your
18 fee to the physician, and then you never get billed for
19 another office visit during that year from that physician.
20 So you may still be paying for specialty care or for other
21 medical services, but for your physician to whom you've paid
22 a retainer, all of your visits are covered. And the

1 physician isn't billing insurance or Medicare. A lot of
2 them have completely opted out of Medicare. And the fees
3 for these practices, when we interviewed them, ranged from
4 \$1,500 to \$5,400 annually. So a little higher than the
5 other model, but the low end is actually sort of the norm
6 for the fee for extra services.

7 Then we talked to a few physicians that were
8 trying to create sort of a hybrid model where paying the
9 retainer is more of an option within their practice. So you
10 can remain with the physician and not pay the retainer, but
11 you may get different services from that physician. In one
12 practice we talked to, the patients who don't pay a retainer
13 are much more likely to be seen by a physician assistant;
14 whereas, the patients who pay the retainer fee are
15 guaranteed to see their physician when they come in for a
16 visit. So that was just one example that someone gave us of
17 how they were trying to differentiate and offer something
18 that people would be willing to pay extra for. So in this
19 model, physicians tend to keep a lot more of their non-
20 retainer patients.

21 But, in general, among the folks that we
22 interviewed, they had really dropped their patient loads.

1 So most of the retainer physicians that we spoke with had at
2 least 2,000 patients that they personally were responsible
3 for before they switched to a retainer practice. And when
4 we spoke to them after their switch, they had from 100 to
5 425 patients. So a big drop. A lot of them said they
6 actually wished they had a few more. They were aiming more
7 for, you know, the 400 to 600 range, but still a lot fewer
8 than they had before. And that's very similar to what GAO
9 found in 2005, a big drop.

10 We also tried to get a sense from the physicians
11 that we interviewed of who was choosing to pay the retainer
12 fee and whether they were seeing big demographic shifts in
13 their patient load once they had made the shift. Some said
14 not really, that it seemed to sort of be a very similar mix.
15 When they did note that there had been shifts, we heard two
16 repeated sort of sets of people. One was complex or sicker
17 patients. For example, one physician thought that she had a
18 lot more cancer patients, that her cancer patients were a
19 higher proportion of her patient load, you know, and felt
20 that she was really serving as sort of a care coordinator
21 and advocate for those patients. And then another set which
22 I think is more in some of the media accounts of these

1 practices are people -- you know, we kept hearing the
2 phrase, "people for whom time is more important than money,"
3 that they're willing to shell out the money for that
4 guarantee that they'll get in to see their physician when
5 they want to and they'll get the extra time. We also asked
6 about the share of their patient load that was Medicare and
7 heard a real mix of anywhere from about 20 percent of the
8 practice to 60 percent of the practice, and some
9 specifically mentioned that they had Medicare beneficiaries
10 whose children were paying their retainer fees as a way to
11 get some extra care for their parents.

12 Most of the physicians that we spoke to really
13 enjoyed their new practice after the transition to being in
14 a retainer-style practice. They thought they had a lot more
15 time to spend with patients. We kept hearing phrases like
16 "This is the kind of doctor I envisioned myself being,"
17 "This is how I was taught to practice medicine." A lot of
18 folks said that they had been really burnt out before they
19 made the transition and that this was something that kept
20 them in medical practice.

21 On the flip side, the hardest part that many, many
22 mentioned was when you give out your cell phone number,

1 you're always on call, and some felt that they really
2 couldn't even go on vacation because their patients expected
3 them to be available when they wanted them.

4 I would say the hardest part of this study was
5 trying to get a handle on what impact this all has directly
6 on Medicare beneficiaries, because this is such a small
7 number of physicians, and then Medicare beneficiaries are
8 only a fraction of their patients. It's like searching for
9 a needle in a haystack. But some physicians stated that
10 they feel like they have more preventive care, better
11 continuity of care, more services in general. Some were
12 able to, you know, cite specific anecdotes where they
13 thought they had improved patient outcomes.

14 One said, "This is a much better lifestyle for me,
15 but I don't think the medical outcomes for my patients are
16 necessarily better." And when we tried to speak with
17 Medicare beneficiary counselors about this as a way to sort
18 of talk to folks that talk to a lot of Medicare
19 beneficiaries instead of trying to seek out the individual
20 Medicare beneficiaries, they weren't seeing widespread
21 access problems, but a couple did mention they were
22 concerned about folks that they had spoken to who had

1 chronic illnesses or the children of folks with chronic
2 illnesses who really found that decision when they were
3 confronted with, "Are you going to pay the retainer and
4 stick with your physician or are you going to switch to
5 another physician?" folks that were in the middle of a
6 chronic illness really found that a more challenging
7 decision to make and thought that the change would be more
8 disruptive for those beneficiaries than probably your
9 average patient within that practice.

10 So that's an overview of what we found with our
11 study, and I'd be happy to take questions.

12 MR. HACKBARTH: Thank you, Elizabeth.

13 Clarifying questions, round one.

14 MR. GEORGE MILLER: This was excellent. I enjoyed
15 reading the chapter, so thank you very much. Do you have
16 demographic information on the physicians in the database of
17 756, where they're from, what they look like, rural versus
18 urban, and --

19 MS. HARGRAVE: We have addresses. They were
20 overwhelmingly urban. I would say there were maybe 12 or 16
21 that weren't in a metropolitan statistical area, and they
22 tended to be in resort towns.

1 MR. GEORGE MILLER: And how about demographic
2 information?

3 MS. HARGRAVE: We don't have a lot of other
4 demographics, because, you know, if you think about sort of
5 the information that you might see in a physician directory,
6 it's really the name, maybe the specialty, and the address.

7 MR. GEORGE MILLER: Okay, all right. And then
8 just a follow-up to that same question, if you had more
9 demographic information on the patients that they saw. Did
10 they give you that information?

11 MS. HARGRAVE: We just don't.

12 DR. KANE: Was your sense that they incurred any
13 additional costs to take care of these patients, like added
14 a medical record or, you know, added a nurse practitioner or
15 some way did they add any costs? I mean, I'm grossing for
16 these people who have 100 to 400 patients. I mean, a
17 hundred is 150K and 400 is 600K.

18 MS. HARGRAVE: Right.

19 DR. KANE: That's a gross. And I'm just
20 wondering, was there anything that you took off for that?
21 Because if you could get even a hundred patients, that's 400
22 visits a year, that's --

1 MS. HARGRAVE: The main thing is that the ones
2 that are going -- so there are several companies that are
3 set up to help transition physicians to this model and
4 actually will take care of collecting the retainer fees from
5 the patients.

6 And if you sign up with one of those companies as
7 a physician, you commit -- you sign a contract with them for
8 something like five years, and they get a third of the
9 retainer fees. At least for one of them. I don't know if
10 that's true for all of them. But, you know, a set-up like
11 that. So the physician may not be getting all of that
12 money, so that's one cost.

13 MR. HACKBARTH: And what is the company doing for
14 its one-third?

15 [Laughter.]

16 MS. HARGRAVE: They do a lot marketing to get --
17 so if the physician doesn't get the 600 patients that they
18 want just from their original panel, they'll go out and find
19 them patients.

20 MR. HACKBARTH: So did you study that at all,
21 Elizabeth, and how they do that marketing, how they target
22 potential customers willing to pay?

1 MS. HARGRAVE: We didn't go into that level of
2 detail, but we did meet with a few of the companies and sort
3 of heard more about the -- they help physicians sort of walk
4 through the transition and, you know, offer meetings with
5 the patients and things like that. So there's sort of a
6 whole set of services that they have up front. And then the
7 ongoing services over that five years are really the
8 marketing and the collecting of the retainer fees so the
9 physician doesn't have to do that.

10 MR. HACKBARTH: It sounds like a good business to
11 be in to me.

12 [Laughter.]

13 DR. KANE: If you already have [off microphone].

14 MR. KUHN: That enrollment business does sound
15 good.

16 I've got a question. Did you look at or have any
17 conversations with the Office of Inspector General about
18 efforts that these organizations have to navigate in order
19 to make sure they're compliant? You know, for example, as
20 you said, the big selling point is the preventive wellness
21 extravaganza that they're selling out there.

22 MS. HARGRAVE: Right.

1 MR. KUHN: But yet at the same time, there can't
2 be a surcharge on any covered Medicare services. So what's
3 the fine line that they have to walk when they deal with the
4 Office of Inspector General?

5 MS. HARGRAVE: That's a really good question. I
6 know Cristina has been talking --

7 MS. BOCCUTTI: Why don't you mention your
8 experience, and then I'll --

9 MS. HARGRAVE: So the Office of Inspector General
10 put out a letter, I think it was in 2004, where they laid
11 out -- it really has to be -- the retainer fee has to go for
12 services that are not covered by Medicare.

13 So it can't just be that you're spending extra
14 time. It has to be something like the physical that's
15 specifically not covered by Medicare, except, of course,
16 PPACA just added some benefits to Medicare that Cristina can
17 talk about.

18 So that was -- OIG hasn't issued anything, any
19 additional statements since that original letter where they
20 laid out that bright line. And when we spoke to folks, we
21 were speaking to them before PPACA had passed, and a few of
22 the consultants said, you know, even if Medicare did add an

1 annual physical, we could always come up with something that
2 we're offering that isn't covered by Medicare.

3 MR. KUHN: My guess is that every one of these
4 folks that's operating one of these is going to have to go
5 see their attorneys by the end of this year because of the
6 new physical that's going to be in PPACA. The surcharge on
7 this, I think everyone is going to have to reorganize
8 themselves in some form or another.

9 MS. BOCCUTTI: Yes, I think Elizabeth heard that,
10 and we've also heard when we have talked with some other
11 providers that there are some issues that are coming up, and
12 one has to do with the annual preventive services that are
13 now part of PPACA. Those haven't really totally been
14 defined, so that's going to be coming up.

15 But also other things we've been hearing, too, are
16 that practices might not be full-on retainer practices or
17 concierge practices, but may be having additional charges
18 for some things that aren't Medicare covered. So these are
19 things that providers have been asking questions about. And
20 you originally asked about the OIG and that report that they
21 had with a clarification, and I think in some regards CMS
22 may be looking into some clarification, may want to be

1 looking into clarifications regarding the upcoming
2 preventive services.

3 MR. KUHN: So my guess is the same-day
4 appointments, the 24/7 access, those kinds of things are
5 probably going to become much more prominent, I would guess,
6 in these than --

7 MS. BOCCUTI: Right, that's a gray area.

8 MS. HARGRAVE: But those are the kinds of things
9 that OIG said that doesn't really count as non-covered,
10 because the visit is still covered, right?

11 MR. KUHN: Right.

12 MS. HARGRAVE: Being able to get the visit when
13 you want it isn't really enough.

14 DR. MARK MILLER: The second model wouldn't run
15 afoul of that.

16 MS. HARGRAVE: Correct, because they're not
17 billing Medicare.

18 DR. BERENSON: That's just where I was going. So
19 there's no obligation if there are covered services that
20 Medicare covers to actually bill Medicare? In other words,
21 these docs don't have to opt out of Medicare? They can
22 simply not bill for covered services and there's no problem?

1 MS. BOCCUTTI: In the first model, they can --

2 DR. BERENSON: I'm sorry. In the second model.

3 MS. BOCCUTTI: In the second model, I think as
4 Elizabeth said, that's the most common situation where they
5 -- physicians who have opted out of Medicare are more likely
6 to be using the Model 2.

7 MS. HARGRAVE: And most of the ones that we talked
8 to in that model have opted out.

9 DR. BERENSON: But they don't have to opt out of
10 Medicare? That's my question. Do they have to opt out of
11 Medicare, or are they --

12 MS. BOCCUTTI: No, they don't, because then the
13 patient -- if the physician has not opted out of Medicare,
14 then the patient -- if the patient can get a bill, a claim
15 to some regard, and then the patient could still submit it
16 to Medicare if the physician was still enrolled in Medicare,
17 whether they're a participating or a non-participating --

18 MS. HARGRAVE: But, in general, they're just not
19 billing the patients for the individual --

20 DR. BERENSON: Aren't they then sort of routinely
21 waiving cost sharing? And isn't that -- I mean, it doesn't
22 seem --

1 MS. BOCCUTTI: I think it's not as common of a
2 model, and it's a confusing situation.

3 DR. BERENSON: Okay.

4 MS. HARGRAVE: I'll give you one example of -- the
5 only physician that we talked to that was in that model that
6 hadn't opted out, in addition to his practice, he was a
7 hospice physician. So he hadn't opted out of Medicare
8 because he wanted to continue participating with Medicare
9 for the hospice work that he was doing. But for his
10 patients, he wasn't billing them, he wasn't, you know,
11 giving them anything that would allow them to go bill
12 Medicare, so effectively was not working within that system
13 but hadn't completely opted out. But he said that his
14 lawyer kept telling him that he should opt out of Medicare
15 to make it clear. But he hadn't yet.

16 MR. ARMSTRONG: Two quick questions. First, in
17 the written report you mention four states where the
18 question came up, the regulatory question: Are these really
19 insurance plans and should they be regulated that way? You
20 describe how they've been resolved. My question is: Has
21 this come up even more recently in any additional states
22 since we wrote this report?

1 MS. HARGRAVE: Not that I've seen, but I haven't
2 looked for it in the last few months.

3 MR. ARMSTRONG: Okay. I ask only because we see
4 that this is growing, and your report talks about, you know,
5 significant growth. And I was not aware of it coming up
6 anywhere else, but I wanted to ask if you knew.

7 Second, it sounds like you've had a chance to talk
8 to a couple of the organizations that helped to organize
9 these. I'm wondering if any of those interviews or if you
10 know of any of these practices that have initiated or tried
11 looking at studies on the impact overall of the per
12 member/per month expense trends or population outcomes when
13 they apply this model to primary care. Or have they
14 expressed any interest in trying to understand the impact on
15 that?

16 MS. HARGRAVE: I think MDVIP, which is the largest
17 organization, has tried to do some of that. They haven't
18 really risk-adjusted it, so it's hard to know -- I mean,
19 they do claim that the overall medical costs for patients in
20 their practices are lower because they're preventing
21 hospitalizations. But it's hard to know because it's not
22 really --

1 MR. HACKBARTH: How would they know?

2 MS. HARGRAVE: Right.

3 MR. HACKBARTH: They don't have access to the
4 claims information. They don't know if the patient is self-
5 referring to the specialist. They wouldn't know necessarily
6 when the patient was admitted to the hospital.

7 MS. HARGRAVE: Exactly.

8 MR. HACKBARTH: It seems it would be very hard for
9 them to do --

10 MS. BOCCUTTI: We're not aware of independent
11 research --

12 MS. HARGRAVE: No.

13 MS. BOCCUTTI: -- that has taken that on, that
14 question on.

15 MS. HARGRAVE: But the organizations that are
16 helping -- to directly answer your question, the folks that
17 are organizing these are trying to come up with ways to show
18 that, but it's not clear.

19 MR. BUTLER: Just a quick technical observation,
20 and MDVIP, the biggest one. It's interesting, if you pay
21 your \$1,500 -- I know this happened to somebody. If you pay
22 your \$1,500, they do aggressively want you in to do your

1 visit, in part because if you don't, it's not tax
2 deductible. You cannot deduct the \$1,500 unless you have
3 shown that you got services for that. I know somebody who
4 got audited that happened with.

5 So they actually promote to make sure that that
6 occurs.

7 MS. HARGRAVE: So tax deductible as a medical
8 expense?

9 MR. BUTLER: Well, if you're taking a medical
10 deduction, you can't -- if you're just paying 1,500 bucks
11 and there's nothing to show that you got medical care for
12 that, it's not deductible from your taxes. So it's one of
13 the reasons MDVIP actually, you know, encourages and they --
14 you know, they get in touch with you and say, "Come in and
15 get your visit."

16 MR. HACKBARTH: It's so high -- it's so difficult
17 to qualify for the medical expense deduction now. The
18 thresholds are so high that --

19 DR. KANE: If you're working, the flexible
20 spending may be -- does it qualify for flexible spending?

21 MR. HACKBARTH: Yes, that's an interesting
22 question. I don't know.

1 DR. NAYLOR: A great report. I'm wondering about
2 the intersection of this service and the evolving home
3 health or medical homes where it's expected that those
4 practices provide care coordination and access. So would
5 primary care providers who are part of systems that have
6 said we are medical homes and are receiving support either
7 through a CMS demo or other be able to legitimately stand as
8 a concierge -- excuse me, retainer doc?

9 MS. HARGRAVE: The thing that we're really using
10 that -- the retainer to represent is that you're paying that
11 extra amount for it. So to the extent that the extra
12 payment to the physician for the medical home is --

13 DR. NAYLOR: For the same service [off
14 microphone].

15 MS. HARGRAVE: For similar services, but not
16 necessarily coming from the patient for that. I don't know
17 whether they'd meet the definition.

18 MS. BOCCUTI: Well, I'll add to that. Last year
19 when we were doing some focus groups and we were asking
20 about access and we had physicians and talking about their
21 acceptance of patients for Medicare and other insurance
22 types, and then we were asking them about -- we had primary

1 care physicians in these focus groups, and we were -- they
2 brought up the issue of concierge care. And I remember
3 vividly one of the primary care physicians saying, "Really,
4 this is a medical home, you know, and I wish we could be
5 charging" -- you know, knowing that there are these fees and
6 sort of creating kind of a comparison to if it were a
7 medical home and you could get fees through that kind of
8 venue without being considered concierge.

9 So I think people have made that sort of -- some
10 people have made a parallel there, which is what I think
11 you're getting at.

12 DR. CHERNEW: This is about Slide 9, which gives
13 the numbers of people. That's actually not just Medicare
14 people, right? Those numbers -- I just want to clarify.
15 That's all people, the 100 to 400 people in their practice
16 they want --

17 MS. HARGRAVE: Yes, right.

18 DR. CHERNEW: And is your sense that most of them
19 are actually not Medicare beneficiaries?

20 MS. HARGRAVE: So it really varied among the
21 people that we talked to. There was one practice that said
22 they had about 60 percent Medicare beneficiaries, and

1 another was more like 20 percent, so it really varied. So
2 some percentage of the 400, 600 patients is Medicare, but
3 not all.

4 MR. HACKBARTH: There does seem to be this
5 disconnect between the amount of publicity and the numbers,
6 and I'm not sure what to make of that, although coverage
7 doesn't always equate with, you know, the actual number of
8 problems. In fact, we've seen some of that in our own
9 research about Medicare beneficiaries having problems with
10 access where there seems to be more coverage of it than our
11 survey data might suggest.

12 But set that aside for a second. The potential
13 revenue here, as Nancy and Bruce were pointing out, is
14 really quite large, if you're talking, you know, 500
15 patients at a thousand bucks each, \$500,000 in revenue for a
16 practice in addition to your fee-for-service revenue. Those
17 are amounts that are sufficiently large even if you share
18 them with, you know, a company. That might cause people to
19 think twice about the model, and even if you can only get
20 200 patients to do it.

21 And so this phenomenon is something that I think
22 needs to be taken seriously. I guess my fear, my worst fear

1 -- and I don't know how realistic it is -- is that this is a
2 harbinger of our approaching a tipping point where you have
3 this huge price discontinuity between what people can get
4 through this model and what they can get by continuing to
5 practice in Medicare. And at some point this discontinuity
6 is going to resolve itself, and it probably won't be in
7 favor of people staying in Medicare. There's too much money
8 to pass up. And you combine that with, as Bob was pointing
9 out the other day, you know, we've got a large cohort -- Ron
10 has made this point -- a large cohort of physicians nearing
11 retirement, and the nightmare I have -- and, again, I don't
12 know how realistic it is -- is that a couple of these things
13 come together, and you could have a quite dramatic erosion
14 in access in a very short period of time. So that's my
15 nightmare.

16 It's a tricky question. If you're worried about
17 that, what you do about it with the policy levers, you know,
18 I've heard some people suggest that maybe the thing to do is
19 to prohibit concierge practice for anybody who wants to be
20 involved in Medicare, so you can't do the fee-plus model et
21 al. and be in Medicare, although my fear about that is that
22 you might be shooting yourself in the foot and making the

1 problem even worse and just drive people out of Medicare
2 altogether and compound a developing access problem. So I
3 think this is a very important phenomenon to try to
4 understand better than we now do.

5 Let's open it up to other round two comments.

6 That was mine.

7 DR. BORMAN: First a question, Elizabeth. Did you
8 get any sense for numbers of individuals who might have
9 closed their retainer-based practice? Because I think --
10 and I imagine that number might even be harder to come by.

11 MS. HARGRAVE: I think so. When we were doing our
12 literature review, we did come across a few news stories of
13 folks that hadn't been able to make it, and one of the 16
14 physicians that we spoke with was sort of not -- didn't have
15 as many patients as he wanted and was really wondering
16 whether the town he was in was large enough to really find
17 enough patients willing to pay the retainer fee.

18 DR. BORMAN: And I think that that may speak a
19 little bit, Glenn, to your concern, albeit it doesn't
20 entirely mitigate it. This seems like something that is
21 really going to have -- is going to be a very niche thing in
22 some fairly sharply defined geographic locales. And that

1 doesn't necessarily make it okay, but it certainly, I think,
2 will limit the market a bit. And I think as more and more
3 people get in the market, more and more people will
4 encounter this problem being able to sustain this kind of
5 practice, and it will to some degree become self-defining.

6 I personally think that maybe one of the take-
7 homes from this is the repetitive comment of people's
8 enjoyment of their practice. And I think one of the things
9 that tells us is that some of the conversations where we
10 have talked about the medical home and primary care, whether
11 it's provided by a physician or other qualified health care
12 professionals, is that we need to make the provision of
13 primary care services something that's professionally,
14 personally rewarding and less hassled, that that counts for
15 a lot, because these people, depending on how you do the
16 math and what these companies are really getting, may or may
17 not in the end be getting huge increments of their prior
18 practice amounts, but what they are getting is presumably
19 less hassle and more time. And those are two of the ways
20 that you can reward physicians.

21 So I do think there is an important take-home
22 message here for the bigger world that the things that can

1 be done to make primary care service provision more
2 streamlined and more pleasurable for the provider to provide
3 are -- that's a take-home message from here that will
4 withstand all the other stuff.

5 I also think that the regulatory piece of this --
6 I mean, I certainly would be worried as hell about the IRS
7 showing up at my door, or the OIG or somebody, and so I
8 probably would turn tail and run on this pretty quickly, you
9 know, once I got encouraged by my lawyer to do something
10 because I'm basically a chicken and I don't look good in
11 orange and white stripes. But, you know, I do think there
12 are things that will self-limit this, but I think there is a
13 take-home message.

14 DR. DEAN: Yeah, I had some of the same questions
15 that Karen just raised. I wondered about the potential size
16 of the population that would enroll in this, and I suspect
17 it's relatively small and localized in certain areas. But
18 the other interesting thing is, as I looked at this, I said,
19 too, that's a medical home. And I'd be curious to have
20 Scott comment on this because this is very similar to what I
21 think Group Health did with your one clinic that got all the
22 attention in Health Affairs. And I think the interesting

1 result of that is that, yes, the investment on the front end
2 was higher, whether you call it a retainer or whatever, but
3 the overall cost for those patients that were involved in
4 this approach to care was significantly less. And so it
5 would be interesting -- I don't know that this is the model
6 we'd support, but the idea that by adding these additional
7 services you both improve the experience of both provider
8 and patient and save money at the same time is certainly a
9 very appealing idea. Does that fit, Scott, with your
10 experience?

11 MR. ARMSTRONG: So just briefly I would say to
12 your point I have really, frankly, mixed feelings about
13 this. On the one hand, we see these practices creating many
14 of the elements of primary care that are the very elements I
15 think we should be advancing. In our practice, we've
16 created these very elements turbo-charged, you know, in 26
17 medical centers and demonstrated that we're driving better
18 health outcomes, lower medical expense trends, and our
19 primary care providers are as happy as these doctors are.
20 They're probably not making as much money, but -- and so to
21 your point, there's elements of this that are really
22 exciting. I think my biggest concern and the reason, Glenn,

1 I would agree with you that we should be looking at this is
2 that these are practices set up to achieve different goals,
3 and I think many of the goals that we are responsible for
4 aspiring to. They're not goals that overall are intended to
5 lower the medical expense trends or improve the overall
6 outcomes for populations of patients. And I think that's
7 the closest I can get to the nutshell on what is my issue
8 with this, despite the fact we've demonstrated these are, I
9 think, really close to what the future of primary care ought
10 to look like.

11 DR. DEAN: Yeah, I mean, I'm very troubled by the
12 sort of elitism that goes along with this, and those things.
13 But the core issues, I think there's something to be learned
14 there.

15 MR. HACKBARTH: It would be interesting, actually,
16 to delve into that, if possible, and it may be impossible
17 because there's so much diversity among the retainer-based
18 practices and what they do. But it does seem, as Scott
19 says, that the initial goal is quite different. And, thus,
20 many of the activities, I think, that Group Health
21 Cooperative is doing in terms of team-based practice and the
22 like are not necessarily found in a retainer practice, which

1 at least in some instances based on press coverage seems
2 just to emphasize more ease of access or longer face-to-face
3 appointments as opposed to active treatment of -- you know,
4 active outreach and all the things that are inherent in the
5 Group Health model.

6 So my basic point is I agree, you know, it would
7 be interesting to see if we could do more of a comparison.
8 Are these basically the same thing just by a different name?
9 I think maybe not, but I'm not sure.

10 DR. DEAN: I think they're not completely [off
11 microphone].

12 MR. HACKBARTH: Yeah.

13 DR. BAICKER: It seems as though we care about
14 this issue for two primary reasons. One, there's an issue
15 of equity across Medicare beneficiaries, and, two, there's
16 an issue of access if the take-up of this by wealthier
17 beneficiaries then crowds out availability of doctors to
18 lower-income people. And they have different ramifications
19 over the short run and the long run.

20 The equity issue, in some ways we don't spend a
21 lot of time and energy worrying about rich people consuming
22 more of stuff in general as long as we think low-income

1 people have an adequate, reasonable set of health care
2 consumption available to them. So I worry about the
3 availability of care for low-income people. If high-income
4 want to go buy lots of extra services, I don't think we're
5 in the business of stopping that. So whether it's a
6 regulatory issue, are these providers extracting more money
7 from the Medicare system than law entitles them to is a
8 separate question. Assuming that that's okay, then I worry
9 less about the inequities across income -- that happens for
10 all sorts of goods, and we can't end income inequality
11 through this program.

12 The issue of access seems like a short-run problem
13 to me insofar as capacity doesn't adjust. So if you have a
14 fixed number of providers and we're worried about low-income
15 people being crowded out, I don't know then if this really
16 morphs into an issue about access to primary care -- you
17 know, capacity of primary care. Is this a workforce problem
18 where there aren't enough physicians to meet the demands?
19 Or is this really a payment issue that we should be worrying
20 about high-income people consuming too much?

21 MR. KUHN: When I read this paper and when I
22 listened to Elizabeth's presentation, my comments are quite

1 similar to what Karen was sharing earlier, and that is, this
2 does really seem like a niche market at the present time,
3 you know, when you look at the numbers that you put out
4 there. If you look at the 756, if that's the total number -
5 - and that number, I'm sure, could move a little bit --
6 that's only one-tenth of 1 percent of all physicians in this
7 country, so it's very, very small. It's very much a niche
8 market.

9 But as I kept reading the paper and listening to
10 the conversations here, what I keep thinking about is that -
11 - so it's hard for me to draw any conclusions, you know,
12 when it's only one-tenth of 1 percent of the market. But I
13 think the one conclusion I do come to is, like Karen said,
14 that we ought to be figuring out what is it that people like
15 about this and how do we begin to incorporate some of those
16 features into the program overall as we think about the
17 other payments out there. So I think if there is one take-
18 away, I think Karen really nailed it, that I think that's
19 it.

20 DR. BERENSON: Yeah, I agree. I see this as a
21 sort of a canary in -- what is it? -- the mine, something or
22 other --

1 PARTICIPANTS: Coal mine.

2 DR. BERENSON: Coal mine, that's what it is. That
3 in and of itself I don't think it's a big deal, but as you
4 sort of laid out earlier, this combined with other factors
5 could -- we could hit a tipping point where docs opt to do
6 any number of other things.

7 There's another model called the Ideal Medical
8 Practice, which also not too many docs have signed up for.
9 This is within insurance. They're not charging any
10 subscriptions, but basically it's doctors with a very
11 sophisticated electronic health record who have no staff and
12 have much lower overhead, and that's how they get time with
13 patients, so they don't have to see nearly as many patients
14 a day. And we don't -- I think it would be important to
15 sort of be relatively open-minded and try to get some
16 empirical data on sort of the relative merits of going in
17 various directions, sort of the team-based approach where
18 the doctor -- everybody's practicing to the top of their
19 license, and the doctor, the physician is really not seeing
20 all patients all the time, to the other extreme where the
21 doctor, only the doctor is seeing all the patients all the
22 time. And my hunch is that both models are probably

1 producing better results than the status quo, which is the
2 hamster on the treadmill phenomenon.

3 I think Group Health, if I had to pick, Group
4 Health is doing it the right way, free up the doctor to have
5 more time and also have a team. But I think we have -- in
6 the specifics of how do we define a medical home, I think we
7 are looking for outcomes more than we should be sort of
8 defining here's what you have to have in place.

9 There's no question that a concierge practice, the
10 Ideal Medical Practice, would fail NCQA, and yet they might
11 be producing pretty good results. So it's another example
12 of where we really need to just sort of look for what the
13 outcome or outputs we want and be a little less prescriptive
14 on exactly how you get there.

15 MS. BEHROOZI: Just briefly, I wanted to highlight
16 a comment that you made on page 8 where you say that a
17 couple of doctors mentioned that they review their patients'
18 medications. And I wrote next to that, wait a minute.
19 Isn't that basic medicine? I mean, since when is this the
20 extra. And I don't even mean, you know, the extra that
21 Medicare doesn't pay, but just the notion is kind of
22 flipping the medical home discussion that people are having

1 about whether this kind of stuff really belongs in a medical
2 home.

3 The flip side of that is that if you let -- if we
4 let too much of this stuff become the extra or the upper-
5 tier care, then what becomes basic care is really eroded and
6 you really have the danger of becoming a two-tiered system.
7 But we're not close to that yet. I realize that there are -
8 - it's only 756 doctors. But that really struck me.

9 MR. BUTLER: So my own anecdotes. I know, I
10 think, six of these primary care physicians, so I must know
11 1 percent of the total.

12 [Laughter.]

13 MR. BUTLER: And they all fit the same profile
14 that the MDVIP -- about 2,000 patients, and they went to
15 600, and they've never been happier. And they would make
16 the argument -- and I've seen some of this firsthand --
17 that, look, we were -- almost all these are private
18 practitioners, so if you're already employed, they're not
19 vacating employment to do this. These are successful, good
20 internists who have been chasing the ancillary dollars and
21 been very busy, whether they're doing bone density in their
22 office or trying to get a piece of that ancillary or this to

1 make a little bit more for how hard they're working, they
2 say enough. And this transition has actually changed their
3 lives in many cases, and they do -- I know, I've seen it.
4 They do spend time. They make phone calls that they don't
5 charge for. They even make home visits. And, yes, I've
6 seen them go over the medications to help manage the cost of
7 it, not, you know -- and so \$1,500 sounds like a lot -- and
8 it is, and, you know, I'm irritated by it in the same way.
9 But, you know, often people pay a lot more than that out-of-
10 pocket. And so I've seen -- gee, you know, I was a real
11 doubter, and believe me, have these on your staff, and now
12 you have 1,400 patients without a primary care physician.
13 It is a short-term problem. But it does shine some light on
14 what makes a physician -- and they haven't, you know,
15 backfilled and said now I'm going to see a lot more of
16 others. They've taken on a different lifestyle and a
17 different approach to their practice.

18 MR. HACKBARTH: That all makes sense to me, and I
19 also wouldn't get too, too comfortable saying, well, it's
20 going to be a niche product at \$1,500. You know, markets
21 are dynamic, and the price may come down to \$1,250 or
22 \$1,000, and they'll start searching for what sucks enough

1 customers into the system. And then when that starts to
2 happen and it affects the access for other people, then the
3 willingness to pay will start to go up as people start to
4 feel their access eroding because more and more people are
5 going into this.

6 So where the equilibrating price is, I don't know.
7 I wouldn't get too comfortable that we've seen sort of the
8 dimensions of what the market for this are at this point in
9 time. There could be a lot of adjustments on both the
10 supply and demand sides. Now Mike will correct everything I
11 said.

12 DR. NAYLOR: I just want to switch this to the
13 beneficiaries' perspective, and I think beneficiaries should
14 expect, all beneficiaries, really excellent primary care
15 services. And, you know, we ought to figure out what are
16 the policy levers to make sure that everybody has access to
17 that. So I think that there are multiple models to
18 achieving that, but I think that constantly focusing on the
19 performance of the system to meet all beneficiaries' needs
20 ought to be our goal. And I hope that we'll look toward all
21 of the transformational policy drivers that achieve that for
22 everybody. So to me, everybody deserves really excellent,

1 well-integrated, well-coordinated primary care services, and
2 we ought to be figuring out how to make sure everybody gets
3 it rather than focusing on the model or the providers of
4 those per se in the current system. I think that there will
5 be multiple providers and multiple systems providing this
6 going forward.

7 DR. CHERNEW: I agree completely with that, and in
8 the spirit of what Glenn said, I think we've recognized for
9 a while that there was a concern about insufficient numbers
10 of primary care physicians, and I think we've recognized
11 through a number of actions that improving the fees that
12 primary care physicians make would help alleviate that. And
13 this is one way that I think at a minimum, looking at it
14 from the outside, it disciplines the market to do that. And
15 the big challenge is to make sure that we have enough chance
16 to react should the Hackbarth nightmare come to pass, but I
17 don't think there's anything inherently wrong with a world,
18 if primary care is valuable and they can earn more providing
19 better care and not doing a bunch of ancillaries to think
20 that that gives us some idea of how we might achieve a
21 longer-run goal of changing the distribution of what
22 physicians are. And I actually think if you could really

1 make some of the money -- we shouldn't think of the set of
2 physicians as just a fixed group of people, you know, X
3 number of primary care physicians, and that's just all we
4 have.

5 I think you'll see -- post Medicare you saw a
6 bigger response in terms of physicians coming in and not
7 coming to various places to satisfy the demands. I think it
8 just gives us some idea of what you would expect would
9 happen if the problems we identified earlier were, in fact,
10 real. So I guess they were.

11 DR. CASTELLANOS: I have a lot to say. Mike, you
12 taught me something. Patients -- and I wanted to jump in on
13 Level 1, but I really couldn't because I didn't have any
14 clarification.

15 I live in Fort Myers, which is right next to
16 Naples, and Naples is a community of 300,000 people with
17 about --

18 MS. HARGRAVE: Sixteen.

19 DR. CASTELLANOS: They have an excess number of
20 this, and we have them in our community, too. And what I'd
21 like to do is give you a physician perspective, and
22 something that Mary started doing, a patient perspective.

1 As a specialist, I deal with a lot of these VIP
2 patients, and quite honestly -- and I don't mean this to be
3 critical -- they have unrealistic expectations. As soon as
4 they come in the room, they want my cell phone number, and
5 they want to know if I can call their brothers and their
6 uncles and their neighbors and stuff like that. And I try
7 to do this to every patient, but I usually don't give out my
8 cell phone number. For the specialist, there's been some
9 issues.

10 Now, as far as the primary care, I can tell you in
11 my community there is an access problem, and especially in
12 the wintertime when there's a tremendous influx of new
13 patients coming in and snowbirds coming in.

14 And, Nancy, you said something about a year ago,
15 and I think your parents live in Naples. You said, you
16 know, there are spots in this world where there's access
17 problems, and this is one of the spots. There is an access
18 problem to primary care.

19 What I'd like to do is -- what I did is I talked
20 to a lot of the doctors in our community about this, seeing
21 this on the -- and I'd like to share an e-mail with you,
22 whoever would like to have it. This is a group of

1 internists that Peter talked about, quality guys, older
2 people, excellent physicians, don't have any ancillaries.

3 Can you put up Slide 11 just for a second?

4 You know, I spoke to them and I said, "What do you
5 think?" They said, "Well, you know, Ron, I'm getting tired.
6 With this SGR uncertainty, the proposed cuts, the unfunded
7 mandates. You know, maybe it's time I should do something
8 like this." And what they did -- and I'll share this with
9 you, and it's not a scientific study, but they went ahead
10 and looked at their patients and sent out a letter to their
11 patients saying that we're thinking about going to this and
12 we will have a retainer fee on a monthly basis. Now, it's
13 not \$1,500, but it was a figure of somewhere around \$50 to
14 \$100 a month. And they said that 55 percent of their
15 patients liked that idea so they could get access, so they
16 could have the doctor's telephone number.

17 So when you're a 75-year-old male or female with
18 lots of comorbidities, you're living in a home by yourself,
19 your kids aren't there, you're frightened, you have a
20 telephone access. You have care that you can depend on. So
21 I think there is something where the beneficiary really
22 looks at this.

1 Now, there's a couple other issues that I'd like
2 to say. You know, I don't like the idea of concierge
3 medicine. I think it's something that we should all be
4 providing to every patient all the time. But it's
5 unrealistic to expect every primary care doctor to do that,
6 especially being the hamster on the treadmill. But I think
7 this may be an elephant in the room because I think patients
8 really want something like this. And if we're not going to
9 provide that in our health care delivery system, then the
10 patients are going to go out looking for it. And if we
11 can't provide the things that a physician wants to be able
12 to practice medicine the way he or she was trained, to have
13 less stress, less burnout, and not have this SGR debacle and
14 the proposed cuts as a threat, I think there may be
15 something here.

16 You know, there's another group of people that you
17 haven't looked at, and I see it in my specialty, and I'm
18 not sure if Karen sees it in her specialty. But we have
19 people that feel they're experts, and when you go there,
20 they drop out of Medicare, and when they do this surgical
21 procedure, you know, the sky's the limit. And this is
22 really concierge medicine because they're doing this as a

1 specialist and as surgical -- I know a lot of the plastic
2 guys do it, and I know some ENT guys that do it. But I
3 think that's another group of people you haven't looked at
4 as concierge medicine-type people.

5 My last and final comment is that we do need these
6 comparison studies looking at cost, volume of services, and
7 quality of service and, more important, access. Thank you.

8 MS. UCCELLO: Yeah, building on many comments,
9 Kate's and others', thinking about this in terms of both the
10 equity and the access, I think it's important to think about
11 this not just in terms of the primary care but also what the
12 ramifications are for the specialty care. And, you know,
13 maybe we don't care if somebody has a lot of money and they
14 want to buy some extra time with the primary care doc and
15 get all these extra tests and that kind of stuff. Well, if
16 that's how they want to spend their money, fine, and if
17 there's no access issues that come down on the primary care
18 side, fine.

19 But now what happens when all the test results
20 come back that may not have been needed and there are false
21 positives or whatever? What's the impact then when they go
22 to the specialists? You know, what is that doing on the

1 cost side, what's that doing on the access side of the
2 specialty docs? Just thinking about it on that side, too, I
3 think is important.

4 MR. HACKBARTH: So there are different ways that
5 you can look at this issue. One is through sort of a
6 normative approach: Is this the way medicine ought to be
7 practiced? Is it equitable for different classes of
8 patients, et cetera? And that's important, legitimate, and
9 a discussion worth having.

10 Another way of looking at it is sort of the way
11 that Mike was describing. Look at this as -- about market
12 signals. What is it signaling in terms of patient
13 preferences, provider willingness to provide service at
14 different prices?

15 I am interested in both conversations, but I'm
16 especially interested in the latter conversation about what
17 the market is signaling and, in particular, wish to avoid
18 Medicare getting behind the curve and in a very abrupt and
19 disruptive way finding that our price is even further out of
20 line than we may have thought, and that access to primary
21 care is going to be even worse than we had assumed for a
22 variety of other reasons.

1 And so, you know, we have proposed and now
2 Congress has adopted steps to help increase payment for
3 primary care, but what this sets me to wondering is whether
4 we are basically, you know, fiddling when things are about
5 to get dramatically worse. That's not an assertion that I
6 know that they will or I believe they will. But that's my
7 fear, that we're behind the curve in terms of the policies
8 that we're looking at.

9 That's my concluding thought on this.

10 DR. DEAN: To me the bottom line is that primary
11 care has to be restructured, and I think that all these
12 different models tell us that.

13 It reminds me, a couple years ago, the New England
14 Journal brought together a panel of specialists and people
15 with a special interest, and they did a session on
16 restructuring primary care. And most of these same issues
17 came out of those discussions. The one statistic I remember
18 is Tom Bodenheimer from California had done the
19 calculations, and he said if the average primary care doc
20 with 2,000 patients in his panel did everything that was
21 typically expected of him, he works 18 hours a day.

22 MR. HACKBARTH: Right.

1 DR. DEAN: And I think that sort of sums it up,
2 where the burnout comes from, and it needs to change. I
3 think we're seeing different models of how it might change,
4 but it needs to change.

5 MR. HACKBARTH: Yeah. And I like the way you
6 framed it in your earlier comments, Tom. If you put more
7 money into primary care, some of it may go to increased
8 take-home pay for the physician. Some of it may go into
9 practice supports that make the job more doable than it
10 seems today.

11 And, you know, the medical home model is in part
12 at least based on the philosophy let's invest more in it,
13 not necessarily to dramatically increase the take-home pay.
14 I don't think that's what's happening at Group Health, but
15 the resources are being invested to make the job more
16 doable, sustainable, attractive to physicians in training.

17 You know, all of this conversation has set me to
18 thinking that maybe we need to rethink what we've said about
19 the medical home. When we talked about medical home, you
20 know, a couple years ago now, it was, well, let's test and
21 see if it saves money; you know, whether the hypothesis is
22 true that if you invest in medical home there will be fewer

1 specialty referrals, fewer avoidable hospital admissions, et
2 cetera.

3 Well, you know, that would be really nice. On the
4 other hand, it may be that even if it increases money, you
5 need to do it in order to make the job doable, to keep
6 people in primary care practice, let alone attract new ones
7 to it. And it may be the savings model, which is actually
8 what's built into the reform law, as I understand it, let's
9 do a pilot to see if it saves money. It may be the wrong
10 way to think about the medical home project.

11 DR. BAICKER: Just to build on both what you were
12 saying and what Mary was saying, it is a sad commentary that
13 we're thinking of extra services as being able to talk to
14 your physician within a couple of days of needed to, doesn't
15 seem like it should be the bells and whistles. How this
16 influx of money into primary care from a limited segment of
17 the population affects the whole system in terms of prices
18 being adequate to gain that kind of access I think is
19 inherently tied up with entry into the profession.

20 For a long time, we sat around bemoaning the fact
21 that there wasn't enough money in primary care, and now a
22 bunch of money is coming into primary care, but it's coming

1 in a very funny form. And so how that extra money filters
2 through into increased entry into it and, therefore, access
3 for other patients and, therefore, the market equilibrating
4 price so that people get the baseline services that we
5 consider reasonable baseline can't be evaluated without
6 evaluating the workforce entry issues, I think.

7 DR. MARK MILLER: I know we're out of time, but
8 just a couple of things. Some of the comments on medical
9 home sort of leave me with this thought, because, I mean,
10 there are pieces here sort of concluding that this is
11 necessarily -- and I think this came out in some of the
12 exchange here. Medical home I think is kind of
13 questionable. In some ways, it seems like you can just boil
14 down those comments, and particularly your last comment, to
15 well, then, maybe it just means more needs to be paid to
16 primary care physicians. I mean, at least as a first step.
17 And, you know, how much the medical home goes along with
18 that is a second question.

19 MR. HACKBARTH: Well, the medical home does two
20 things. One, more is paid, but it's also paid in a
21 different way. To get the more, you don't have to do more
22 visits and more services. It's paid as a per month payment

1 per patient, which allows you to build infrastructure with
2 it as opposed to, you know, just chase it.

3 DR. MARK MILLER: And fair enough, but I think
4 what these models do is they make that payment. They don't
5 necessarily bring the rest of the infrastructure along with
6 it. My only point is that the first lesson of this may be a
7 payment lesson, which is sometimes what I hear on some of
8 this exchange. And then it's a second question of whether
9 the infrastructure is something that we want, and want in a
10 certain way, team or individual physician, and is there a
11 way to get that, or whether you can get some effect from the
12 pay -- the change in pay, both either in level and form in
13 and of itself. But it's just the kind of marrying those two
14 things -- we should be very careful and not necessarily, in
15 my opinion, treating this as a medical home.

16 And I had one other question for Ron, which was
17 this: You talked about what your patients who came from
18 these practices said. You know, they had higher demands and
19 that type of thing. Did you find any greater coordination
20 with the physician who sent them?

21 DR. CASTELLANOS: Yes, I did. He sometimes or she
22 sometimes even came with the patient.

1 DR. MARK MILLER: Did what? [Off microphone.]

2 [Laughter.]

3 DR. CASTELLANOS: Came to the office for the
4 office with the patient. The physician.

5 DR. MARK MILLER: I got to hear this again. You
6 said --

7 [Laughter.]

8 DR. CASTELLANOS: He was really trying to figure
9 out how to do it.

10 MS. HARGRAVE: That's something that we heard in
11 our interviews, too, that it's a service that several of the
12 people that we interviewed offered, that they will go to
13 specialty visits with their patient.

14 MR. GEORGE MILLER: But, you know, we sit here and
15 listen to this, and we laugh at something that's funny, but
16 the market has figured out a way to do this right. I mean,
17 if you read that slide there and why this is being done, the
18 market has figured out that I need less patients, amount of
19 money, and I can give better service. Instead of us
20 figuring out how to do this, maybe we ought to listen to
21 what the market says works right. And, again, what Tom just
22 said I think says it best. It's the right amount of money

1 with the right amount of patients being able to give the
2 right amount of care. And you don't have all the things in
3 Slide 11, so maybe that's a lesson we learn.

4 Like his panel, I have a panel also. I live in a
5 neighborhood where all of my neighbors are physicians, and I
6 see them leaving, and they tell me all of the problems with
7 the system in my driveway.

8 [Laughter.]

9 MR. GEORGE MILLER: And it's mostly these things.
10 They're overworked, they've got too much to do. And Tom
11 said if they did everything right according to what
12 everybody requires, it's 18 hours a day. That's not
13 practical. And maybe we ought to focus on what's right and
14 try to design a system around that.

15 DR. BORMAN: Again, I support that there are
16 important messages we take out of here. I want to come back
17 to something Herb said, though. In the last wave of
18 enthusiasm, you're making me real nervous about drawing
19 sweeping, huge conclusions from 0.1 percent of people. And
20 I just want to be real careful that we do this in a way to
21 pull out what's important and what's appropriate. There's
22 nothing here we've heard, there's nothing here about

1 relating to quality measures, about relating to outcome. I
2 mean, not just the infrastructure, which you've
3 appropriately highlighted, but the other thing -- and I know
4 you don't mean to imply that, but I'd want to be real
5 careful about readers of this or listeners to this, you
6 know, be a little bit skeptical here that in our enthusiasm
7 that we don't get carried away, that we work very hard to
8 objectively identify what are some take-home things that we
9 can make better about this, but that we just be a little bit
10 careful. You know, I can see the headline now: "MedPAC
11 endorses concierge medicine for all." Just be a little bit
12 careful here.

13 MR. HACKBARTH: Thank you, Karen. That's a very
14 important concluding comment for people in the audience.
15 There is a shortage of facts. And thank you, Elizabeth, for
16 bring at least some basic ones to bear, and we need more
17 thoughtful analysis before we leap to any conclusions or any
18 policy recommendations.

19 So thank you again, and let's move on to our next
20 topic, which is clarifying Medicare's authority to apply
21 least costly alternative policies, a topic we last talked
22 about in the spring.

1 MS. RAY: Good afternoon. As a Commission, you
2 have raised concerns about enhancing Medicare's ability to
3 innovate. In 2009, the Commission raised concerns about the
4 pace of Medicare's demonstrations. Most recently, in our
5 June 2010 report to the Congress, Commissioners discussed
6 that Medicare might be able to improve health care, quality,
7 and efficiency if it were given broader authority to
8 demonstrate and implement new delivery models. The
9 Commission also voiced concerns about the level of resources
10 allocated for the development of policy innovations.

11 As we push Medicare to be a more intelligent
12 purchaser, Commissioners also raised concerns about
13 Medicare's flexibility to use innovative purchasing
14 policies. In the June 2010 report, Commissioners discussed
15 several purchasing policies that have the potential to
16 increase the value of the program that Medicare lacks clear
17 authority to implement.

18 I am back here today to talk about one specific
19 policy that we raised in the June 2010 report and that is
20 called least costly alternative policies.

21 Under least costly alternative policies, or LCAs,
22 payment for a group of clinically similar services is based

1 on the least costly item. LCA policies do not require any
2 new or additional collection of pricing data. Medicare uses
3 existing statutory payment formulas to set the payment rate
4 of a group of clinically similar services.

5 When applying least costly alternative policies,
6 it is necessary to assess the evidence on whether a service
7 is clinically similar to one or more other services. By
8 setting the rate based on the least costly item, least
9 costly alternative policies have improved payment accuracy.
10 This, in turn, has resulted in savings for beneficiaries,
11 the 20 percent cost sharing for Part B services, as well as
12 savings for taxpayers and the program.

13 Medicare's administrative contractors have applied
14 least costly alternative policies for durable medical
15 equipment items and Part B drugs in their geographic
16 jurisdictions since the mid-1990s. In one instance, CMS
17 implemented a least costly alternative-type policy
18 nationally to pay for two biologics under the Hospital
19 Outpatient Prospective Payment System in 2003.

20 We anticipate that opportunities to apply these
21 policies will increase as more clinical information becomes
22 available.

1 Your mailing materials included a case study about
2 two drugs that treat advanced eye disease. There may be an
3 opportunity to apply a least costly alternative policy in
4 the future once a head-to-head NIH study that is comparing
5 these two drugs is completed in 2012. Currently,
6 researchers have estimated the difference in Medicare's
7 payment rate per dose at \$2,000 per dose for one drug versus
8 \$50 per dose for the other.

9 Medicare has applied least costly alternative
10 policies based on the statute's "reasonable and necessary"
11 provision that no payment may be made for any expense that
12 is not reasonable and necessary for the diagnosis or
13 treatment of an illness or injury. Recently, a beneficiary
14 challenged the use of a least costly alternative policy to
15 pay for a Part B inhalation drug. The U.S. District Court
16 agreed with the plaintiff's argument that Medicare must
17 follow the detailed statute in paying for Part B drugs. The
18 court concluded that the Secretary exceeded his authority in
19 applying least costly alternative under the reasonable and
20 necessary authority.

21 Health and Human Services appealed this ruling and
22 the Federal Appeals Court agreed with the lower court

1 decision, finding for the plaintiff. Since the appeals
2 ruling, Medicare's contractors have formally withdrawn the
3 least costly alternative policies for Part B drugs.

4 Therefore, we are here today for you to discuss a
5 policy option of giving Medicare the authority to apply
6 least costly alternative policies to Part A and Part B
7 services. Using this clear statutory authority, CMS could
8 develop a systematic process to consider and implement least
9 costly alternative policies. Such a statutory change could
10 be coupled with a requirement that the program evaluate
11 opportunities for its application. For example, the statute
12 might require that CMS assess the clinical similarity of
13 existing services and two newly-covered services.

14 You might want to consider this option because in
15 the past, CMS has always not been able to use new
16 flexibility. Your mailing materials included a case study
17 of a pricing flexibility called inherent reasonableness that
18 CMS has used only once.

19 A policy option of giving Medicare authority to
20 use least costly alternative policies could be linked to a
21 policy option that ensures that a clear and transparent
22 process be developed for applying these policies.

1 Characteristics of the process included being clear and
2 transparent, permitting opportunities for public input and
3 comment, identifying and defining groups of clinically
4 similar services, ensuring access to the most costly service
5 if it is medically necessary, and just as an aside, the
6 current process does include this, and permitting a
7 beneficiary to gain access to the most costly service if
8 that is his or her preference. Again, the current process
9 does include this feature.

10 I want to emphasize that this new flexibility is
11 not intended to impede patient access to necessary care.

12 So this is an illustrative example of the steps to
13 apply a least costly alternative policy, and in this
14 illustrative example, we're looking at a new service.

15 And so first you would want to determine whether
16 or not it falls into a Medicare benefit category, and if it
17 does, is it reasonable and necessary. And if it is, then
18 you would want to determine whether or not it's clinically
19 similar to existing services. And then the rate for that
20 service, if it was clinically similar to one or more
21 existing services, would be set according to the statutory
22 formulas, but based on the least costly item. Again, as I

1 mentioned previously, this would not require any new
2 collection of pricing data.

3 So to implement this authority, the Secretary
4 could use existing infrastructure developed under the
5 coverage and payment processes or the Secretary could
6 develop a new pathway or some combination of both. This
7 slide summarizes some features of the current coverage and
8 payment processes.

9 For example, on the coverage side, there is a
10 specific opportunity on the national coverage side for
11 stakeholders to make a request for an item or service or
12 product to go through the national coverage process. On the
13 payment side, that process is usually started by CMS,
14 sometimes because of a Congressional mandate.

15 In terms of implementation, coverage policies are
16 most frequently implemented locally, but also nationally, as
17 well. By comparison, payment policies are usually
18 implemented on a national basis.

19 In terms of transparency, both coverage and
20 payment policies have opportunities for notice and comment.
21 The difference is payment policies most frequently, of
22 course, go through the Federal Register process. On the

1 coverage side, they go through an online process where
2 either CMS or the contractors post draft policies online.

3 In terms of formal technical advice, that tends to
4 be a little bit better developed on the coverage side. On
5 the national coverage side, CMS can sponsor external
6 technology assessment, sometimes through AHRQ, or seek
7 advice on clinical topics through the Medicare Evidence
8 Development and Coverage Advisory Committee. On the local
9 coverage side, the Medicare contractors can -- are required
10 to consult with the Carrier Advisory Groups, or now they're
11 called the Contractor Advisory Groups.

12 On the payment side, this formal process for
13 getting external technical advice is a little less
14 developed. There is, however, on the hospital outpatient
15 side the Advisory Panel on Ambulatory Payment Classification
16 Groups.

17 So to close on this slide, again, the Secretary
18 could build upon these processes or develop new processes or
19 some combination of both.

20 So to summarize, least costly alternative policies
21 have improved payment accuracy, and this in turn has
22 resulted in savings for beneficiaries, taxpayers, and the

1 program. Their legal foundation, the Secretary's legal
2 foundation to apply them is unclear, and future
3 opportunities to apply them will increase as more clinical
4 information becomes available. We seek comments about the
5 policy options that we have discussed and any additional
6 research that you'd like.

7 MR. HACKBARTH: Let's begin on this side with
8 clarifying questions. Cori and then Ron.

9 MS. UCCELLO: Okay. I'm just a little confused on
10 what kind of the options are. Is one option still to do
11 this through the coverage determination process and another
12 through the payment process, or is it everything through the
13 payment process but using some of the coverage stuff?

14 MS. RAY: Well, I think even to back up from there
15 would be if just looking at Slide Number 6, one way to go
16 about this is to give the Secretary the authority to
17 implement least costly alternative and then you could --
18 from there, you could leave it to the Secretary to decide
19 the pathway to do that.

20 DR. MARK MILLER: Do you want me to pick up,
21 Nancy? The way I would think about this is I think one
22 thing that kind of came out in our conversations and one

1 thing that we want to put in front of you guys is that this
2 authority is not without its controversy, okay, and I think
3 the key thing if this authority is going to be clarified and
4 pursued by the Medicare program is that a process is
5 developed in order -- where certain principles are met, and
6 I think that's the key slide, is sort of what is the process
7 going to be where all stakeholders can feel that they had
8 input and were treated well, had the ability to bring
9 information, that the beneficiary has the ability, either
10 because they're willing to pay more or because clinically
11 it's been determined that they can get the drug.

12 What I think Nancy was doing with the end of the
13 presentation was to say there's two existing processes that
14 you can sort of help think about how things move through the
15 agency, one on the coverage side, a little different
16 characteristics, one on the payment side. I don't think
17 she's saying, or we're saying you have to pick, but these
18 are the characteristics you might blend, you might say, no,
19 I want to put it on that path but I want to modify that
20 path, you know, that type of thing. I think that's what
21 Nancy's trying to get -- what we're trying to get across
22 here. Does that even get close to your question?

1 MS. UCCELLO: I think so. So I'm not sure this
2 follow-up question is relevant, but I'm still going to ask
3 it. You know, with all the new comparative effectiveness
4 initiatives and the restrictions on using the results from
5 those to determine coverage, how does that then inform this
6 question?

7 DR. MARK MILLER: I mean, the way I would answer
8 it is that the coverage process will produce -- I mean, the
9 new clinical effectiveness process will produce information
10 that could inform this process.

11 In this instance -- Nancy, make sure this is
12 correct -- we're talking about something that's determined
13 to be covered. What we're really trying to figure out is
14 whether it's clinically similar and hence goes to one price
15 or the other. That's the way I have it organized in my
16 mind.

17 A nod here would help me out a lot here.

18 MS. RAY: Yes.

19 DR. MARK MILLER: Okay.

20 MS. RAY: Yes.

21 MR. HACKBARTH: And just to follow up on that, so
22 the language about on the prohibition of using comparative

1 effectiveness information is specific to the coverage
2 process and not to the payment policy process.

3 MS. RAY: I think so. I would want to double-
4 check that, but I think that is correct, and I think the --

5 MR. HACKBARTH: That is my recollection, as well.

6 MS. RAY: -- and my recollection is that the
7 policy can't solely be based on the one study, that there
8 needs to be other studies, but I would want to go back and
9 double-check that.

10 MR. HACKBARTH: So does that help, Cori? Ron and
11 then Mike.

12 DR. CASTELLANOS: I have two questions. One is on
13 page 11, you talk about the clinical appropriateness, where
14 you can get access to the more -- to these products if
15 they're clinically appropriate, the more expensive drug.
16 Maybe it's drawing a fair line, but on page 17 at the bottom
17 of the material, you said Medicare coverage authority for
18 beneficiaries to gain access to a more costly service, if
19 that is his or her preference. So it's both clinical and
20 preference?

21 MS. RAY: I guess I was talking about two
22 different instances. In the first instance, so let's say

1 there are three widgets and they have been found to be
2 clinically similar, but for people with, you know, purple
3 ears, they just -- and that's one percent of the population,
4 let's say -- they tend to do better with widget number one.
5 There is -- my understanding is that the physician can go to
6 the medical director of -- the contractor medical director
7 to start that process going so the patient could get the
8 more costly item and Medicare would pay for the more costly
9 item and/or an appeals could always be done.

10 Now, the second case is that, you know what, I
11 want widget number A no matter what and I am willing to pay
12 for that, and that, I think, I was thinking that that could
13 be accommodated through the advanced beneficiary notice, and
14 that is through the coverage process.

15 DR. CASTELLANOS: So there are two processes?

16 MS. RAY: Yes.

17 DR. CASTELLANOS: Okay. Thank you. The next
18 question is just -- probably it's just -- you know, in
19 April, they took it away from the Part B drugs, but it still
20 exists under DME. How is that worked under DME?

21 MS. RAY: That's a very good question. When I
22 checked in August, those least costly alternative policies

1 for the DME items were still up in the database, in the
2 coverage database, and we are in the process of trying to
3 contact some of the DME contractors to exactly figure out
4 how they are being applied.

5 DR. MARK MILLER: But there is some sense that
6 perhaps the decision on the drugs had a rather chilling
7 effect across the board, and that's what we're trying to
8 sort out.

9 DR. CASTELLANOS: Thank you.

10 DR. CHERNEW: [Off microphone.] Ron asked my
11 question.

12 MR. HACKBARTH: Other clarifying questions?

13 MR. BUTLER: I don't quite understand. Can you
14 think of examples where it works the other way? Rather than
15 something new being expensive and not necessarily producing
16 a better result, but the other, something new that is
17 cheaper that somebody is contesting that the existing thing
18 is more effective and therefore we don't let go of the
19 higher price of the existing product, even though the new
20 product may be cheaper and produce the same result?

21 MS. RAY: Are you asking me, can I think of an
22 example like that?

1 MR. BUTLER: Yes.

2 MS. RAY: Yes, I can.

3 MR. BUTLER: Okay, because your examples go the
4 other way in here, in the --

5 MS. RAY: Under the DME fee schedule, the negative
6 pressure wound therapy pumps, the payment is based on the
7 original pump and that price is much -- at least according
8 to an OIG report, that's a pretty recent report -- that
9 price, that payment rate is much greater than what would be
10 charged if payment was based on the newer negative pressure
11 wound therapy pumps, yet Medicare is still paying based on
12 the original one.

13 MR. BUTLER: So there is that case, too, in your
14 write-up?

15 MS. RAY: Yes.

16 DR. BERENSON: I was very happy to see the text
17 box and your brief comment about inherent reasonableness. I
18 was at CMS when it got shut down when we had market prices
19 showing that our fee schedule was much too high. But it
20 seems to me it's not a subset of least costly alternative.
21 It strikes me that it is a separable topic deserving -- I
22 actually think it may have broader application and is

1 second-best to competitive bidding for DME, but is there a
2 reason you sort of have it as -- or you sort of put it in
3 here, and does that have to be that way?

4 DR. MARK MILLER: So what I think we should talk
5 about here, Nancy, is kind of the back and forth, some of
6 the back and forth we had on this when we were preparing
7 this. At least one take-away from that conversation I got
8 was that the infrastructure to execute inherent
9 reasonableness in the agency was just a much heavier lift in
10 order to kind of pull it off, and that was my --

11 MS. RAY: Yes.

12 DR. MARK MILLER: All right. Why don't you --

13 MS. RAY: I mean, I think in terms of implementing
14 inherent reasonableness, I think the difficulty there is the
15 collecting pricing data that is sufficient to meet the
16 standards that CMS put into the final 2005 rule that they
17 issued on this policy, and it is a different policy than
18 least costly. Whereas least costly you're determining if
19 items are clinically similar, with inherent reasonableness,
20 I mean, it can be limited to one item and you're saying if
21 data out there suggests that Medicare's payment rate is at
22 least 15 percent off, then we can adjust the payment rate

1 either up or down by 15 percent. But I think there, the
2 threshold is collecting the pricing data.

3 Now, as far as the decision to move forward on the
4 least costly alternative policies and focusing on that and
5 not inherent reasonableness, again, we just picked -- I
6 mean, one of the reasons is that we discussed least costly
7 alternative at length in the June 2010 report.

8 DR. MARK MILLER: The only thing I would add to
9 that, I mean, one way to think about the least costly
10 alternative is you know the two prices and the difficulty is
11 trying to figure out the clinical effectiveness, which I
12 don't think is a small lift in and of itself. The other
13 way, you have to produce the pricing --

14 DR. BERENSON: Yes. All I'm saying is we should
15 keep them separate and if we want to make a decision that we
16 don't want to tackle inherent reasonableness, then I think
17 that's fine. But I just don't want to lose it as -- I mean,
18 it's its own topic, I guess is my only point.

19 DR. KANE: Are there any studies of the effective
20 LCA, or I guess it's similar to reference pricing, on the
21 likelihood of a newer lower cost item coming into the
22 market? So I remember sitting on a doctoral committee for

1 someone who looked at drugs and that looked at countries
2 with referencing pricing and said in countries with
3 reference pricing, where the lowest price drug is the price
4 all the drugs are paid for, they were less likely to have
5 lower cost substitutes introduced. Now, I don't know if
6 that's just that one study, or is that a common phenomenon?
7 I guess what's the impact on the market and on future
8 innovation? Has anybody looked at that even around these
9 LCA or grouping types of pricing policies? Maybe nobody
10 knows. I just wondered.

11 MS. RAY: I think the literature on the effective
12 reference pricing done by other countries, I mean, I think
13 it seems to be mixed, and I'm definitely not an expert on
14 it. Some will say that it does have an impact on the
15 market. Others will say that in terms of beneficiary access
16 and outcomes, there is no problems. I guess I could look at
17 the literature one more time and come back to you with, you
18 know, a better answer to that.

19 MR. HACKBARTH: The thesis --

20 DR. KANE: The question is whether when you have a
21 bundle of services with a reference pricing-type policy,
22 that manufacturers of similar types of services, especially

1 if they have one already in the bundle, may not want to
2 lower the overall reference price by bringing in a lower-
3 cost equally clinically effective substitute, and that is
4 the doctoral thesis I sat in on. That was a finding. But I
5 don't know how universal it was or whether anybody had done
6 a real analysis of this at a broader scale. Let's just say
7 the widget manufacturers might actually have a cheaper deal
8 they could get out, but they don't want to lower the overall
9 reference price for all their other products because they're
10 cannibalizing themselves.

11 MR. HACKBARTH: I guess what I'm stuck on is the
12 other side of that. If you don't have it, then what's the
13 incentive to come in with a lower cost product --

14 DR. KANE: That's another -- yes. Also, it would
15 reduce the desire to even do that R&D.

16 MR. HACKBARTH: Right.

17 DR. KANE: I didn't know if anybody has studied
18 the rate of innovation and whether it differs when there are
19 products that are bundled like that as opposed to not.

20 MR. HACKBARTH: Yes. Jennie?

21 MS. HANSEN: This is separating out the two
22 issues, I think, Bob saying that the reference, or, excuse

1 me, the inherent reasonableness is something that is
2 separate from the other pricing aspect of it. Just
3 especially with the new court case coming out, what might be
4 the incentive to take this on at this point as an issue is
5 more of a question. Why might we be more successful now to
6 take this on as an issue? And then, separately, is there
7 any access to information in commercial plans that have a
8 decisional process that could be somehow understood as to
9 how decisions get made along the way.

10 MR. HACKBARTH: The first part, if I understood
11 your question correctly, the court case interprets current
12 law and says, here is what the Secretary or cannot do within
13 the current statute. What we would be recommending here is
14 the Congress amend the statute to give the Secretary
15 explicit authority to do X, Y, and Z, and then the court
16 case, the current court case is moot. Do you want to
17 address the second part?

18 MS. RAY: Right. Right. As far as use of least
19 costly alternative by commercial plans, I would have to get
20 back to you on that. To my -- I don't want to misspeak. I
21 have not run across them, but I would want top get back to
22 you.

1 DR. DEAN: [Off microphone.] -- the formularies
2 are --

3 DR. BORMAN: In general, I support this line of
4 inquiry. I think that the materials were nicely presented,
5 both in written and in the slides. One could envision what
6 people have already touched on, the interdigitation with
7 comparative effectiveness. But also, you can kind of sort
8 of almost SNF value-based purchasing lurking to some degree
9 behind here and efficient provision of services and accurate
10 pricing, so many things that the Commission is on record
11 for, potentially take this under that umbrella. And so in
12 our conversation about enabling CMS to do the job that's
13 been assigned to it on behalf of the program, that there
14 seems to be value in considering this. I think obviously
15 there's a fair amount of sharks swimming here and we need to
16 be pretty careful about being crisp about what is the
17 question. As Bob has pointed out, there's different pieces
18 here in terms of IR versus this, but I think there's value,
19 too.

20 So my clarifying question, however, would be do we
21 have some sense about the scope of this, and by that, here's
22 why that occurred to me. The examples that we've seen

1 primarily are devices and drugs, and I can kind of envision
2 how that rolls out. However, your slide just said new
3 service, and in theory, that could be something other than a
4 drug or a device. It could, in fact, be a procedure, for
5 example. So do we need to do some thought about that, or do
6 we need to just say we think that this relates to types of
7 services being imaging, lab tests, drugs, as opposed to
8 saying this would potentially apply across the program?
9 Because I can think of an example just off the top of my
10 head that might be open operation for arterial disease of
11 the lower leg versus a catheter-based service, and while
12 they can achieve the same short-term result, there are
13 durability issues with the catheter-based.

14 And so then you've got to talk about what's the
15 result over a multi-year time, and then how do you judge the
16 equivalency of that in an LCA kind of setting.

17 So I guess my gut feeling is that this would have
18 to be more restricted to things like devices, drugs, tasks,
19 but I'm not sure and we might need to explore that as a sub-
20 question if we go forward with this.

21 MS. RAY: And I just want to clarify just one
22 point. The illustrative example where I started out with a

1 new service, again, it does not necessarily -- I mean, that
2 was just an example. It could be an existing service, as
3 well.

4 MR. HACKBARTH: So in this area, there's some
5 history, legal history, legislative history. These are not
6 new issues. If we are to recommend to Congress that
7 Congress amend the statute to explicitly authorize these
8 policies, it seems to me that we would do well to quite
9 explicitly address the sort of issues that have come up in
10 the past and that have been both a political, legislative
11 barrier, and in some cases a legal barrier. And some of the
12 issues that come to my mind are these.

13 One, people have argued that this is a bad idea
14 because it will discourage innovation, sort of the point
15 that Nancy raised. Now, other people might say, well, it
16 won't discourage innovation. It will just refocus
17 innovation on creating products that are lower cost and
18 better. But that's sort of one type of issue, what is its
19 effect on the innovation system.

20 A second issue that it seems to me has been
21 implicit if not explicit is, well, this is illegitimate
22 intrusion in market pricing. You know, the market is

1 setting prices for these things and here along comes the
2 government and says, no, here is a different price, as
3 opposed to the current system where basically we take what
4 the price is that's being charged and we pay it. Frankly,
5 that's an argument that I don't get in that it seems to me
6 that there's not a functioning market here when people are
7 basically setting the price and everybody's paying it
8 without comparing it to other comparable products. That's
9 what makes a market function, is that comparison of value
10 and that doesn't happen at the patient level for a variety
11 of reasons. It seems to me it's got to happen at the payer
12 level. But that's another type of argument against this
13 that is heard that I think needs to be taken head-on if
14 we're going to be at all persuasive in doing this.

15 Then a third type of argument against it, well, is
16 that the decisions will be made poorly. They won't be based
17 on appropriate evidence, appropriate experts won't be
18 involved, et cetera. And so there are sort of procedural
19 responses to them, some of which Nancy began to outline in
20 the paper.

21 And then sort of the fourth type of argument is,
22 well, not all patients are the same and even if you do your

1 best good faith effort, say, oh, these are comparable
2 products, for some specific categories of patients, those
3 comparisons may not be relevant and so there needs to be a
4 safety valve whereby the patient with a really unique set of
5 needs and circumstances can get access to a different
6 product.

7 There may be other arguments, as well, but my
8 basic point is because of the history around this, if we
9 want to be persuasive, I think we need to really bing, bing,
10 bing, say here are the issues that have been raised and
11 here's our sense of how you might respond directly to those
12 issues.

13 So that's my round two kick-off comment. Let's
14 proceed, other round two comments. Ron and then Mike.

15 DR. CASTELLANOS: I'd like to digress just a
16 second to give you an experience that I had with LCA. My
17 personal experience with LCA was with the Part B drugs for
18 cancer of the prostate. I think I'm going to start out by
19 saying I got a phone call from Mark Miller once saying,
20 "Ron, is there a new treatment for cancer of the prostate?"
21 And I said, holy, I didn't read USA Today. I guess I missed
22 something. And I said, not that I'm aware of, Mark. Why?

1 And he says, "Because since we changed the LCA policy,
2 there's been a 20 percent decrease in the use of that drug."
3 And I said, holy, what's happening?

4 So I went back to our society and we tried to
5 figure it out, and I think there are some answers, but not
6 an answer good enough to say that it accounts for the whole
7 20 percent. Instead of giving it to a person all the time,
8 we do it in a minute or pulsatile, and that's a new form of
9 treatment and it's the appropriate thing to do. But that
10 bothered me that 20 percent usage was dropped as soon as
11 payment went down. That really bothered me.

12 I also said, you know, there's been a lot of
13 screaming and a lot of fighting and teeth chomping over the
14 cost, because what we were doing, we were getting paid a
15 tremendous amount of money based on the average price,
16 wholesale price. This wasn't something I established. This
17 was a Medicare regulation. And I don't want to say it was
18 insane, but we were getting paid unreasonably high for doing
19 nothing. We do get paid appropriately now, and I think
20 price accuracy has really made a difference in this drug.

21 So I can only say this, and it's not a very nice
22 thing to say, is that when I was at a meeting after April 20

1 when the LCA policy for Part B drugs were removed, and that
2 was announced at a urology meeting and there was a whole
3 bunch of cheering, and there was only cheering for one
4 reason, and I'll leave that up to you to figure that out.

5 So what I'm saying to you now is I think this can
6 be a good policy if it's truly clinically equivalent in
7 efficacy, and especially if the physician has the ability to
8 say, I want another option, and the patient has an option of
9 preference. So has it worked for Part B drugs for cancer of
10 the prostate? You bet it has. We have payment accuracy and
11 there hasn't been any really, real disruption of efficacy of
12 care.

13 DR. CHERNEW: I'm curious as to the extent to
14 which different aspects of bundling or other things that
15 might be going on could help us get around some of this
16 problem. So I don't see, for example, in the wound therapy
17 one why you couldn't envision that it will pay a certain
18 amount for wound therapy and let whoever is getting that
19 have to make the choice, or we'll pay a certain amount of
20 treatment of whatever it is.

21 It strikes me that many of the bundling things
22 work, and I think my general sense is it's going to be

1 extremely difficult to move through to the system we want to
2 get to if we try to, on a case-by-case basis, have a hearing
3 about the equivalence of this versus that. And I understand
4 that purple ears is a really good example because I haven't
5 met many of the people, but there's always people that have
6 various types of things explaining why in their case it's
7 different and physicians have different opinions. Just the
8 geographic variation literature shows you why it's so hard
9 to go this route.

10 So while I'm generally supportive of this as a
11 rule, I think that there's probably better ways to solve the
12 problem, the basic problem, and one of the things that I
13 would like to see happen in general is have potentially the
14 beneficiary share in some of the savings if they choose the
15 less expensive one. The way it works now is you just don't
16 pay for the more expensive one, but the beneficiary doesn't
17 get anything out of that. But if you set the price a little
18 bit higher, the beneficiary chose the more -- they would
19 have an incentive and you could see it working out.

20 So I think that there's -- least costly
21 alternative is certainly sensible in a lot of the cases that
22 are discussed. When you see some of these things, it's kind

1 of annoying. But I think if you really were going to think
2 about how to set this up, you'd try and achieve the same
3 goal through a broader, easier to work on an ongoing basis
4 kind of strategy. That's my sense.

5 MS. BEHROOZI: This is the kind of thing that we
6 do in our drug program, in particular. I think Karen's
7 right that there's some lower-hanging fruit than others.
8 And, of course, with Part D drugs, it's administered through
9 plans, but at least in Part D drugs, there's some
10 opportunity, I guess, for Medicare that should be pretty
11 long-hanging, one of them you identified that's pretty
12 glaring, Nancy.

13 I just want to distinguish it from a formulary,
14 though, because in a formulary, you might have tiered
15 copayments, and the problem for the payor is that even
16 though the person at the highest tier might be paying a lot
17 of money out of pocket, the payer is still exposed to all
18 the difference between what might have otherwise been the
19 reference price that they would pay and the, you know,
20 outrageously priced other thing that the beneficiary has not
21 all that strong a disincentive to purchase. They might be
22 paying \$50 for a non-preferred brand drug, but what the plan

1 ends up paying is \$150 as opposed to the beneficiary paying
2 \$10 for the preferred and the plan only paying the other \$40
3 or something like that. So I think that's really important
4 to keep in mind.

5 And, Glenn, in your point about the market, it's
6 really important for the one who is the payor to be an
7 active purchaser in the market, because as you said, price
8 is not an immutable thing. I mean, it's not just about
9 whether manufacturers will develop lower-price products,
10 Nancy, but they will lower their prices to get onto your
11 reference price list. I mean, we had a circumstance,
12 because what we do is pay the full price, there's no
13 beneficiary cost sharing -- that's what exists at the
14 reference pricing level -- but then people have to pay the
15 entire difference if they want something else. And so
16 having that strong an incentive, that strong a protection of
17 beneficiaries and that strong a message to beneficiaries,
18 this is the least costly clinically effective drug,
19 manufacturers want to get there so that their product will
20 be purchased.

21 And we had a circumstance where the popular brand
22 name statin, which shall go unnamed, pretty much came down

1 to the level of the generic because they did not want to be
2 closed out of this reference pricing structure that we had.
3 And we actually lowered our drug spend -- not lowered our
4 drug trend, we lowered our drug spend by a percent, '07 to
5 '08, and this was one of our most -- our strongest tools.

6 I just want to say, then, in terms of the
7 legitimacy of the process is key, and you've really focused
8 on that, for us, it's transparency of decision making and
9 the trustworthiness, of course, of the decision making,
10 experts' independence, review, constant review, staying
11 current all the time, and, of course, the right of appeal
12 for the purple ear people and the ability for people to pay
13 that extra out-of-pocket, the other \$1,950 for the drug that
14 will do the same thing if they want to. And then once they
15 feel like all of that is available to them, certainly our
16 experience was that then people felt like, okay, fine, so
17 I'll just take the free drug. That's fine.

18 MR. HACKBARTH: So value-seeking purchasers,
19 that's what makes markets work effectively, and so what Mike
20 is suggesting is that one way to think about this is how do
21 we engage others to be those value-seeking purchasers,
22 whether it's providers who have to buy this product out of a

1 bundled payment, and we've seen some of that with the advent
2 of DRGs for inpatient services.

3 DR. CHERNEW: [Off microphone.]

4 MR. HACKBARTH: Right. Right, where it can be
5 patients who are rewarded for buying -- using the lower-cost
6 product, or conversely penalized for using a higher-cost
7 one. Or you can do it at the insurer level, and so -- but
8 the one thing that's sort of non-negotiable is you've got to
9 have value-seeking purchasers to make markets work and
10 sometimes that basic point seems to be lost in debate.

11 Other round two comments? Bob?

12 DR. BERENSON: Well, in round two, I will revise
13 and extend, or whatever the language is, my round one
14 remarks about IR. I guess I'd want you to consider putting
15 it not on an equal basis with LCA, but on a parallel basis
16 rather than sort of just a text box that there's a sort of a
17 separate discussion of IR.

18 And it seems to me that this could be a pretty
19 valuable tool if, in fact, competitive bidding for DME sort
20 of gets sidetracked again. It's sort of an alternative.
21 And frankly, I don't know what's contemplated under
22 competitive bidding for the markets that don't have

1 competitive bidding, whether maybe others know what happens.
2 Do we use the bids that come in from the markets that bid to
3 adjust the fee schedule for the remainder of the country, I
4 guess would be my question, and it seems to me it's
5 complementary to using the IR authority, or similar to the
6 IR authority. We try to get marketplace information to
7 identify services that are significantly overpriced.

8 I think it's worth at least laying out the
9 argument for doing IR. If it turns out that it's too
10 onerous to actually go through the about 12 bullets here
11 that the agency would have to go through, at least we have
12 identified another place where CMS doesn't have the
13 discretionary administrative dollars to save mandatory
14 dollar-side money and we could at least make that case. Or
15 it could be that CMS didn't implement this because they no
16 longer see that there's a lot of savings in it. I don't
17 know. I just think we need to understand this a little more
18 and give it a little bit more attention, is all.

19 DR. MARK MILLER: And I wouldn't characterize it
20 as taking up LCAs because they're against, you know, taking
21 up IR. This is just where we kind of went to first. And I
22 think if we do take it up and look at it, one serious

1 portion of the time that we spend looking at it will be
2 trying to figure out whether there's a more streamlined way
3 to execute it, because I think there is some cumbersomeness
4 to it.

5 But I just want to ask David, do you know the
6 answer to the question on markets in DME that don't have
7 competition?

8 MR. GLASS: [Off microphone.]

9 DR. MARK MILLER: He said he --

10 MR. GLASS: I don't think there is an answer yet,
11 but I'm not sure.

12 MR. KUHN: I think they just use the standard gap-
13 filling process that they have now for those products that
14 are outside of those ten MSAs, is my guess.

15 Looking at the last bullet there in terms of the
16 comments about policy options, let me just try to talk to
17 two of them here for a moment. One is in the paper, you
18 talked a little bit about LCA being done nationally and what
19 process could be used for that, and a discussion was to use
20 the NCD process. We could look at that further, and I think
21 it's worth looking at further, although I do worry about
22 clogging up the NCD process as part of that.

1 MS. RAY: I think that that is one concern about
2 that, given the resources that they have right now and the
3 fact that, I don't know, I guess maybe they do about a dozen
4 NCDs a year or something like that.

5 MR. KUHN: Right. It's cumbersome and it's slow
6 and I think it would slow the process down. You know, you
7 could give the Secretary, allow him to consider cost as part
8 of the NCD process to do it, but I think it would be
9 cumbersome to do, so that would be an issue.

10 The other option, and I'm not wedded to this but
11 I'm just tossing it out as something we might want to
12 consider as we go forward, I think it was in the spring when
13 we had Sean Tunis here talking about coverage with evidence
14 development and the CED process, and if you remember that
15 conversation with Sean, it basically was while there might
16 not be enough evidence to go ahead and cover something, CMS
17 would go ahead and cover it for now but then collect the
18 evidence on a go-forward basis and then kind of defer a
19 decision until later on. And that was kind of detailed in
20 the June report.

21 So kind of picking up on that theme, for lack of a
22 better term here, maybe call this evidence-based guided

1 payment and basically you could put some items into the LCA
2 process now, create an LCA benchmark so all these items
3 would go into that process at the current time and that if
4 the different innovators that came up with the product were
5 able to produce the evidence that they deserved a payment
6 above the LCA benchmark, then they could move forward,
7 because I think the process we're all kind of looking at
8 right now is that there's a differentiation, and we've
9 talked about how do we bring someone down. Maybe we ought
10 to look at this differently and say, okay, we're going to
11 all come in kind of at this space and if you want to be
12 higher, produce the evidence to go higher as we go forward.

13 So again, I'm not sure I'm terribly wedded to
14 that, but it's a different option to look at as we go
15 forward.

16 MR. HACKBARTH: So what I hear you saying is
17 basically shift the burden of proof.

18 MR. KUHN: Exactly.

19 MR. HACKBARTH: Right now, the burden of proof is
20 on CMS to prove equivalency, as it were, and you would say
21 it's on the sponsor of the new product to show it's
22 different.

1 MR. KUHN: Exactly. That would be the big
2 difference here. So that might be another policy option we
3 might want to consider or to look at a little bit more as we
4 go forward.

5 MR. HACKBARTH: [Off microphone.] Round two? Any
6 others? Thank you, Nancy.

7 The last session today is a report on the recent
8 growth in hospital observation care. Dan, you can take down
9 your Elizabeth sign. Yeah, there you go, so nobody calls
10 you Elizabeth.

11 MR. GAUMER: Good afternoon. Okay. In recent
12 months, the growth in hospital observation services has
13 become more widely documented in the media, and many of
14 these stories have tied the trend in the growth of
15 observation care to an increase in Medicare beneficiaries'
16 financial liabilities.

17 CMS has been active on this in the last few months
18 as well. They've scheduled an open door forum, which they
19 had in August. They've sent letters to hospital advocates
20 with concerns about the growth, and they've also
21 commissioned some research on the subject, which is due out
22 later in the fall, I believe.

1 Some have contended that the Medicare RAC program,
2 which is the Recovery Audit Contractor program, has had some
3 influence on the observation care growth. However, at this
4 point in time, we haven't had clear documentation of this
5 increase, with the extent of it, and also whether or not the
6 RACs have been tied to the increase.

7 MedPAC has reported on observation care growth in
8 the 2010 March report, and at that point, we showed
9 significant growth from '07 to '08 and at that time, you all
10 expressed or some of you expressed some interest in the
11 subject. And as a result of the interest and, therefore,
12 the growing awareness in the subject, we've put some
13 information together and we'd like to get your ideas and
14 your opinions on the subject.

15 I'm going to very quickly provide a little
16 background information and then I'm going to walk you
17 through the results of three of our research questions, and
18 as usual, at the end, I'd be happy to take your questions
19 and Dan's going to also assist with taking questions as
20 well.

21 CMS defines observation care as a well-defined set
22 of specific clinically appropriate services which include

1 ongoing short-term treatment, assessment, and re-assessment
2 that are furnished while a decision is being made regarding
3 whether patients will require further treatment as hospital
4 inpatients, or if they're able to be discharged from the
5 hospital.

6 Generally, observation care is an outpatient
7 service and generally thought of as a lower intensity
8 service. Hospitals may choose to systematically manage
9 their observation patients as a part of an observation unit,
10 or they may not. When they are managed by a unit, this may
11 occur in a separate department with specifically devoted
12 staff.

13 In cases where patients are not managed through an
14 observation unit, the patient is generally placed in any
15 available bed and managed by their admitting physician.

16 Most recent data available on this from 2003
17 indicates that about 29 percent of U.S. hospitals have
18 observation units or were expected to start observation
19 units very shortly. However, we're trying to get a little
20 bit more current than '03. The best anecdotal information
21 we can put together suggests that observation units have
22 become more common since 2003.

1 The decision a physician faces of whether to admit
2 a patient to inpatient care or treat the patient in
3 observation is defined by two independent sets of CMS
4 criteria. Medicare defines coverable observation care as
5 that which is reasonable and necessary, eight hours or
6 longer, and ordered by a physician. Medicare also advises
7 providers that the decision to discharge a patient from
8 observation or admit the patient as an inpatient can be made
9 in less than 48 hours, usually in less than 24 hours. CMS
10 adds that only in exceptional cases should observation cases
11 spend more than 48 hours.

12 On the inpatient side, CMS suggests that
13 physicians should consider a variety of clinical and
14 resource-related factors in making their decision. They
15 suggest physicians should order admission for patients who
16 are expected to need hospital care for 24 hours or more, and
17 treat other patients on an outpatient basis.

18 Hospitals are reimbursed a single payment per stay
19 covering all observation hours and the associated emergency
20 department and clinic visit. Observation cases originating
21 in the ER are generally considered higher severity than
22 clinic cases and yield a higher reimbursement rate.

1 Observation rates are significantly lower than inpatient
2 rates. For example, after adjusting for the wage index, a
3 patient presenting in the ER with chest pain and served on
4 an observation patient basis would yield a \$720 payment, and
5 the same patient served on the inpatient side would yield a
6 \$7,600 payment.

7 However, it's important to note here that if a
8 beneficiary is admitted as an inpatient following their
9 observation stay, they have no out-of-pocket liability for
10 the individual tests and procedures they incurred as an
11 outpatient. But if the beneficiary is discharged directly
12 from observation care, they are liable for the co-insurance
13 tied to each individual outpatient service.

14 Experts have noted various economic benefits for
15 providers resulting from observation care and observation
16 units such as maximizing inpatient unit capacity, reducing
17 the number of unreimbursed or denied inpatient claims, and
18 reducing staffing costs.

19 As I alluded to a moment ago, observation care
20 alters the beneficiaries' financial liabilities in two ways.
21 First, as outpatients, beneficiaries in observation care pay
22 a 20 percent copayment for their actual observation

1 services. And on top of that, if there are other services
2 on the outpatient side that they incur, they pay roughly 20
3 to 40 percent of those -- of that care as co-insurance. In
4 contrast, on the inpatient side, the beneficiary pays a
5 fixed deductible of approximately \$1,000.

6 Second, because observation time is not counted
7 towards the three-day prior hospitalization rule used to
8 trigger the skilled nursing facility coverage, it is
9 possible that an increase in observation volume will result
10 in fewer beneficiaries qualifying for SNF coverage, and
11 therefore leave more beneficiaries to pay the full cost of
12 their SNF care.

13 DR. MARK MILLER: Hey, Zach, just before you go
14 on, and I can't remember if we put this somewhere else in
15 the presentation, the \$720 is what they get for the
16 observation, but they can bill on an outpatient basis for
17 other services provided? Am I correct?

18 MR. GAUMER: That's correct, yeah.

19 DR. MARK MILLER: Okay. And I can't remember if
20 we organized that somewhere else, but I think it's important
21 that it get said somewhere.

22 MR. GAUMER: Okay. It will come up again.

1 DR. MARK MILLER: I apologize.

2 MR. GAUMER: No, no, but we did touch on it here.

3 So moving on to our findings. The number of
4 Medicare claims for outpatient observation care grew rapidly
5 from 2006 to 2008, growing from approximately 900,000 claims
6 to 1.1 million claims. Given changes in Medicare enrollment
7 over this period, this equates to roughly a 26 percent
8 increase in the claims per thousand beneficiaries. In
9 contrast, during the same time period, the number of all
10 Medicare outpatient claims per beneficiary grew about 4.5
11 percent.

12 In addition, the number of observation hours grew
13 even faster than raw claims, at 37 percent per thousand
14 beneficiaries. More rapid growth in observation hours
15 suggests that growth in the length of observation claims has
16 grown.

17 Overall, from 2006 to 2008, the average length of
18 observation claim increased from 26 to 28 hours. However,
19 growth in observation claims differed across the
20 distribution of claim length. Claims of 48 hours or more
21 increased over 70 percent. This rapid growth resulted in

1 the longest category of claims growing as a share of claims,
2 also.

3 In 2006, claims of 48 hours or more accounted for
4 8 percent of all claims, and in 2008, they accounted for
5 approximately 12 percent of all claims. Just in contrast,
6 non-reimbursable claims, those one to seven hours in length,
7 declined 2.5 percent during the same time period and
8 declined to a level of 7 percent of all claims.

9 The conditions associated with observation claims
10 are often cardiac-related and generally consistent from year
11 to year. Chest pain accounted for, by far, the largest
12 share of claims at 21 percent in 2008.

13 The next most common was heart disease at less
14 than 5 percent. Among the 15 most common observation
15 conditions, 7 were cardiac-related and 14 were also on the
16 top 15 list in 2006. The fastest growing conditions were
17 syncope, vertigo, and claims with unclassified condition
18 codes. In contrast, the fastest growing conditions for
19 claims 48 hours or more were non-cardiac pain-related
20 conditions.

21 Before I explain our second finding, I'll give a
22 little bit of background on the Medicare RAC program, so

1 we're kind of going back to the background here for a
2 second.

3 Under the Medicare RAC program, CMS contracts with
4 a set of auditors on a contingency fee basis to
5 retrospectively detect and correct past over or under
6 payments for any providers participating in the Medicare
7 program. The RAC program began as a demonstration program
8 limited to just a few states.

9 In March 2005, auditors began reviewing the claims
10 of all providers in three states -- California, Florida, and
11 New York. The demonstration was expanded to three other
12 states in 2007 just before it ended, and then finally the
13 program was expanded nationwide as a permanent program in
14 2010, January of 2010.

15 The demonstration ultimately recovered
16 approximately \$900 million and 85 percent of that was from
17 inpatient hospitals. Some have hypothesized that Medicare's
18 RAC program spurred hospitals to increase their use in
19 observation care. The presence of the RAC demonstration in
20 only a handful of states from '06 to '08, provided us with a
21 natural experiment to test the RAC observation growth
22 hypothesis.

1 Therefore, a comparison of observation utilization
2 in hospitals in California, Florida, and New York versus
3 hospitals in all other states should, therefore, allow us to
4 identify the impact of the RAC demonstration.

5 Second finding. Overall, data from hospitals in
6 the three RAC states suggest that the Medicare RAC program
7 may have had a modest affect on observation growth between
8 2006 and 2008, but that there were other factors present.

9 First, we found that hospitals in the three RAC states had
10 consistently lower levels of observation utilization. The
11 number of observation claims was consistently 11 to 12
12 claims per thousand beneficiaries lower than hospitals in
13 RAC states -- I'm sorry -- at hospitals in RAC states than
14 at hospitals in non-RAC states. And the same trend existed
15 in the context of observation hours.

16 In light of the lower levels, the utilization of
17 observation claims grew slightly more rapidly at hospitals
18 in RAC states, increasing by eight claims per thousand
19 beneficiaries versus seven claims per thousand beneficiaries
20 in non-RAC states.

21 Just as we observed on the national level, growth
22 in observation claims differed across the distribution of

1 claim length at both hospitals in RAC and non-RAC states,
2 and claims of 48 hours or more grew most rapidly. Growth
3 appeared faster at hospitals in RAC states as the number of
4 claims increased 88 percent from 2006 to 2008, and that's
5 just within the largest category, the 48-plus hours.

6 However, when comparing the growth rates of RAC
7 and non-RAC states, it's important to recall that the growth
8 rate of RAC states is based on lower levels of utilization.
9 But the main point here is that these long claims grew
10 rapidly nationally in both RAC and non-RAC states.

11 In addition, claims of 48 hours or more grew as a
12 share of all observation claims in both RAC and non-RAC
13 states, and they accounted for a somewhat larger share in
14 RAC states. From '06 to '08, claims of 48 hours or more
15 increased from 12 to 16 percent of all claims at hospitals
16 in RAC states, growing 4 percentage points. In contrast, at
17 hospitals in non-RAC states, claims of 48 hours or more
18 increased 3 percentage points from 8 to 11 percent.

19 Adding to our finding that observation care
20 increases were not limited to hospitals in RAC states, we
21 observed that hospitals in these states were no more likely
22 to have rapid growth in observation claims than other

1 hospitals. For example, the 706 hospitals in the three RAC
2 states accounted for approximately 19 percent of all
3 hospitals nationally. But in contrast, after ranking all
4 U.S. hospitals by their growth rate in observation claims,
5 we found that hospitals in the RAC states accounted for 20
6 percent of hospitals with the most rapid observation growth
7 rates. Therefore, hospitals in RAC states did not appear to
8 be driving growth nationally.

9 The story was slightly a bit different in the
10 three RAC states because a disproportionate share of
11 hospitals accounted for the majority of observation claims.
12 So specifically within California, Florida, and New York
13 collectively, approximately 30 percent of hospitals
14 accounted for 55 percent of all observation claims in 2008,
15 and 90 percent of the increase in the number of observation
16 claims from 2006 to 2008.

17 Some have also hypothesized that the increase in
18 observation claims resulted from a conscious effort by
19 hospitals to reduce short inpatient stays. We observed
20 evidence of this on the national level and to a slightly
21 greater degree in RAC states. Nationally from 2006 to 2008,
22 the number of one-day inpatient stays declined from

1 approximately 49 one-day inpatient stays per thousand
2 beneficiaries to approximately 46 one-day stays. A similar
3 decline occurred at hospitals in RAC states, except that in
4 absolute terms, we observed the decline in one-day inpatient
5 claims was approximately one claim greater per thousand
6 beneficiaries in the RAC states.

7 In addition, statistical tests of the correlation
8 between the change in the number of observation claims and
9 the change in the number of one-day stays displayed a light
10 to moderate correlation. This correlation was present on a
11 national level and slightly stronger for hospitals in RAC
12 states. Evidence suggests that observation growth is the
13 result of a broader national trend in increased scrutiny of
14 short stays and that Medicare's RAC program is not the only
15 payer exerting pressure on providers to limit short
16 inpatient stays. Anecdotal information suggests that
17 private payers are also exerting pressure on hospitals to
18 avoid short inpatient stays. In addition, all-payer
19 hospital data displayed a comparable national growth rate in
20 observation care from '06 to '08.

21 Looking at that all-payer data on a state level,
22 we found that Medicare-specific observation growth rates was

1 not always higher than the all-payer observation growth
2 rate. For example, in New York, the Medicare-specific
3 observation growth rate was higher than the all-payer growth
4 rate. And in California, the Medicare-specific growth rate
5 was lower than the all-payer growth rate. This
6 inconsistency existed across all the states and suggests
7 that other payers or other factors beyond the RACs may be
8 influencing observation growth.

9 A recent study in the American Journal of Medical
10 Quality also suggests that efforts by both Medicare and
11 private payers to more closely monitor short inpatient stays
12 as the impetus to initiate a new hospital observation unit.
13 In this case, the authors concluded that after six months,
14 their new hospital observation unit had achieved its primary
15 objective to decrease the number of unreimbursed admissions.
16 This unit also increased the number of the hospital's
17 observation claims by 72 percent in that six-month period,
18 decreased the average length of inpatient stays, and
19 decreased the number of facility-wide readmissions.

20 Finally, at a CMS-hosted forum on observation care
21 in late August, hospital participants suggested that a
22 variety of relatively recent regulatory changes made to

1 outpatient reimbursement policy and admission and
2 observation criteria may have contributed to the growth in
3 observation care.

4 In recent news reports, and also at CMS's forum, a
5 number of cases were cited asserting that Medicare
6 beneficiaries' financial liabilities have increased as a
7 result of being served as observation patients. You've
8 probably read one of these recently yourself, but the common
9 theme of these stories is that beneficiaries end up being
10 surprised with large bills for outpatient co-insurance or
11 very large bills for SNF care that they thought Medicare
12 would be covering.

13 As I described earlier, outpatient observation
14 carries different liabilities for beneficiaries. Rather
15 than paying the inpatient deductible of \$1,000,
16 beneficiaries pay outpatient co-insurance which may vary
17 significantly depending on the scope of services, tests, or
18 procedures provided to the beneficiary while they were in
19 outpatient care.

20 The more likely source of greater liability for
21 the beneficiary stems from their not qualifying for SNF
22 coverage, because their time in observation does not count

1 towards the SNF three-day prior hospitalization rule.
2 Anecdotally, it appears that beneficiary liability has
3 increased as observation volume has increased.

4 However, a quantitative analysis of the complete
5 outpatient out-of-pocket costs of observation patients would
6 assist in our understanding the specific impact for
7 beneficiaries.

8 In conclusion, we've observed a clear growth in
9 observation care. This growth may partly reflect hospitals
10 coping with greater public and private payer scrutiny of
11 short inpatient stays. Hospitals may be attempting to
12 reduce the financial risk of inpatient claim denials by
13 choosing to treat certain Medicare beneficiaries as
14 outpatient observation cases.

15 Although this trend does not appear to have a
16 dramatic impact on the overall Medicare spending, there
17 appears to be the potential for this trend to increase
18 beneficiary liability in some instances involving SNF care.

19 We're very interested in gathering your ideas and
20 opinions and we'd be happy to answer any questions.

21 MR. HACKBARTH: Thank you, Zach. Let's see. I
22 think we're starting on this side this time, so Round 1

1 clarifying questions, Tom and then George, and Nancy and
2 Herb.

3 DR. DEAN: Thank you. This is interesting because
4 we do a lot of this. I'm curious. In the individual
5 groups, is there much variation between individual
6 hospitals?

7 In other words, I'm curious, if some of this is
8 sort of a local approach to the decision-making because it's
9 an area that's caused a lot of confusion for us as
10 physicians as to what's covered and what's not covered, and
11 every time I ask about it, I seem to get a different answer.
12 And so, this is a model that we've resorted to, but I'm
13 curious if it varies much from one medical community to
14 another.

15 MR. GAUMER: We dove down a bit in the RAC states
16 and looked at a subsample of about 225 hospitals and there
17 was a significant degree of variation, I guess, for that top
18 quartile of hospitals in those RAC states. But I haven't
19 really looked beyond those three RAC states to dive down a
20 lot more. But I guess I'd also reference that across
21 states, on a state level, there seems to be some wide
22 variation as well. So I would assume that probably yes.

1 MR. GEORGE MILLER: Also very good work and I
2 certainly enjoyed reading the chapter. A couple of things
3 that came out at me, and I'll just ask if you did any study.
4 Is there a correlation between the same time period you did
5 this study and the perceived increase in volume in ERs
6 around the United States?

7 Do you know or did you look at that study and see
8 if there's a correlation between increased volume and the
9 increase in observation?

10 MR. GAUMER: I did not look at that increase, but
11 we can look at it.

12 MR. GEORGE MILLER: Yeah, and this is just my own
13 intuition that that may be a part of the problem, also. And
14 then one of the challenges is what Tom just said. There's a
15 different criteria for Medicaid observation status versus
16 Medicare observation status, and that's some of the
17 confusion. I know physicians always ask that. I'm trying
18 to remember the diagnosis. You can put a patient in
19 observation status for one thing, but can't do it for the
20 other, and I'm sorry, I don't remember that.

21 But could you look at that, also, and see where
22 that conflict may drive it?

1 And then finally, you mentioned in your paper
2 about the denials. My sense is that denials may be a strong
3 driver of this issue. Do you know the magnitude of denials
4 over the last three years as well, both for Medicare and the
5 private care -- private payers, I'm sorry.

6 MR. GAUMER: I can give you a very broad sense of
7 what happened as a result of the RAC demonstration, but in
8 terms of private side or private insurer denials, I don't
9 have any sense of that. But I've got one slide about the
10 RAC program, there were roughly a billion dollars in
11 overpayments which are essentially denials, and 85 percent
12 of that was for inpatient hospitals, and I think the
13 majority of that \$830 million we're looking at inpatient
14 admission-type stuff. So I can get better information for
15 you, but I think largely that's what we're looking at.

16 MR. GEORGE MILLER: Yeah, I'll come back in round
17 2.

18 MS. KANE: Yeah, I'm just trying to understand how
19 the observation unit is accredited with a decrease in
20 readmissions since they weren't admissions to begin with if
21 they were observation units. So does that just mean that
22 they didn't treat them well in the observation unit and then

1 they were discharged and then they came back in? That only
2 counted as an admission rather than a readmission?

3 MR. GEORGE MILLER: No, they were an observation;
4 then they became an admission.

5 MS. KANE: But, I mean, so how did you avoid the
6 readmission? How do you get a --

7 DR. CHERNEW: [Off microphone].

8 MS. KANE: Yes, but how did you reduce the
9 readmission? How would it reduce the readmission rate?

10 DR. CHERNEW: [Off microphone].

11 MS. KANE: Oh, so the second time around?

12 MR. GEORGE MILLER: Right, right.

13 MS. KANE: Okay.

14 MR. KUHN: Just a quick question. On Slide 6 when
15 you look at the percent of change from '06 to '08, did the
16 Medicare pricing change much during that same time frame as
17 well?

18 MR. GAUMER: I'm going to look to Dan on this one.
19 He's our outpatient expert.

20 DR. ZABINSKI: Let's see. There was a big change,
21 I want to say, from '07 to '08 in just, I don't know, how
22 the whole thing was defined. In '07, hospitals could get

1 specific separate payments for observation services. Had to
2 meet a fair number of criteria, but they could. In '08, CMS
3 essentially packaged all observation care. There's a
4 special category with, say you have an ER visit along with
5 some observation care, where there's a combined payment for
6 the two.

7 And that resulted in a higher payment than what
8 the observation care was the previous year, but it's a
9 combined payment. It's a really different animal in '08
10 compared with '07 and earlier.

11 DR. BERENSON: I wanted to pursue what Mark was
12 getting at earlier, which is for a typical observation day
13 for chest pain, does the \$720 cover the sort of hotel
14 functions, the bed and the nurse, or does it also include
15 the oxygen, the cardiac monitor, the IV access, all of that
16 stuff? Or are they billed separately?

17 DR. ZABINSKI: Again, that really depends. It's
18 going to include the nurse, any -- you know, if you have a
19 separately paid -- you know, some drugs in the outpatient
20 payment system are separately paid, some are not. If it's a
21 separately paid drug that gets administered, that's going to
22 add to the payment. If it's a packaged drug, that's not

1 separately paid. It depends what you're talking about.
2 Like an MRI. If you get an MRI along with it, that's going
3 to add to the cost. That's going to be separately paid.

4 DR. BERENSON: So do we know if, sort of, what the
5 range of outpatient claims amounts are? I mean are we in
6 fact paying lots to some hospitals for observation more than
7 the pro rata share of what they would have gotten on an
8 inpatient DRG? Do we know that?

9 MR. GAUMER: We did not do that as a part of this
10 analysis, but as we were going along with our analysis we
11 realized that we need to do this.

12 There is some work going on, on this. You know.
13 I noted CMS is doing some work. I think they've contracted
14 with a consultancy to get some of this done, and I think
15 they're going to get at that. So if they can't get it,
16 maybe we'll do it too and get back to you.

17 MR. ARMSTRONG: As a barely recovered hospital
18 administrator, maybe still recovering, and someone who's
19 looking at the health care system a little bit more broadly,
20 I just would affirm we're seeing that this trend is
21 happening, and I think it's a result of more than just
22 Medicare policy.

1 Two questions, and I don't know that they're
2 answerable, but building on what George had said. This
3 analysis seems to bring to it a point of view that says
4 observation use is an alternative to inpatient use, and I
5 think it's possible it's actually an alternative to other
6 uses of other parts of the ambulatory care system as well
7 and that it could be a trend driven by lack of well managed
8 outpatient care, lack of access to primary care, higher
9 volumes of emergency room visits to begin with. I don't
10 know for sure, but I just think it's a question that's worth
11 asking about.

12 And then second, when I look at these trends, I
13 think one question I would raise as to whether this is good
14 or bad would be any information we'd have about the health
15 or quality implications of being two to three days in an
16 observation status unit versus two to three days in an
17 inpatient bed. Infection rates or other information like
18 that, I don't know if those are analyses that are even
19 possible, but it's certainly a question that comes to my
20 mind.

21 MR. GAUMER: We did a literature search to snoop
22 around for some of that, and there really wasn't a lot out

1 there. So we're still looking, and hopefully someone will
2 come out with something soon. So I'll have to get back to
3 you on that as well.

4 MS. BEHROOZI: Just on the anecdotal reports of
5 patients being surprised by SNF, SNF stays not being
6 covered, I wonder if you have looked or if it's possible to
7 look at on the impact on payable SNF claims by Medicare.

8 MR. GAUMER: No, not yet, but we want to do that
9 as well. So I would love to get back to you on that.

10 MR. BUTLER: So two quick ones: One, I assume the
11 people that are surprised on the 20 percent co-pay are
12 those, as I referenced in the last session, that don't have,
13 the 10 percent that don't have any supplemental, that are
14 paying out-of-pocket. So it's probably a small percentage
15 of the population that is actually paying that co-pay,
16 right?

17 MR. GAUMER: I believe that's correct.

18 MR. BUTLER: Depending on the supplemental plan,
19 but in general.

20 MR. GAUMER: Yes, I think that's true.

21 MR. BUTLER: The second thing is more technical.
22 The big growth in the 48th hour and beyond, you know, I

1 thought there was some restriction even in being able to
2 bill or being credited for anything beyond 48 hours that was
3 somehow, that was fixed, and so part of this increase is not
4 maybe a real increase but a documentation issue in what's
5 going through the system. Is that true?

6 MR. GAUMER: There are two points, I think, to
7 make in response to that. The language about the criteria
8 of observation care, on that slide, I'll go back to it.

9 I was essentially -- the text I was speaking was
10 essentially reading the policy that Medicare has on this,
11 where it says the hospitals should not exceed, or only in
12 exceptional circumstances should the observation exceed, 48
13 hours. So there's no hard, fast rule specifically.

14 But I've heard through the course of this that a
15 lot of hospital billing systems are set up to truncate to 48
16 hours, and so when they submit a claim it comes in at 48
17 hours no matter what. It could have been 72 or 49; it comes
18 in at 48.

19 So you see that in the claims data. You see a
20 spike at 48, and that's why we decided to look at the trends
21 in terms of 48 or greater -- because we think that a lot of
22 the 48-hour claims are actually somewhat longer.

1 MR. BUTLER: Yes, I know that's what we were
2 doing. Then there's no difference in the payment to us.

3 MR. GAUMER: Right.

4 MR. BUTLER: Except for additional ancillaries
5 that would be ordered in those additional hours.

6 MR. HACKBARTH: Can I follow up on Peter's first
7 question? So for the 20 percent co-insurance on the
8 additional services, typically, most beneficiaries are going
9 to have supplemental coverage of some form to help cover
10 those. However, on the SNF care, so if they're deemed
11 ineligible for SNF care because they didn't meet the three-
12 day hospitalization requirement, that would not be typically
13 covered by the supplemental coverage because it's an
14 uncovered service.

15 MR. GAUMER: That is correct.

16 DR. MARK MILLER: And just on the point of how
17 much you get paid, the way I understood it when we talked
18 about it is if you're in less than eight hours you don't
19 even get the observation payment.

20 MR. GAUMER: Right.

21 DR. MARK MILLER: If you're over eight hours you
22 get the observation payment, the 720 or whatever it was, and

1 then nothing else, no matter how long, but you can bill for
2 the ancillaries. And I think that's what you're saying,
3 right?

4 MR. GAUMER: Yes. No, that's good.

5 DR. NAYLOR: So I really applaud the focus on
6 observation days and on both the quality issues as well as
7 the beneficiaries' liability issues. I think this is really
8 important.

9 Can you comment on, and it probably was in this
10 great report, but the percentage of people who are
11 subsequently hospitalized following observations versus
12 discharged and if you know anything about the differences --
13 you mentioned it in the report -- on staffing in observation
14 units, although people can go throughout the hospitals, but
15 versus the traditional inpatient?

16 MR. GAUMER: Okay. This is kind of a tricky data
17 issue, so I'm going to try not to get too far into the weeds
18 on it. But generally it can be hard to follow, the
19 observation claim, into the inpatient side of the data
20 world. Okay.

21 But luckily, looking at hospital cost reports,
22 there is some good information there on the all-payer

1 universe. So we're looking at Medicare, private, everybody
2 that's coming through the hospital, and generally on that
3 level, across the nation, about 16 percent of all
4 observation cases get admitted.

5 Just based upon my own opinion, I'm going to guess
6 that it's comparable for Medicare. That's kind of what I've
7 heard when I ask some experts what they've thought. But I
8 would love to try and get some more detail from that
9 inpatient data.

10 I just need more time to do it, so I'll try to do
11 it.

12 DR. MARK MILLER: Anything on staffing?

13 MR. GAUMER: I'm sorry?

14 DR. MARK MILLER: The second question on staffing,
15 differences in staffing.

16 MR. GAUMER: Ah, yes. The observation units, what
17 I've read on the observation unit is that devoted staff,
18 people that are devoted, they are physicians, hospitalists
19 often and nursing staff that are devoted specifically to the
20 observation unit, and that observation unit can exist in its
21 own room or it can exist kind of in a virtual sense
22 throughout the hospital.

1 Generalizing again, hospitals that don't have the
2 observation units often will rely on the staff of the unit,
3 the inpatient unit or even the ER, where the patient gets
4 placed. So the admitting physician will be tracking that
5 patient, and the staff devoted to that bed, wherever it may
6 be, will be responsible for the hourly care or the
7 monitoring.

8 MR. HACKBARTH: Any other clarifying questions?

9 DR. CASTELLANOS: On Page 14, you suggested the
10 forum suggested regulatory changes that may have had an
11 influence. What are those regulatory changes that were
12 suggested?

13 MR. GAUMER: These are some of the things that Dan
14 was referring to.

15 DR. CASTELLANOS: Okay.

16 MR. GAUMER: So policy changes in outpatient
17 policy, and then at this forum folks were also citing
18 changes to the observation criteria as well as the inpatient
19 criteria.

20 And I think just to give you a taste for what was
21 being said, I think in terms of the observation and
22 inpatient criteria I think folks were saying that generally

1 these criteria were being made more difficult to interpret
2 generally, whether that meant more strict, less strict, more
3 difficult to interpret.

4 DR. CASTELLANOS: That heads off my next question.
5 On Page 4, you mention that a lot of the providers are using
6 guidelines from QIOs, trade associations and private
7 consultants.

8 And I guess my question really is to what extent
9 are the hospitals using this software, the black box,
10 specifically maybe InterQUAL from McKesson?

11 MR. GAUMER: I've heard that roughly 80 or 85
12 percent of hospitals are using InterQUAL from McKesson. The
13 articles I've read have not given much information about
14 what's contained in that software, but that it's used pretty
15 widely across the hospital industry.

16 You know at the same time hospitals are using
17 other consultancies. It sounds like some choose to use the
18 QIOs. It sounds like a lot of hospitals are coming up with
19 their own admitting criteria, probably all. I don't really
20 know, but there's a lot of evidence out there. Sorry.
21 There are a lot of criteria out there to read that are
22 written by QIOs, consultancies, hospitals, even physician

1 groups and such. So there's a lot of information out there,
2 a lot of different ideas.

3 DR. CASTELLANOS: I'll follow up with that
4 question in level two.

5 MR. GAUMER: Okay.

6 MR. HACKBARTH: Okay, round two. Oh, I'm sorry.

7 MS. UCCELLO: Just a quick question, 16 percent
8 overall observation stays get admitted. Does that vary by
9 the length of observation stay?

10 MR. GAUMER: I don't know the answer to that.

11 DR. CASTELLANOS: Round two.

12 DR. BORMAN: I think that clearly the use has gone
13 up. I think this is extraordinarily difficult to dissect,
14 and you guys have made a really great run at it. There are
15 just a lot of moving parts that have gone on here, and I'm
16 not sure that in the end we'll know the answer, and in the
17 end I'm not sure we need to know the answer. I think maybe
18 we need to understand sort of the pieces that have fed into
19 it.

20 I personally believe one of the biggest nuggets
21 here is disparate use of terminology or the same terms
22 meaning different things. For example, observation services

1 provided by physicians, according to CPT definitions, are
2 something that you would think marry up to a hospital,
3 considering an event, an episode of care of a patient being
4 an observation service, but that's not necessarily so at
5 all. And that leads to enormous confusion.

6 And then, as the other practicing physicians at
7 the table can attest to, you regularly get these calls about
8 recoding your admission and doing different things in order
9 to optimize performance for the hospital side, yet that may
10 or may not be consistent with how you bill on the physician
11 side for observation. So there's an enormous morass in here
12 that I think would be very difficult to tease out.

13 I think the more important trends are it's going
14 up. Are the things that we're moving into doing with this,
15 are they safe? Are they appropriate? Do they bring value
16 to the beneficiary?

17 Should we be doing something different? Is there
18 a way that we want to do observation?

19 What is the value? Should there be more
20 strictures around it?

21 As opposed to necessarily trying to drain a swamp
22 here, that I think will be very difficult. For example, if

1 you extend this out to 48 hours, you can start to get a lot
2 of operations that may or may not be appropriate performed
3 on a totally ambulatory basis because now you've basically
4 converted it into a 36-hour admission.

5 So I think there are just a lot of things here.
6 We need to ask ourselves what is our purpose in looking at
7 this. And if it's to dig into the details, we have a
8 wonderful analytic staff. I have no doubt they can do it.
9 If they can't, nobody else can.

10 But if the object is to say is there something
11 here about policy, are we incenting the right things, then
12 maybe we need to frame our questions more clearly to that
13 end.

14 MR. HACKBARTH: Good point and good question, so
15 let me ask Mark to respond to that.

16 As I recall, the genesis of this was that I think
17 George and Peter, maybe Herb, had raised the question about
18 what's going on with observation days and a lot of people
19 had associated it with the RAC program.

20 So initially, I think we were just trying to
21 respond to that Commission request: What do the data
22 indicate?

1 But now you've framed sort of the next question.
2 Okay, we've begun some data analysis. What's the end point
3 on this? Where are we ultimately headed with this
4 conversation?

5 DR. MARK MILLER: And that's exactly right in
6 terms of it, and I think this is not unusual for us, to kind
7 of muck around a bit in the data and try and see if there's
8 something here.

9 For myself, I think it's relatively clear that
10 there is at least one beneficiary angle that has come out of
11 this, and maybe more, but certainly one.

12 On the payment side, I mean, and this is a long
13 way around of I'm not sure. On the payment side, there's at
14 least two more pieces of information that I want before I
15 start to think of is there a payment policy objective here.
16 One is I want to see what the other billings are going on
17 around the observation stay. If I can't do that, then I'm a
18 little unsure what I'm to do.

19 And I'm also kind of curious about how many of
20 these do turn into the inpatient setting. I know we have a
21 general number, but I'm curious about that. So we are
22 obviously mucking around with the data.

1 The exact next step for policy and payment are
2 unclear to me, and I have a couple ideas and a couple things
3 I want to see. On the bene side, I think there are at least
4 a couple things that we may have things to say about.

5 DR. BORMAN: I personally think the beneficiary
6 side is the clear thing out of what you've shown us so far,
7 where we need to be deeply interested in that piece I think,
8 and then the point of is there a bundle of services around
9 here that's not being captured as a bundle and that would be
10 appropriately captured as a bundle. Those are the two
11 things that I think potentially jump out.

12 And then maybe is there a safety/quality issue
13 here that we may not be equipped to speak to necessarily,
14 but we may at least uncover and ask someone else to take it
15 forward.

16 MR. HACKBARTH: Let me just pick up on the
17 beneficiary aspect of this and invite people to react during
18 a round two. It doesn't seem right to me to hold the
19 beneficiary responsible and potentially have them handed the
20 entire bill for a SNF stay after they've been three days in
21 an observation unit. If they are three days in the
22 hospital, whether it's classified for payment purposes as an

1 inpatient stay or as an observation stay seems to me ought
2 to be irrelevant for whether the beneficiary is covered for
3 an ensuing SNF stay. To leave them holding the bag just
4 doesn't seem right. So I invite anybody to explain why
5 that's wrong-headed.

6 Let's see. So, Tom.

7 DR. DEAN: I would, first of all, just certainly
8 reinforce what Karen just said about the confusion that
9 surrounds this whole issue. It's a constant source of
10 confusion for us.

11 In response to Peter's question, I think there are
12 some things that are not paid for by supplement policies,
13 even for those people who have them. The one that we get
14 the most flack about is drugs -- that as I understand it,
15 when a patient is admitted for observation, they can bring
16 their own medications and they can supply their own
17 medications, except the problem is they'll bring in a bottle
18 with half a dozen different kinds of pills in it and there
19 is simply no way that the hospital staff can verify what
20 those are. So they use hospital supplies, and then they get
21 billed at hospital charges. You know the \$5 aspirin and all
22 that sort of stuff.

1 And I don't know. I hadn't encountered this
2 before, but I suspect that maybe supplement policies don't
3 cover that, if there is a rule that they could bring their
4 own. I'm guessing because I know it has come up quite a
5 bit, and people will object to the idea of their being
6 admitted to observation for things like that. I suspect it
7 may cover for other things, at least I'd say that's the one
8 that we've gotten the most objections about.

9 The three-day stay issue, I guess it's hard for me
10 to comprehend. That comes up also a lot in our situation,
11 and we watch it very carefully, that I can't believe that a
12 hospital staff would try to admit somebody to skilled care
13 after three days of observation. Maybe they do, but I know
14 that that's sort of a very basic requirement although, to
15 get more basic about it, there's a lot of question about
16 that requirement in general. But that's beyond the scope of
17 our discussion.

18 And I guess finally, and this might be off the
19 topic a little bit, but I'm wondering about the other
20 regulatory things. We went through a big turmoil this last
21 year about the physician supervision issue, and I don't know
22 whether that has come up in your discussion or not. That

1 was where CMS said that for a patient that was admitted for
2 observation for a wide variety of services, including simple
3 IV therapy if I admitted somebody that was dehydrated, the
4 physician had to be in the hospital all the time they were
5 receiving that service or else it would not be paid for. It
6 created a great stir, and finally CMS backed off on that
7 requirement.

8 My understanding was that they were seriously
9 looking at reinstating that, and it was completely
10 illogical because if I had admitted that patient there was
11 not a problem. Yet, in our situation at least, it's the
12 same staff, the same beds, same nurses, everything. But if
13 they were on observation, the nurses were not allowed to
14 supervise; you had to have a physician there. On the other
15 hand, if they were on observation, the physician had to be
16 there, completely nonsense.

17 And finally, CMS backed off because they got this
18 huge pushback, but my understanding is that they're still
19 contemplating applying that requirement. I don't know. Do
20 you guys?

21 DR. ZABINSKI: On this most recent outpatient
22 rule, they've sort of made clear that I think they're going

1 to do what you said they decided to do, sort of back off on
2 it, the requirement that the physician be there all the
3 time. At the beginning, if I recall, it's like at the
4 beginning the physician has to be there just at the start of
5 it. Then after that staff can handle it.

6 DR. DEAN: I just wondered if that was part of CMS
7 pushback to try to stem this trend. I don't know. I mean
8 it's not a logical response.

9 MR. HACKBARTH: Are we able to determine how
10 frequently patients go to SNF care after observation care?

11 DR. ZABINSKI: I haven't been a part of doing that
12 yet, but my basic understanding is that we can link those
13 two things. So I'm hopeful.

14 DR. BAICKER: I think this is a really interesting
15 fact pattern, strongly suggesting that is a case where the
16 financial incentives are changing labeling in a way that
17 doesn't map to real changes in care, and I'd be very
18 interested to see more drilling down on the scenarios in
19 which it most affects provider reimbursement and the
20 scenarios in which it most affects beneficiary out-of-pocket
21 liability, and how those correlate. So you could look at
22 observation care after an initial admission versus not after

1 an initial admission, to get a the readmission incentive and
2 map the specific provider incentives for that observation
3 care to how much of the cost is then really getting
4 displaced onto patients who are then paying for skilled
5 nursing facility care that they wouldn't have to otherwise.

6 I'm sure there are lots of other cases, but it's
7 much more frequently that the incentives are more aligned.
8 This seems like a direct displacement that we don't see that
9 often and that we should be particularly concerned about the
10 financial incentives it creates for the providers.

11 MR. GEORGE MILLER: Yes, I was going to say
12 something similar.

13 And I agree with you, Glenn, that in this
14 particular issue, for the beneficiaries who come to a
15 hospital but may be in observation status, they really don't
16 know that. They're there in the hospital to be cared for.
17 They should not suffer financially because of that quirk.
18 From a policy standpoint, we could fix this.

19 So, of the conclusions, I would strongly suggest
20 that we come up with something that would deal with this
21 issue very specifically while we look at all the other
22 issues that have been raised around the table. But this is

1 something from my perspective, from a policy standpoint, we
2 should be able to fix relatively easily and very quickly
3 because it is unfair. It's just absolutely unfair.

4 MS. HANSEN: I can only concur with what's been
5 already said.

6 I guess I do have one question that intrigues me.
7 That is if in fact, now with this 30-day readmission kind of
8 under the bright lights, how much this will possibly change
9 over time because people, systems will not want this on
10 their record to be a real, true readmission, but an interim
11 stabilization opportunity and have this be reimbursed at
12 least at this level, again with the punitive potential
13 issues onto the beneficiary. But just as a point of
14 notation, since 2008, we now have the 30-day readmission
15 component side of it. So I wondered if that's something
16 just to be attuned to as a workaround. You know. Not to
17 get reported in that way. So that's something, that light
18 should be shone on this early just so that it doesn't become
19 a mechanism to deal with this differently. Yes, yes.

20 MR. GAUMER: Okay. That sounds good.

21 Mark, do you want to say more about the
22 readmissions? I don't know.

1 Okay. I thought you were looking at me.

2 MR. HACKBARTH: Well, you would think that all
3 other things being equal, with a focus on readmissions and
4 the link and payment to readmissions that this would become
5 more of an issue in the future, rather than less.

6 MR. GAUMER: Yes.

7 MS. HANSEN: Just, I said that I also concurred
8 with the policy discussion changes on behalf of the
9 beneficiary. I wonder if even some interim kinds of things,
10 so that people upon admission are just notified formally
11 that this is the case because what happens with some people
12 who are quite ill and perhaps need the SNF a little bit
13 later. I mean they are the ones who are most surprised. If
14 there is any kind of way to kind of let people know this is
15 going to be one of their responsibilities until we get the
16 policy fixed.

17 MR. HACKBARTH: Let's see. Anybody else on this
18 side?

19 MR. ARMSTRONG: Just briefly, I want to concur
20 with many of the recommendations made.

21 Just one additional point would be, and this
22 perhaps comes because I'm new to the Commission, but it

1 seems as if what we're observing is a system. Different
2 interventions create different kinds of results, and we
3 can't always predict what they are. I mean the volume of
4 in-the-office provider ancillaries, they're kind of all over
5 the place. And it feels a little like whack-a-mole where
6 you knock it down one place, then it pops up somewhere else,
7 but it's always moving around.

8 Anyway, it's just provocative to me to imagine how
9 we pay attention to how the whole system is working and
10 every once in a while just check in on are we seeing blips
11 that we either predicted or didn't predict because of some
12 of the policy changes that we've made in the past, rather
13 than responding, staying kind of a step ahead or at least
14 co-equal with some of those changes.

15 MR. BUTLER: Okay, a couple of comments. Is it a
16 quick technical fix to say if you stay longer than 72 hours
17 that's the same as a 3-day stay and therefore you qualify
18 for the 3-day stay? That would be another way for the SNF.
19 That would be a very simple technical fix.

20 DR. MARK MILLER: Well again -- and I'm not
21 proposing this. I mean you could also just say that
22 observation days count, whether it's one or two.

1 MR. BUTLER: Right.

2 DR. MARK MILLER: I mean you're sort of saying if
3 three occur, then they count.

4 MR. BUTLER: Or if you had one day on observation
5 and two days as an inpatient, yes.

6 DR. MARK MILLER: Right. I mean those are the
7 kinds of things, yes.

8 MR. BUTLER: Right, because I think that probably
9 is the biggest liability. But, okay.

10 So more general comments, we haven't really said
11 it that clearly, but the difference between being an
12 inpatient and an outpatient is going to really get blurred
13 here rapidly. We have some cases, for example, that we do
14 as an outpatient that we're required to bill as an
15 inpatient. There's no outpatient code.

16 Now you want to save some money? You know, force
17 it into? We have joint replacements that go out the same
18 day. We have to bill them as inpatients. They don't ever
19 get in a bed. Figure that one out.

20 So this blurring is tricky, and it's going to only
21 get trickier I think.

22 Second is --

1 MR. HACKBARTH: On that example, Peter, it's
2 because joint replacement isn't on the list.

3 MR. BUTLER: Right, it's not an outpatient
4 billable code. So go figure, right?

5 Okay. You talk about your lowest cost
6 alternative, and I give you an idea.

7 Okay. So where was I?

8 I think in general the hospitals, first of all,
9 are not doing observation days in any way for positive
10 financial results. They don't look at these things and say
11 these are profitable. They're avoiding not getting paid on
12 the inpatient side.

13 And I think the difference between RAC and non-RAC
14 is we're all getting ready for RAC whether it's there or
15 not. We're all getting ready for readmissions, whether
16 there or not. We all have confusing admission criteria that
17 are being deployed, and it's across all payers.

18 So I think those collective things are saying we
19 better err on the side of making these observations, which
20 in general I'm told, as we look at our data, are actually
21 more expensive. Unlike what you speculated in the paper,
22 it's actually more expensive, especially if it's on the

1 unit. You have to be more attentive to the vitals and the
2 checking-up than you would if they were inpatient. So it's
3 not like a cheaper first day if you have it an observation.
4 So that's just one thought.

5 And then the last, maybe more important one is
6 here we're building, going to open a new facility with a
7 huge ER that has 60 rooms in part because we see medicine
8 moving towards the emergency room in order to manage these
9 very things. We will have observation rooms, so that we
10 think as a congestive heart failure comes in or as a chest
11 pain comes in we have both the ancillaries and the staff to
12 handle it as the continuum care much better there than
13 having the elderly go in a unit, get disoriented, stay
14 several days and come out worse than when they came in.

15 So as I think Scott was pointing out, I think it's
16 an important part of the continuum. In general, these are
17 good things if done in the right way, but certainly they
18 shouldn't be -- the beneficiary can't be liable as a result.

19 DR. CHERNEW: I only wanted to say that while I
20 agree that this issue about beneficiary liability is an
21 important one and seems quite unfair we have had discussions
22 about churning from nursing homes, where people are going

1 into the inpatient stay when they shouldn't. So a solution
2 that just makes the observation qualify them for a higher
3 SNF payment may not be one we want to jump on until we know
4 more of exactly what's going on and how to deal with other
5 types of issues around the broad spectrum of caring for
6 certain types of patients.

7 DR. CASTELLANOS: I want to get back to that black
8 box thing. You know, it bothers me because what that black
9 box is doing, or the InterQUAL is doing, is making admission
10 based on financial considerations. CMS is asking me as an
11 admitting physician to consider the medical predictability
12 of some adverse thing happening, the severity of the
13 symptoms, et cetera, but yet the black box which is used by,
14 what, 85 to 90 percent of the hospitals is predominantly
15 making these decisions.

16 As Karen very eloquently said, even if I admit the
17 patient, I get something from the hospital saying we want
18 you to change the status. And sometimes they change the
19 status, and it's another clarification without my
20 notification. They get one of the hospitalists or another
21 doctor, even though I'm the admitting doctor, to change the
22 status. So that bothers me quite a bit.

1 The second issue is the beneficiary side and Tom
2 is absolutely correct. This three-day admit doesn't make
3 any sense. And we heard this morning that some of the MA
4 programs don't require that and directly put the patient
5 into a SNF if he or she requires SNF. To me, I don't know
6 where you get that three-day decision.

7 I've had patients, and I can give you clinical
8 issues -- an 84-year-old frail lady, no family, no nothing,
9 with a fractured pelvis, and that's all she had. She had a
10 little blood in the urine, and that's how I got involved.
11 Yet, she couldn't go home. She has a fractured pelvis. She
12 went to a SNF for eight weeks and had thousands and
13 thousands of dollars a bill, and it's just not fair.

14 The last thing is something I was reading on this,
15 and I'm just asking you if you could look into it -- the
16 Oregon health plan policy. They don't ask the hospitals to
17 make a level on care determination, but instead the Oregon
18 health policy pays hospitals for outpatient services if less
19 than 24 hours and pays inpatient rates for anything above 24
20 hours.

21 I'm just wondering. I don't know anything about
22 the Oregon health plan. But if they can do it and have good

1 statistics and good results, it's maybe something we should
2 look into.

3 DR. MARK MILLER: Ron, on your first point, I
4 wasn't quite sure what, on the InterQUAL.

5 DR. CASTELLANOS: Yes.

6 DR. MARK MILLER: What was the complaint?

7 DR. CASTELLANOS: I guess my problem is it's a
8 black box making the determinations, and at one time -- I'll
9 level it.

10 At one time, I think Medicaid didn't use this.
11 They didn't allow these types of softwares to make these
12 decisions. They do it now.

13 And I know when we talked --

14 DR. MARK MILLER: See, Ron, this is why I wanted -
15 - I'm not sure this is a Medicare policy. That's what kind
16 of threw me when you made it.

17 DR. CASTELLANOS: Well, it's not a Medicare policy
18 now, but it was now, and now it's been reversed. And we
19 talked a little bit about this when we talked about the
20 groupers last year.

21 I guess what I'm saying, Mark, is that these
22 determinations are predominantly dictated and done perhaps

1 with physician concurrence, but without looking at some of
2 the clinical indication that I think are very important.

3 MR. KUHN: One of the areas that could be looked
4 at here, that might be worth checking out, is that when
5 there is ultimately a denial and then they have to go
6 through this extensive appeal process, then these kinds of
7 tools, these decision support tools you're talking about,
8 Ron, come into play here.

9 Maybe one of the ways we can get a better
10 understanding of this as we come back to this issue is have
11 MedPAC staff talk to some of the Medicare Administrative
12 Contractors, the MAC Medical Directors, because they deal
13 with this issue day-in and day-out.

14 They're out there advising providers and probably
15 one of the best sources of information we could probably get
16 on this. So that might be the place to delve into what
17 you're talking about there.

18 DR. CASTELLANOS: Thank you.

19 MR. HACKBARTH: And the 3-day requirement, 3-day
20 hospitalization requirement for SNF eligibility, boy, that's
21 been around as long as I can remember, going at least back
22 into the early eighties, late seventies, if not before. And

1 I don't know who thought that was a good idea and what the
2 rationale was.

3 MR. BUTLER: I think it goes right back to the
4 beginning.

5 DR. BERENSON: To try to prevent it from being a
6 long-term care benefit, yes.

7 DR. STUART: It's worth noting that that was
8 repealed by the Medicare Catastrophic Coverage Act, and
9 there was a period of time when non-hospital-related SNF
10 care was covered. So there is some and there has been some
11 research around that. So if that's something that you
12 wanted to bring back, there is a small literature about
13 that.

14 DR. CASTELLANOS: There was discussion this
15 morning that the MA programs, some of them don't require
16 that. So that policy is in effect today by some MA
17 programs.

18 DR. MARK MILLER: Right, but also those programs
19 often have prior auth and that type of thing, can have
20 limitations on benefits as well.

21 DR. CASTELLANOS: I just think it's something
22 that's been around for a long, long, long time, to me

1 doesn't make sense from a clinician viewpoint and may be
2 something we should look at.

3 DR. BERENSON: If I could just add, the listening
4 meeting on ACOs that I went to, there was some discussion
5 that ACOs might be able to waive the three-day stay just
6 like an MA plan. If there's an integrated group doing
7 active management, perhaps that's something they would want
8 to do.

9 MS. HANSEN: And just to point out that the PACE
10 projects don't have that limitation either. So it seems
11 like there are all different little pockets around it.

12 MR. HACKBARTH: Yes. Okay. We are at the end of
13 today. All that remains is -- and thank you, Zach and Dan,
14 well done.

15 All that remains is the public comment period, and
16 let me briefly remind you of the ground rules for the public
17 comment period. Please limit your comments to no more than
18 two minutes. When you see this red light come back on, that
19 will signify that your two minutes are up. And please begin
20 by introducing yourself and the organization that you
21 represent.

22 MS. TOMAR: Is this on?

1 MR. HACKBARTH: Yes.

2 MS. TOMAR: I'm Barbara Tomar. I'm with the
3 College of Emergency Physicians, and I'd just like to make a
4 couple of comments about observation and the discussion we
5 just had.

6 First, I think one of the drivers for the increase
7 in observation use happened when the Medicare outpatient
8 program switched from a limitation of only three conditions
9 and diagnoses that were eligible for Medicare payment for
10 observation to an unlimited number. That happened in 2008.
11 So that was one area where utilization started to go up.

12 Secondly, I really want to make sure that you
13 understand there's a real differentiation between the
14 dedicated observation units and then people who are in
15 observation status on inpatient floors. A lot of our
16 members who are emergency physicians also run an observation
17 unit, and it's also staffed by the emergency department,
18 nurses and other clinical and ancillary staff. And there
19 are a lot of rules in Medicare under observation about what
20 you have to do and the timing. The average length of stay
21 in those units is 15 hours, and only 1 percent of patients
22 in some of the studies that have been published have ever

1 stayed more than 48 hours. So I just think that's
2 important. There are really two distinct types of units.

3 The other thing I just wanted to mention was with
4 regard to the three-day stay rule. We have long been on the
5 public record as wanting to support counting time in
6 observations toward the three-day stay. That rule is in the
7 original Medicare law from 1965, and I think probably some
8 of you are aware that there was a challenge to that in the
9 courts. It winded its way up to the federal district court,
10 and in 2008 they denied the plaintiff's request to count
11 observation. But it is something that could be done
12 administratively. Thank you.

13 MR. LINDE: Keith Linde, AARP.

14 I just wanted to drive home the point that was
15 made over here a little earlier about the drug costs in the
16 outpatient setting. Part B, as you know, only covers non-
17 self-administered drugs. If you have Part D, it doesn't
18 work so well, and even though you have Medigap the Medigap
19 doesn't cover Part D drugs. If you have Part D, you have to
20 go through your pharmacy. The Part D providers don't cover
21 it. So it's a problem even if you have supplemental
22 coverage.

1 Admittedly, the SNF denial as non-coverage is a
2 much bigger financial liability issue than the drugs. But
3 those \$5 aspirins in the outpatient setting can really
4 balloon and snowball, and it's something that would affect
5 all observation stays, not just the ones that go to SNFs.
6 We've been getting letters, complaints from our members
7 about this issue. They're concerned about it.

8 Thank you.

9 MS. MCEL RATH: Sharon McElrath of the AMA.

10 In terms of the black box I think one of the
11 things that changed, that's also relevant, is that CMS did
12 have a rule, going back to they had some edits that were
13 also from McKesson called the Cox (phonetic) edits that said
14 they weren't going to use the black box edits. They were
15 going to use CCI edits which are ones that are vetted within
16 the physician community before they take effect.

17 What happened with this, as I understand it, was
18 that CMS sent out something to the QIOs who were doing
19 medical review in the hospitals and saying, well, now you
20 can use the commercial software. So first the QIOs were
21 using it. Well, the QIOs at least had a rule that said
22 before you deny something it has to be reviewed by a

1 physician of the same specialty. So maybe there weren't so
2 many problems that people were seeing then.

3 Well then CMS transferred that function to the
4 contractors. So it predates the RACs.

5 And as people have said, it's the whole thing of
6 you know you're going to reviewed, you're going to get
7 denied. So facing that and knowing that those people were
8 all using InterQUAL then, and InterQUAL made it much easier
9 for the hospitals then to use them. So one of the reasons
10 that the hospitals all took up the InterQUAL, as we
11 understand it, is because that's what the other people were
12 using, because Medicare changed its policy regarding
13 commercial software.

14 MR. HACKBARTH: Okay, we are adjourned for today
15 and reconvene at 9:00 a.m. tomorrow.

16 [Whereupon, at 5:23 p.m., the meeting was
17 recessed, to reconvene at 9:00 a.m., Tuesday, September 14,
18 2010.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Tuesday, September 14, 2010
9:00 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, JD, Chair
ROBERT BERENSON, MD, FACP, Vice Chair
SCOTT ARMSTRONG, MBA
KATHERINE BAICKER, PhD
MITRA BEHROOZI, JD
KAREN R. BORMAN, MD
PETER W. BUTLER, MHSA
RONALD D. CASTELLANOS, MD
MICHAEL CHERNEW, PhD
THOMAS M. DEAN, MD
JENNIE CHIN HANSEN, RN, MSN, FAAN
NANCY M. KANE, DBA
HERB B. KUHN
GEORGE N. MILLER, JR., MHSA
MARY NAYLOR, PhD, RN, FAAN
BRUCE STUART, PhD
CORI UCCELLO, FSA, MAAA, MPP

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AGENDA	PAGE
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Public Comment	139

1 P R O C E E D I N G S [9:00 a.m.]

2 MR. HACKBARTH: Okay. Let's get started. It is
3 time for us to begin. Good morning.

4 So our first session this morning is on addressing
5 the growth in ancillary services in physician offices.

6 Ariel?

7 MR. WINTER: Good morning. I want to begin by
8 thanking Dan Zabinski and Kevin Hayes for their help with
9 this presentation.

10 In this year's June report, we discuss the in-
11 office ancillary services exception to the Stark Law, the
12 growth of ancillary services in physicians' offices, and
13 potential strategies to address this growth. We do not make
14 any recommendations in this report.

15 In today's session, we will start off by
16 presenting some data comparing the growth of ancillary
17 services in physicians' offices with the growth in hospital
18 outpatient departments. This analysis was requested by some
19 Commissioners. We will also briefly review the policy
20 options we described in the June report and assess whether
21 you are interested in developing any of these into
22 recommendations for a future report.

1 We've included background material in your paper,
2 but I'm going to briefly highlight some key points. First,
3 the physician self-referral law, also known the Stark Law,
4 prohibits physicians from referring Medicare or Medicaid
5 patients for certain designated health services to a
6 provider with which the physician has a financial
7 relationship.

8 However, the law generally allows physicians to
9 provide most of these services, such as lab tests, imaging,
10 physical therapy, and radiation therapy in their offices,
11 and this is known as the in-office ancillary services
12 exception.

13 This slide highlights some of the key potential
14 benefits and concerns about physicians performing ancillary
15 services in their offices. Proponents point out that the
16 exception enables physicians to make rapid diagnoses and
17 initiate treatment during a patient's office visit. This
18 could improve patient convenience, their adherence to
19 treatment recommendations, as well as coordination of care.
20 And there's also an argument that this expands access to
21 care.

22 However, additional capacity for services like

1 imaging could lead to a higher volume. In addition,
2 physicians who invest in equipment for their offices have a
3 financial incentive to order additional services and several
4 studies, including work done by the Commission, provide
5 evidence of a relationship between self-referral and higher
6 volume.

7 Over the last several years, there's been an
8 increase in imaging, lab tests, physical therapy, and
9 radiation therapy provided in physicians' offices. As
10 described in the June report, ancillaries, particularly
11 diagnostic imaging, account for a significant share of Part
12 B revenue for several specialties.

13 In a proposed rule issued in 2007, CMS asked for
14 comment on whether certain ancillary services should no
15 longer qualify for the in-office exception such as services
16 that are not needed at the time of an office visit to help
17 physicians with diagnosis or treatment. To date, CMS has
18 not taken further action on this.

19 Some Commissioners have asked us to compare trends
20 in the growth of ancillary services and hospital outpatient
21 departments with the growth under the physician fee-
22 schedule, and the next few slides present these results.

1 This table shows the average annual change in the
2 number of services per fee-for-service beneficiary from 2003
3 to 2008. The bottom line is that for all three categories
4 we examined, diagnostic imaging, outpatient therapy, and
5 radiation therapy, the number of services has grown faster
6 in physician fee-schedule settings than in outpatient
7 departments and other settings.

8 I want to point out that outpatient therapy
9 includes physical therapy, occupational therapy, and
10 speech/language pathology services.

11 Although not shown on this slide, the average
12 annual payments for diagnostic imaging have actually grown
13 faster in outpatient departments than in physician fee-
14 schedule settings. And this runs counter to the trend we've
15 seen for growth in the number of imaging services.

16 The reason for this is that physician fee-schedule
17 payments for imaging fell by about 12 percent in 2007, due
18 in large part to a provision in the Deficit Reduction Act
19 that capped fee-schedule rates for the technical component
20 of imaging studies at the level of the outpatient rate.
21 This provision primarily affected MRI and CT codes. During
22 2008, physician fee-schedule payments for imaging began

1 growing again.

2 This chart shows cumulative growth in the number
3 of imaging services per beneficiary for outpatient
4 departments and physician fee-schedule services from 2003
5 through 2008. And the hospital outpatient services are
6 indicated by the green line and fee-schedule services by the
7 red line.

8 The first point to highlight is the steep
9 reduction in the number of imaging services in outpatient
10 departments in 2008, which was primarily due to a policy
11 change that packaged many outpatient department imaging
12 services with their related procedures. In other words,
13 some imaging services were no longer paid separately from
14 their associated procedures.

15 The second point is that even though physician
16 fee-schedule payments for imaging fell by about 12 percent
17 during 2007, the number of services continued growing during
18 this year.

19 The third point is that the DRA payment reductions
20 to fee-schedule imaging payments have sparked concerns that
21 CT and MRI studies will migrate from physicians' offices to
22 outpatient departments. In fact, from 2007 to 2008, the

1 number of CT studies grew faster in physician fee-schedule
2 settings than in outpatient departments, and the number of
3 MRI scans grew at comparable rates in both settings. These
4 data are not on the chart.

5 Another concern is that the trend of hospitals
6 purchasing physician practices has led to an increase in the
7 number of imaging studies referred to hospitals by
8 physicians. Unfortunately, we are unable to test this
9 hypothesis because we are not able to identify if physicians
10 are employed by hospitals using Medicare claims data.

11 This chart compares the cumulative growth of MRI
12 and CT services to all physician services. It differs in a
13 couple of ways from the prior chart. First, it focuses
14 exclusively on physician fee-schedule services, whereas the
15 prior chart included both fee-schedule and outpatient
16 department services.

17 Second, it measures changes in both the number and
18 intensity or complexity of services. The prior chart only
19 showed changes in the number of services. And it shows
20 growth in 2009 based on an AMA analysis that was presented
21 at the April RUC meeting. We've added the AMA numbers here
22 to give you a sense of how things have changed in 2009.

1 There are a couple of differences I want to point
2 out between our numbers and the AMA numbers. The AMA uses a
3 file from CMS with about 90 percent of physician claims from
4 2009. For our analyses we used files from CMS with 100
5 percent of claims and we will get the 2009 file in about a
6 month or so. So we haven't yet done our own analysis of
7 2009 claims. And second, AMA uses a different method than
8 we do to calculate changes in the intensity of services.

9 The chart shows the rapid increase in MRI and CT
10 scans from 2003 to 2006, following by a deceleration in the
11 rate of growth since then. According to our analysis, MRI
12 and CT services grew by 2 percent in 2008 versus 3.6 percent
13 growth in all physician services. The AMA numbers for 2009
14 are very similar.

15 It's important to point out that although growth
16 in MRI and CT has slowed down in recent years, these slower
17 growth rates were preceded by several years of rapid growth,
18 and over time, the volume of physician services has shifted
19 from evaluation and management and other services towards
20 imaging. There are reasons to be concerned that some of
21 this increased use of imaging may not be appropriate.

22 This slide lists the options that we described in

1 the June report to address concerns about the growth of in-
2 office ancillary services, and for the sake of the
3 presentation, we've separated radiation therapy and
4 outpatient therapy from diagnostic tests.

5 These strategies could be considered individually
6 or in combination and each one has strengths and weaknesses.
7 Before we delve into these options, it's important to point
8 out that physician self-referral creates incentives to
9 increase volume under Medicare's current fee-for-service
10 payment system which rewards higher volume.

11 Under a different model, however, in which
12 providers received a fixed payment for a group of
13 beneficiaries or for an episode of care, they would not be
14 able to generate additional revenue by ordering more
15 services. Therefore, the preferred long-term approach to
16 addressing self-referral is to develop payment systems that
17 reward providers for constraining volume growth while
18 improving quality.

19 But because it will take several years to
20 establish new payment models and delivery systems, you may
21 want to consider interim approaches to addressing self-
22 referral.

1 Improving payment accuracy is another strategy for
2 addressing the growth of self-referral, but because there is
3 separate work going on in this area, we have not listed it
4 separately on this slide.

5 Before and after the publication of the June
6 report, we met with several provider groups to learn about
7 their perspectives on this topic and to solicit their input
8 on policy approaches. We've also received letters from many
9 organizations, and many of these groups are noted on this
10 slide. Most of the groups raised significant objections to
11 the options that we discussed in the June report. However,
12 some organizations have supported tighter limits on self-
13 referral, namely groups representing physical therapists,
14 radiologists, radiation oncologists, pathologists, and
15 clinical labs.

16 The first approach we described in the June report
17 was to exclude outpatient therapy and radiation therapy from
18 the in-office exception. And this was based on the
19 rationale that physician investment in these services may
20 influence clinical decisions about the treatment of
21 patients.

22 In addition, therapeutic services are generally

1 not ancillary to an office visit because they involve
2 multiple sessions and are rarely initiated on the same day
3 as a visit. However, this change would limit clinically
4 integrated groups that treat a wide variety of cancers using
5 a range of modalities, including radiation therapy and
6 chemotherapy.

7 For example, a medical oncologist would no longer
8 be able to refer patients to a radiation oncologist who is
9 in the same group for radiation therapy. Therefore, we
10 developed another option that would limit the in-office
11 ancillary exception to physician practices that are
12 clinically integrated.

13 What we're trying to do here is balance the risks
14 of higher volume associated with self-referral with the
15 potential benefits of a clinically-integrated practice which
16 is comprehensive and coordinated care.

17 A key issue would be how to define clinical
18 integration, and here we propose two possible criteria. The
19 first one, which was described in the June report, would
20 require that each physician in the group provide a
21 substantial share of his or her services, such as 90
22 percent, through the group. The goal of this rule is to

1 increase the likelihood that the physicians in the practice
2 interact with each other frequently, share information about
3 patients, and follow the same clinical pathways.

4 Currently, groups can contract with or employ
5 specialists on a part-time basis to perform and supervise
6 ancillary services. For example, a group can contract with
7 a radiologist one or two days a week to supervise or perform
8 -- supervise and interpret imaging studies. Such
9 arrangements would no longer be permitted under this
10 requirement.

11 The second potential criteria, which we've
12 developed since the June report, would require the group to
13 have Electronic health record technology and to use it for
14 specific functions such as tracking patients with certain
15 conditions, using clinical decision support tools,
16 transmitting information across settings, and using
17 computerized order entry.

18 The required EHR functions could be based on the
19 meaningful use criteria that physicians must meet in order
20 to receive an incentive payment for adopting EHRs. The goal
21 of this criterion is to increase quality of care, improved
22 care coordination, and reduce the necessary use of services.

1 We do recognize that this would be a fairly high bar for
2 many groups to meet. However, physician groups that met
3 both of these criteria would be well-positioned to
4 participate in ACOs and to receive bundled payments.

5 An important question under this approach is
6 whether a clinical integration requirement should apply only
7 to therapeutic services or should it also be applied to
8 diagnostic tests. On the one hand, requiring practices that
9 provide any type of ancillary service in their offices to
10 meet these tests of clinical integration could improve care
11 coordination, quality, and adherence to clinical guidelines.

12 On the other hand, many small groups that provide
13 imaging or clinical lab tests in their offices may find it
14 difficult to meet these standards.

15 Finally, it's important to point out that even
16 clinically-integrated groups have an incentive to drive up
17 volume under the current fee-for-service payment structure.
18 So eventually, the payment systems would need to be changed
19 to hold providers accountable for costs and quality.

20 The next three options focus specifically on
21 diagnostic tests. Under the approach on this slide, tests
22 that are not usually provided on the same day as an office

1 visit would be excluded from the in-office exception. One
2 of the primary justifications for the exception is that it
3 enables physicians to make rapid diagnoses and initiate
4 treatment during a patient's office visit.

5 For our June report, we found wide variation in
6 how frequently different types of tests are furnished on the
7 same day as an office visit. For example, the rate at which
8 imaging services are provided on the same day as a visit
9 range from about 50 percent for standard imaging, like plain
10 X-rays, to 26 percent for ultrasound to 10 percent for
11 advanced imaging.

12 Under this approach, CMS would calculate the
13 percent of the time that each type of test was performed on
14 the same day as a visit, and then set a threshold for how
15 frequently tests would need to be provided on the same day
16 in order to qualify for the exception. For example, the
17 threshold could be 50 percent. Tests that fall below the
18 threshold would not be covered by the exception and
19 therefore, physicians would no longer be able to order and
20 perform these tests in their offices. CMS could rebase this
21 threshold every few years to account for changes in
22 technology and practice.

1 The next strategy is to reduce payment rates for
2 tests that are performed by self-referring physicians.
3 Studies by the Commission and other researchers have found
4 that physicians who furnish imaging services in their
5 offices refer patients for more imaging than other
6 physicians.

7 In addition, research by OIG has found that
8 patients of physicians who own clinical labs received more
9 lab tests than all Medicare beneficiaries, on average. The
10 objective of this approach is to recapture some of the
11 additional Medicare spending that is associated with self-
12 referral of diagnostic tests.

13 A key question would be how to determine the size
14 of the payment reduction. This could be based on empirical
15 estimates of the effect of self-referral on volume, or
16 taking into account activities that are duplicated when
17 tests are ordered and performed by the same physician, or it
18 could be based on the normative standard based on a policy
19 judgment.

20 Under the approach on this slide, Medicare would
21 require some physicians who both order and perform advanced
22 imaging studies to participate in a prior authorization

1 program. The focus would be on self-referring physicians
2 who order many more advanced imaging services for a given
3 condition than their peers.

4 Many private plans have been using prior
5 authorization programs to control the growth of high-cost
6 imaging and to ensure its appropriate use. These programs
7 are based on appropriateness criteria developed by specialty
8 societies, literature reviews, and clinician panels. The
9 main benefit of this approach is that it would target
10 inappropriate use rather than prohibiting self-referral, but
11 this proposal does raise multiple concerns and questions.
12 For example, the administrative costs of running such a
13 program could be quite high, and there would also be
14 administrative burdens on physicians who participate.

15 There are also questions about whether the
16 guidelines that these programs use are based on sound
17 evidence. And there's also a lack of independent evidence
18 that these programs have a long-term impact on spending.

19 The strategy on this slide relies on changing the
20 payment system by combining multiple services into larger
21 units of payment, a concept known as packaging or bundling.
22 Packaging refers to combining a primary independent service

1 with its associated ancillary services into a single payment
2 unit, and it generally refers to services provided during a
3 single encounter by a single provider. Under bundling,
4 services provided during multiple encounters are combined
5 into a single payment.

6 Either approach could create incentives to use
7 ancillary services more efficiently. However, there would
8 need to be a great deal of analytic work to identify and
9 price cohesive bundles of services and to address situations
10 in which multiple providers furnish services within a
11 bundle. So this probably represents a longer-term policy
12 direction.

13 This slide illustrates one potential path for
14 combining multiple strategies. Congress or CMS could
15 exclude a set of services from the in-office ancillary
16 exception unless a physician group met criteria for clinical
17 integration, or the group is part of an accountable care
18 organization, or the services provided were part of a
19 bundled payment which creates incentives for efficiency.

20 So to sum up, we've described several options to
21 address concerns related to the growth of in-office
22 ancillary services. We'd like to get your feedback on

1 whether you'd like us to develop any of these strategies
2 into future recommendations. And, of course, we'd be happy
3 to take any questions.

4 MR. HACKBARTH: Okay, thank you. Let's begin with
5 our Round 1 clarifying questions. I see hands on this side.

6 MS. UCCELLO: In terms of the same day or the non-
7 same day imaging tests, you alluded to this. Are there
8 access problems that that helps address? Like, are there
9 long waiting times at stand-alone facilities or this helps
10 people get around or not?

11 MR. WINTER: Are you referring to limiting the
12 exception so that physician groups can no longer perform
13 certain tests --

14 MS. UCCELLO: Just currently --

15 MR. WINTER: -- or are you referring to the
16 general environment?

17 MS. UCCELLO: Yes.

18 MR. WINTER: Okay. We have not -- I'm not aware
19 of access concerns with regards to imaging generally. There
20 have been some studies about mammography specifically by GAO
21 which have not found widespread access problems. They found
22 some sort of localized issues in rural areas. I'm not aware

1 of evidence that there are access problems in regards to
2 advanced imaging like nuclear medicine, MRI, CT, or
3 ultrasound, but we can look at the literature again and see
4 what that shows.

5 DR. CASTELLANOS: Good presentation. Really
6 appreciate it. I'm going to clarify, a little bit more
7 clarified. I think we need to do something to control
8 utilization. There's just no question. My point on Slide
9 7, maybe you could go to it, is that I think we've already
10 done some under the various issues on imaging.

11 Now, I agree, your slide shows this, but there's
12 some other data that shows that all imaging, not just MRI
13 and CT, has definitely decreased down 2 percent last year to
14 3.3 percent, while physicians' all services were up to 4.6.

15 I just want to clarify that point, that I think we
16 have done a lot already through a number of issues, the DRA,
17 et cetera, to show that all imaging has decreased. I agree
18 that MRI and CAT scan is part of all imaging, but if you
19 look at the whole package, I think you really see that it
20 has decreased compared to all physician services.

21 MR. WINTER: And for the 2008, I don't have the
22 AMA numbers for all imaging. They didn't report that for

1 2009. I will look at that in the coming months. For 2008,
2 we found that imaging across the board, looking at both
3 volume and intensity, grew at 3.3 percent, and all physician
4 services grew at 3.6 percent. However, there were some
5 categories within imaging that grew faster than 3.6 percent,
6 like echocardiography and CT studies.

7 DR. CHERNEW: You mentioned a little bit about
8 site of care. How much is the difference in the total
9 amount that's paid for one of these services if it's done in
10 the physician office or if it's done in an outpatient
11 department?

12 MR. WINTER: Imaging specifically or across the
13 board?

14 DR. CHERNEW: Well, for the type of services
15 you're talking about.

16 MR. WINTER: Okay.

17 DR. CHERNEW: So in other words, if we pushed
18 everything, for example, out of the physician office into
19 the outpatient department, would we be paying more per unit
20 service, because now they're getting a different -- or are
21 we paying less?

22 MR. WINTER: Okay. So for imaging, under the fee-

1 schedule, they used to be able to get paid more than the
2 outpatient department. The DRA put a cap in and said, "You
3 can't get paid more under the fee-schedule for the technical
4 component." However, you can still get paid more in the
5 outpatient department. So there are definitely imaging
6 codes that are -- where the outpatient rates are higher than
7 the fee-schedule rates for the technical component, and we
8 can do some more work to quantify that.

9 DR. CHERNEW: Is it significantly higher?

10 MR. WINTER: It could be. I'd have to go back and
11 look at the data. For the professional component, it's the
12 same regardless of setting. The next thing would be
13 outpatient therapy. By statute, the payment rates are the
14 same across settings, outpatient, physician office, SNF,
15 wherever, as long as it's paid separately.

16 Radiation therapy. I want to go back and look at
17 those payment rates. When I looked at it three or four
18 years ago, there were examples of codes that were paid more
19 under the physician fee-schedule than in the outpatient
20 department, but that might have changed in recent years so I
21 want to go back and look at that again.

22 DR. NAYLOR: So this was a terrific overview of

1 the issue and I wanted to clarify Page 11. The definition
2 of clinical integration, you mentioned that you cannot link
3 physicians to the increasing number of physicians that are
4 now being employed by hospitals or health systems.

5 So does this definition, if a physician moves into
6 a large practice as part of a health system, isn't it easier
7 for the physician to meet these criteria? Because they're
8 much more likely to have electronic health records than
9 physicians not as part of -- who are not employed by
10 hospitals or health systems.

11 So I just thought it might be easier for them to
12 meet these two expectations around being able to say, "90
13 percent of my practice is part of a group and I also have
14 that record." So I was just wondering if there's a way to -
15 - well, is that an issue?

16 MR. WINTER: Well, to the extent that they are
17 going to be in a larger practice when they're employed by a
18 hospital, I would expect they're more likely to be able to
19 meet those criteria because they're more likely -- the
20 physicians are more likely to be fully employed by the
21 practice, more likely to have EHR technology. I think the
22 literature says that, but I'm not -- I'd have to go back and

1 look and consult with my colleagues, like John Richardson.

2 One thing to point out, though, is that there was
3 a recent study that looked at adoption of EHR technology by
4 hospitals and found that only about 2 percent currently use
5 the functions that are required to get incentive payments
6 under the meaningful incentive -- under the incentive
7 payment program so that very few hospitals actually
8 currently comply with the meaningful use criteria.

9 So I'm not sure that just because you're part of a
10 hospital it means that you would comply with the meaningful
11 use criteria. But again, you may want a more flexible
12 standard if you decide to adopt an EHR technology criteria
13 for the in-office exception. You may not want to go all the
14 way to where the department has gone with regards to
15 meaningful use criteria.

16 DR. NAYLOR: I'll just follow up then, if a
17 physician refers then to services within that health system,
18 it seems that this could create a great incentive for them
19 to do that, and if we can't track it, we won't know. Is
20 that essentially right? We can't track the physicians' use
21 of services within a system?

22 MR. WINTER: Right, not using claims data, right.

1 We certainly can't tell whether they're employed by the
2 hospital.

3 MR. HACKBARTH: Clarifying questions?

4 MR. BUTLER: So same topic. My understanding,
5 based on the material, is that there currently is a 75
6 percent threshold for this clinical integration and we're
7 looking at maybe it should be 90 percent, is one way to look
8 at this recommendation, right?

9 MR. WINTER: Right. And then the 75 percent test,
10 just to clarify, that applies only to members of the group,
11 so owners or employees. It doesn't apply to independent
12 contractors.

13 MR. BUTLER: Independent contractors are excluded?

14 MR. WINTER: Right.

15 MR. BUTLER: So this is still something that I
16 remember Jay talking about a little bit of this option, but
17 I think to the average person, even to some of us, clinical
18 integration doesn't -- you know, it's just such a nebulous
19 term. And so, help me a little bit about bringing that to
20 life and what it means. I understand that I think if you
21 have a multi-specialty group practice of 70 doctors in a
22 building and there are a bunch of ancillaries and that's

1 where they provide their care, they probably meet the test
2 because that's where they have their practice. Right?

3 So give me an example where you would not likely
4 meet that 90 or 75th percentile. Give me a couple of
5 examples. That would help me.

6 MR. WINTER: Okay. So if you're a practice and
7 you provide some imaging services and you do them one or two
8 days a week and you bring in a radiologist, contract with a
9 radiologist to come in and supervise and interpret the
10 studies, you bill for the professional component and the
11 technical component, and the other days when the radiologist
12 isn't there, you don't perform this, you don't perform the
13 studies, so you schedule all your patients on those one or
14 two days.

15 Or this could also apply to pathology services
16 where you bring in a pathologist a couple days a week to
17 read the slides. Those kinds of arrangements would not
18 comply with this proposal.

19 Another example could be if you're performing
20 radiation therapy services as part of a multi-specialty
21 practice and you contract with different radiation
22 oncologists to come in different days of the week to oversee

1 what's going on, then that kind of arrangement would also
2 not comply. But based on our discussions with physician
3 groups and organizations, it seems that in most cases where
4 multi-specialty groups are providing radiation therapy, they
5 employ the radiation oncologist full-time because the
6 sessions are done five days a week generally.

7 MR. BUTLER: The differentiator really is their
8 use of independent contractors more than anything because
9 you're likely, as that physician, to be in that office more
10 than 90 percent of your time. It's just how you are using
11 the other specialties to support the radiologist or the
12 radiation oncologist? Is that the key differentiator?

13 MR. WINTER: Right, right.

14 MR. BUTLER: Okay.

15 DR. MARK MILLER: That's right. And the
16 arrangements, you were saying it would not comply with this
17 policy, but under the current 75 it does comply, just to be
18 clear on that.

19 And just to follow up one other thing, it's true
20 that you can't necessarily track, if they become part of the
21 system and start making referral -- back to Mary's question
22 -- but if it moves to the hospital side, it then gets paid

1 under the outpatient payment system?

2 MR. WINTER: Correct. If the service is provided
3 in a hospital outpatient department, that's true. But if
4 they're providing the services --

5 DR. MARK MILLER: It will remain in the office?

6 MR. WINTER: -- in the physician office, that's
7 billed under the fee-schedule. So we don't know if that
8 revenue eventually flows to the hospital because the
9 hospital owns the practice.

10 MR. HACKBARTH: Let me --

11 DR. CHERNEW: My understanding was, if the
12 hospital bought the practice and the practice met some
13 criteria, it could qualify as then being part of the
14 hospital outpatient department.

15 MR. WINTER: And that's a good point. So if it
16 meets the provider-based standards, then it can qualify as
17 an outpatient department and bill as an outpatient
18 department. But those standards include financial
19 integration, administrative integration, I think the same
20 billing so I think the hospital has to do the billing.

21 DR. CHERNEW: [Off microphone].

22 MR. WINTER: Proximity, they can be off-campus and

1 meet those criteria. So there are different rules if you're
2 on campus than off campus. I'm describing the off-campus
3 criteria.

4 MR. HACKBARTH: They have to be under the
5 hospital's license in some way?

6 MR. WINTER: That's right, its licensure, shared
7 licensure.

8 MR. HACKBARTH: Could I just follow up on Peter's
9 question? So one of the options that we're looking at is
10 saying, well, you're allowed to self-refer only if you are
11 in a clinically integrated group. Got that. Now, under the
12 existing law, there is a definition of the group. Remind me
13 what the function of the existing group definition is. It's
14 not defining the boundaries of the exemption. What purpose
15 does it play?

16 MR. WINTER: So physician groups have greater
17 flexibility to provide in-office ancillary services than
18 solo physicians, so they can use a centralized building,
19 like a centralized lab facility. They can contract with a
20 different physician to supervise the test or perform the
21 test. So there's much more flexibility, and -- does that
22 answer your question, or --

1 DR. BERENSON: I want to follow up where Ron was
2 going on Slides 6 and 7 because I think it's pretty
3 interesting, what the response was to a significant pay cut.
4 It seems to me there's a natural experiment here that adds
5 to the literature of behavioral response and I just want to
6 understand that I understand this.

7 It seems that when we reduce significantly the
8 prices paid, the fees paid for advanced imaging, in fact, we
9 had a moderation of the growth. Growth rates dropped rather
10 than -- at least some of the literature would suggest you
11 get a behavioral offset to increase volume. You actually
12 had a moderation of the volume growth, is that basically
13 right?

14 MR. WINTER: [Nodding affirmatively.]

15 DR. BERENSON: Okay. And do we have -- and it
16 looks like the services that were not subject to the caps
17 didn't go up to make up the difference. I mean, they also
18 moderated, is that a way to --

19 MR. WINTER: It's a little more complicated than
20 that. GAO looked specifically at this question of the
21 services that were affected by the cap and those that
22 weren't and they found that services affected by the cap

1 grew at a rate -- and they were just looking at technical
2 component and global services and not professional component
3 -- those grew at a rate of 7.4 percent between '07 and '08,
4 and services that were not affected by the cap grew at a
5 much slower rate of two percent. So they actually found
6 that the rate of growth was faster, but they didn't track
7 the trend. They didn't show what the trend was in the prior
8 year for those codes, and so it could actually have been
9 higher and come down but still be higher than the other
10 codes.

11 DR. BERENSON: But doesn't that finding suggest
12 that the advanced imaging services grew pretty fast still
13 after the cut? I mean, that was the 7.4 percent, you are
14 saying?

15 MR. WINTER: Right. Right. And the advanced
16 imaging services that were affected were mainly MRI codes in
17 that year, some CT codes, but also nuclear medicine codes.
18 And so this slide doesn't show the nuclear medicine.

19 DR. BERENSON: And what's really going on, I
20 assume, is, well, at least anecdotally I heard that there
21 was the DRA sort of caps sort of froze the purchase of new
22 machines by a lot of practices that otherwise might have

1 done so, so you didn't have the influx of new volume from
2 new sources. But the places with existing equipment perhaps
3 increased their volume in response. Do we know --

4 MR. HACKBARTH: [Off microphone.]

5 DR. BERENSON: Yes. Is there any sort of
6 information that sort of teases that out a little bit?

7 MR. WINTER: We don't have information from claims
8 data because we don't know how long the practices owned the
9 machine. We could use claims data to identify when a
10 practice began billing for something and then we could
11 presume, well, they bought the machine then. But a practice
12 that was billing all along, we can't tell, well, did they
13 replace the machine in this year or they're using the same
14 machine with the older technology because they didn't want
15 to go out and buy a new one. So it's a little bit
16 complicated.

17 The other thing to point out is that the changes
18 in the capital markets made it more difficult to finance
19 acquisition of these machines around the same time, so that
20 might also have dampened the demand for new equipment.

21 DR. BERENSON: But I guess to summarize, then, at
22 least a significant pay cut, fee cut that generated revenue

1 savings to the program wasn't offset by a significant
2 behavioral volume increase, and if anything, there might
3 have been a volume decrease. Is that basically the summary?

4 MR. WINTER: I think it's fair to say that played
5 a role.

6 DR. BERENSON: Okay. Thanks.

7 MR. KUHN: Ariel, two quick questions. On Slide
8 3, where you talk about one of the reasons or one of the
9 rationales for the in-office ancillary exception was the
10 convenience of the service, same day service has been one of
11 the reasons that has been given, do we have from the claims
12 data a pretty good sense of how many of those services are
13 being provided the same day and how many of them on
14 subsequent days? For example, someone comes in to see their
15 physician. The physician says, I need to get an image of
16 this. Go across the hall and see my assistant, or go across
17 the hall and see the assistant, and he or she says, well,
18 we'll schedule you a week from Tuesday. Come back then. So
19 I'm curious, do we have a pretty good sense of what's going
20 on the same day and how much of this is being perpetuated in
21 subsequent visits to the physician office?

22 MR. WINTER: We have a sense of how frequently

1 tests and physical therapy services are done in the same day
2 as a related office visit. In terms of tracking what
3 happens down the line, like how many visits do they get
4 after the test, we haven't done that analysis. But we
5 presented results in our June report showing that for many
6 of these kinds of services, they are provided less than 50
7 percent of the time in the office. I mean, the standard
8 imaging, like plain X-rays, were the highest at 50 percent.

9 MR. KUHN: Okay. Thank you. And the second
10 question I have is not part of the presentation you made,
11 but I am just curious if you can give me an update on this.
12 I don't know, four or five years ago, MedPAC as one of the
13 chapters in one of the reports did a pretty exhaustive look
14 in terms of kind of the safety issues related to imaging and
15 physician offices and talked about the lack of regulation,
16 lack of accreditation practices and physician office.

17 Can you give us an update kind of where -- what
18 has changed since that chapter and kind of where we are in
19 terms of kind of the safety side of this kind of technology
20 in the physician office?

21 MR. WINTER: Sure. So we recommended that the
22 Secretary develop quality standards for both the technical

1 component of imaging, which is actually performing the test,
2 acquiring the image, and for the professional component,
3 that is the work of the physician interpreting the results.
4 We recommended this for all imaging services across the
5 board, but we prioritized that these should be done first
6 for advanced imaging and services that are growing more
7 rapidly and are higher cost.

8 In 2008 in MIPPA, the Congress required mandatory
9 accreditation for advanced imaging services, namely MRI, CT,
10 and nuclear medicine studies, for the technical component
11 only. So it doesn't apply to the professional component.
12 And it was limited to those three types of services, and PET
13 is a -- as well as PET, which is a subcategory of nuclear
14 medicine. It did not apply to ultrasound or standard
15 imaging. CMS is in the process of implementing those
16 standards right now. They have selected three accreditation
17 organizations that providers can go and get accredited from,
18 and if they're not accredited after, you know, within a
19 couple of years, they won't be able to bill the program
20 anymore for the technical component.

21 So I would say our recommendations have been
22 implemented in part. What's still out there are -- or

1 what's still lacking are standards for ultrasound and other
2 kinds of imaging on the technical component side, and what's
3 also lacking are standards for the professional component,
4 with the exception of mammography, which was covered through
5 MQSA.

6 DR. KANE: Yes. I had a question on Slide 6.
7 That dramatic drop that you mentioned at the same in 2008
8 there was a bundling of the imaging services with other
9 things. Does that mean that when they got bundled that you
10 can no longer capture the use of imaging, or that they just
11 didn't use imaging in that bundled service? Are you just --
12 what is that? Is that a measure of a reduction in the use
13 of imaging or is it the fact that you can no longer capture
14 the imaging part of the bundled service?

15 MR. WINTER: So I think that the hospital would
16 still bill for a packaged service. I'm looking to see if
17 Dan is here to nod his head, but I -- is that right, Dan?

18 DR. ZABINSKI: What?

19 MR. WINTER: Is that right? Okay.

20 DR. MARK MILLER: So why don't you come up here,
21 Dan.

22 DR. KANE: You can get back to me if you want to.

1 MR. WINTER: So come on down. So they're probably
2 still billing for it, but if they are, we're not capturing
3 that in the data stream. We're just capturing -- those
4 services are not reflected because now they are being paid
5 as part of the independent procedure.

6 DR. ZABINSKI: The cost of the thing is reflected
7 in the payment rate for the primary procedure.

8 DR. MARK MILLER: So in other words --

9 DR. ZABINSKI: It is not an explicit separate
10 payment --

11 DR. MARK MILLER: -- of her two choices, the
12 second choice was does this mean that the actual volume has
13 fallen, or is it more difficult to count separately because
14 it's part of a bundle, and I think this is --

15 DR. ZABINSKI: It's more difficult to count.

16 DR. KANE: Okay. So we just --

17 DR. ZABINSKI: I don't know if it's gone up or
18 down --

19 DR. MARK MILLER: Right, because it's now part of
20 a bundle.

21 DR. ZABINSKI: Right.

22 DR. KANE: That's just a little bit misleading, I

1 think, if the incentive -- or I think we need to just
2 clarify that that drop does not necessarily mean a drop in
3 volume. It just means we just may not be capturing it
4 because it's now in a bundle --

5 DR. MARK MILLER: Well, just to --

6 DR. KANE: -- or we may, but we don't know or
7 something.

8 DR. MARK MILLER: I thought Ariel actually tried
9 to make that point when he put the slide up, and I'm
10 actually glad you brought this up because there's real mixed
11 questions about physician's office versus the hospital.
12 But, I mean, one point is to the extent that if it does
13 convert to an outpatient payment system, you also have
14 greater opportunity to start paying on a bundled basis. But
15 it doesn't mean that everything goes under the outpatient.
16 But he did try to point that out as he went through it, that
17 this was something of an anomaly on the OPD side.

18 DR. KANE: Yes. I just wasn't sure what that
19 green line was capturing.

20 So I have one other question. On Slide 11, the
21 possible criteria of requiring a group to have EHR
22 technology and use it for specific purposes, I guess this is

1 just the whole meaningful use notion. How does one audit
2 how someone is using their EHR technology? And I'm just
3 wondering, is that a feasible and enforceable criteria for
4 deciding whether or not you can bill for something?

5 MR. WINTER: Right. I'm not clear how that --
6 what their auditing standards are for verifying that
7 hospitals or physicians are using those functions. I'm
8 looking to see if John is here, more help. Is he there?
9 There he is. John, is there anything more to say about
10 that?

11 MR. RICHARDSON: [Off microphone.]

12 MR. WINTER: We'll have to look into that and
13 we'll get back to you.

14 DR. STUART: I think we can all agree that there
15 is a strong financial incentive for provision of these
16 ancillary services, given the current fee-for-service
17 structure. My question is, is there a literature on the
18 marginal value that these services provide and is that
19 marginal value different in outpatient settings as opposed
20 to physician settings. And I can think of a couple of
21 areas.

22 If the provision is truly unnecessary, then you

1 would expect to see higher rates of negative results on
2 tests. You would probably also see some duplicative tests
3 and you would almost certainly see higher intensity tests
4 than might be recommended by guidelines.

5 So is there a literature that supports this,
6 because if there is, you might have another approach
7 altogether, which would focus on what the tests are showing
8 and there might be penalties if you exceeded some threshold
9 rates.

10 MR. WINTER: I'm not aware of a literature that
11 looks at sort of duplicate studies, negative results,
12 negative findings, comparing self-referral settings versus
13 other settings. There may be a literature that looks at
14 this like within hospitals, where there's generally more
15 clinical data that you can capture to address these
16 questions.

17 There's one study I can think of off the top of my
18 head which looked at the intensity of services referred by
19 self-referring physicians versus non-self-referring
20 physicians and it was radiography services and they found
21 that physicians who owned the equipment used in their
22 offices tended to refer more of the high-intensity kinds of

1 radiography services, and I can get you the specific results
2 for that. And I'll look into the broader question, as well.

3 MR. HACKBARTH: Round one clarifying questions?
4 George?

5 MR. GEORGE MILLER: Yes. On Slide 9, you had
6 mentioned consultation with stakeholders. I was curious
7 what feedback you received particularly from the physical
8 therapists about ownership of those services by any number
9 of physicians, particularly orthopedics, and what feedback
10 they gave you. I have some anecdotal information. I'm just
11 curious what you received.

12 MR. WINTER: So the feedback we've gotten is very
13 strong support for removing outpatient therapy, physical
14 therapy services from the in-office exception. Their
15 concern is that -- that they've expressed to us is that
16 physicians -- referring physicians are getting into this
17 area and buying up therapy practices and encouraging
18 therapists -- or telling therapists that if you don't join
19 me, I'm going to stop referring to you.

20 MR. GEORGE MILLER: Right. Right.

21 MR. WINTER: So there's some -- they're feeling --
22 and again, this is their view, I'm not validating this --

1 MR. GEORGE MILLER: No, I understand. Right.

2 MR. WINTER: -- they're feeling pressure to join
3 up with or be acquired by physician practices.

4 MR. GEORGE MILLER: Okay. And then the follow-up,
5 is there then literature to support increased use of
6 physical therapy services to somewhat justify that, that
7 anecdotal feeling, because I've heard the same thing from a
8 couple of physical therapy groups.

9 MR. WINTER: There's some older literature from
10 the early and mid-'90s which shows that when physicians
11 provide therapy in their offices, they are more likely to
12 use it for musculoskeletal conditions. There was a study by
13 Swedlow based on California Workers' Compensation data which
14 showed that and another study which had a similar finding, I
15 think by Jean Mitchell. I'm not aware of recent studies,
16 though, since the '90s.

17 DR. BAICKER: I'm guessing in the round two
18 discussion, we'll dive more deeply into thinking about
19 quality of care and the productivity of this use in terms of
20 producing outcomes, so I wonder as a precursor to that how
21 much do we know about whether these types of physicians are
22 different from others and whether the patients they serve

1 are different from others, and I'm getting at that to think
2 about if we are going to try to gauge the marginal
3 productivity by looking at outcomes, are we comparing apples
4 and oranges? Are the types of physicians that have the
5 capacity to do this in-house in different types of areas,
6 serving different income, ethnicity, age patients so that
7 we're not going to be able to compare, or is this a pretty
8 heterogeneous slide of the population of physicians and
9 patients who practice this most heavily?

10 MR. WINTER: So from the claims data, we can tell
11 that there are certain specialties more than others that are
12 getting into this area, which we described in our June
13 report. Ones that are specialties that derive a lot of
14 their revenue from ancillary services, particularly imaging,
15 include cardiology and vascular surgery and orthopedic
16 surgery and a couple of others, including internal medicine,
17 by the way, so it's not simply specialists.

18 In terms of the geographic distribution, we have
19 not looked at that with claims data, but HSC has done
20 several site visits and I think they've found that in
21 certain areas more than others, this kind of what they've
22 termed entrepreneurial activity is more prominent, and maybe

1 Bob can speak to that. I can't offhand. Examples that come
2 to mind might be Miami or maybe Phoenix.

3 In terms of the impact on -- in terms of
4 demographic characteristics of their patients, I'm not aware
5 of research that's looked at that. It would be a little bit
6 difficult. You could try to do with the information from
7 the Medicare denominator file that we have information on
8 demographic characteristics and try to link that to patients
9 of physicians who were seen by these practices, but that
10 research, I don't think any research has been done in that
11 area yet.

12 DR. MARK MILLER: I would have thought you would
13 have said just one other thing, which is what you and Jeff
14 did, I think it was in the June report, I can't remember
15 which report it was in, you know, all the literature showed
16 that ownership has higher volume. What these guys did is
17 they tried to organize the claims data by episode so that
18 you had some control for similarity of patients and disease
19 staging, and I'm not saying perfectly risk adjusted, but
20 some attempt, and to reexamine that literature and say, are
21 you finding it, and you found five to 100 percent
22 differences in rates depending on what modality. So they

1 basically confirmed it with an attempt to control on
2 differences at least among patients. But I think the
3 biggest thing that we're probably stymied on is the
4 demographics of the physician, which are definitely pointing
5 to --

6 MR. WINTER: Yes, and I'm glad Mark raised that.
7 We also controlled for different markets where the
8 physicians were located and for physician specialty, so we
9 tried to adjust for as many factors as we could.

10 The other thing I wanted to mention is that with
11 regard to specialty hospitals, which is a different but
12 related situation, they do tend to locate more in higher-
13 income areas. They tend to serve different kinds of
14 patients than general hospitals. So there's some literature
15 there.

16 DR. DEAN: There's another set of procedures that
17 I've been concerned about, and I wonder if it's included in
18 this. That's the screening procedures that are offered
19 directly to the public that in turn presumably generate
20 other procedures. The one I'm thinking about is the
21 coronary calcium screening that either both hospitals and
22 physician groups tend to offer, usually at some ridiculous

1 low price, \$50 for a CT scan and then you usually get
2 several other things with it. That whole practice has been
3 criticized both by some professional organizations as well
4 as the Preventive Services Task Force, both because it
5 amounts in a fair amount of radiation exposure and there's a
6 lot of concern about where it leads in terms of a number of
7 other procedures that most likely were not indicated in the
8 first place. I suspect that those data would not show up in
9 this analysis, is that right, or --

10 MR. WINTER: I mean, if they're not covered by
11 Medicare, they wouldn't show up, no.

12 DR. DEAN: Well, they might -- the initial thing
13 would not be covered by Medicare. The second round of tests
14 may well be, and I don't know how you'd get at that, but I
15 was assuming none of that would show up here.

16 MR. WINTER: No.

17 DR. DEAN: And I'm not sure how widespread it is,
18 but I think it's fairly widespread.

19 MR. WINTER: To the extent there are follow-up
20 tests that are covered by Medicare and paid by Medicare,
21 yes, we capture those in our data. But we can't relate
22 those to an initial screening test that wasn't covered.

1 DR. DEAN: Okay.

2 MR. HACKBARTH: I'm going to engage in some
3 bundling here and bundling a round one clarifying question
4 with a round two comment.

5 DR. BERENSON: That's packaging.

6 MR. HACKBARTH: That's packaging? Well, I don't
7 know. That's right. Okay. I'm going to package, not
8 bundle, and I want to offer the round two comment to give
9 people an opportunity to react when their turn comes.

10 So the clarifying question, I just want to make
11 sure I understand the implications of two of the options
12 that you've described, first, the option prohibiting from
13 referring for their own therapy services and then the option
14 prohibiting from referring for imaging services not provided
15 the same day, probably a lot of MRI and CT.

16 So, as you know, I used to run a large group, a
17 multi-specialty group with in-house imaging, in-house
18 therapy services, and the like, two-thirds capitated, one-
19 third fee-for-service, in the one-third fee-for-service a
20 lot of Medicare patients. So as I understand the
21 prohibition on referring for therapy, a group like that
22 could not refer to its own therapists and could not use its

1 own MRI and CT under the other option, even though it has
2 built this practice, organized this practice in a way that
3 is guided by the fact that it's a largely capitated group.
4 It tends to be very value-focused. It would be flatly
5 prohibited from self-referral under these two options.

6 MR. WINTER: Under the option where you carved out
7 radiation therapy and outpatient therapy --

8 MR. HACKBARTH: Yes.

9 MR. WINTER: -- and under the option where you
10 carved out tests that were not done on the same day,
11 frequently done on the same day, that's correct.

12 MR. HACKBARTH: Yes. Okay. So I find that
13 troubling, a troubling implication of that kind of approach.
14 Obviously, the option which would say that there's an
15 exemption for clinically integrated groups would help my
16 former colleagues. As Peter says, the definition of
17 clinically integrated, it's easy when applied to Harvard
18 Vanguard. It may not be as clear in other circumstances and
19 start to raise some tricky issues that I'm not sure I fully
20 understand.

21 Among the options that you laid out, there are
22 three that strike me as more targeted and then, therefore,

1 perhaps more appealing. One is the idea of packaging
2 wherever that's feasible, and Karen, I think this is an idea
3 that has, in the past, you've mentioned, made some sense.
4 There's a lot that goes on in the surgical world and maybe
5 there's an opportunity to expand our efforts of packaging
6 and dealing with some of these issues. It wouldn't be a
7 comprehensive solution, I imagine, but conceptually, that
8 seems to me worth pursuing further.

9 Similarly, another targeted approach would be
10 targeted prior authorization, and Ron, this is something I
11 think you've mentioned in the past. You've said to me
12 multiple times, let's focus on the appropriateness of what's
13 being done for the patient. So if, in fact, we can target
14 prior authorization to people who have a demonstrably odd
15 pattern and then look at their specific services and focus
16 on whether they're appropriate or not, that seems like a
17 targeted approach that at least merits some further
18 exploration.

19 A third approach that interests me -- and just be
20 clear, I'm not endorsing any of these because I'm sure they
21 raise complicated issues, but these are the ones that strike
22 me as worth pursuing further -- is the notion of reducing

1 the payment rates for self-referred services based on the
2 principle that we're paying twice for some activities. They
3 don't need to be duplicated when there's a self-referral
4 situation. And this is an idea that we've enforced in other
5 contexts. You know, the same thinking underlies the reduced
6 payment for imaging of contiguous body parts. The same
7 principle exists in surgery when there are two procedures
8 done. You don't get paid the full rate for both of them.
9 And so this is an idea that I think is consistent with past
10 MedPAC, past Medicare policy that makes sense. There isn't
11 duplication of all of these activities and some reduction in
12 payment seems conceptually appropriate.

13 So those three approaches all strike me as more
14 targeted. I'm a little reluctant about the more sweeping
15 approaches because I think there could be some collateral
16 damage, as it were.

17 My starting point on all of this is that the
18 problem is not self-referral per se. The toxic combination
19 is self-referral combined with fee-for-service payment,
20 often combined with mispricing of the services. It's when
21 you get the three of those together that you have the risk
22 of abuse, and so I don't like anything that sort of across

1 the board will slow efforts to organize care delivery, bring
2 services under one roof. That strikes me as counter to
3 other things we're trying to accomplish. Let's see if we
4 can do more targeted things to get at the real problem, is
5 my thinking. So I invite people to react to that.

6 So let's proceed to round two, starting over here,
7 Cori and then Ron.

8 MS. UCCELLO: I'll just react to this targeting
9 prior authorization. It seems to me that at the very least,
10 providing information to providers on where they stand in
11 terms of ordering tests generally is useful, even if it's
12 not ultimately used on the payment side. I think somewhat
13 of a risk in that is -- I don't know if this was in Atul
14 Gawande's article or what, but when physicians are seeing,
15 well, I'm below average or I'm average -- well, I'm above
16 average but I'm doing it correctly, or I'm below average and
17 I'm doing it correctly, I mean, there's not necessarily a
18 lot of information -- you don't know necessarily what to do
19 with that information when you get it. But I think thinking
20 along those lines is appropriate.

21 MR. HACKBARTH: And one of the things that we've
22 recommended in the past, Cori, is confidential feedback to

1 physicians on an episode basis, how their patterns of care
2 compared to their peers within the same market. As you
3 know, CMS is in the process of rolling out that sort of an
4 effort.

5 MS. UCCELLO: And a question regarding -- back to
6 you, Glenn -- on the packaging and reducing payment rates.
7 In terms of timing, Ariel said that the packaging or
8 bundling was maybe more of a long-term approach. Is
9 reducing payment rates a bridge to that or would that also
10 take a while to implement that kind of strategy?

11 MR. WINTER: Well, let me just clarify a bit.
12 Packaging is probably -- it could be done on a shorter-term
13 basis if you're talking about services provided in the same
14 encounter by the same clinician or hospital, and so CMS in a
15 single year implemented a new packaging policy for many
16 types of imaging services because they tend to be provided
17 by the hospital when they do the independent procedure, like
18 ultrasound guidance as part of a surgical procedure. Those
19 things are provided together by the same provider. It's
20 fairly easy to combine them into a single unit.

21 You could think about applying that on the
22 physician fee schedule side, but because of the way

1 physician services are valued through the RUC process, which
2 can take some time, you have to -- you could come up with a
3 comprehensive code that included, you know, multiple
4 discrete services, but that would have to, I think, go
5 through the CPT panel and then the RUC would have to assign
6 a value to that code. And this has happened recently for
7 nuclear cardiology codes and I think for echocardiography
8 codes. And so there's precedent for this, but I think it's
9 a slower process on the physician fee schedule side by the
10 nature of how that works.

11 But there is also a faster way to do it, which is
12 CMS could say we're applying an across-the-board 50 percent
13 reduction on multiple imaging studies done on contiguous
14 body parts, which they did in response to one of our
15 recommendations. So there is a faster track for that, as
16 well.

17 You were asking about reducing the payment rates
18 for tests done by self-referred physicians. If Congress
19 were to make a policy judgment like they have for services
20 provided by primary care physicians -- primary care services
21 provided by primary care practitioners and were to say,
22 we're going to reduce these payment rates by five percent or

1 ten percent across the board, well, that can be done
2 relatively quickly.

3 The kind of process or idea that Glenn has latched
4 onto, which is going through sort of code by code and
5 looking at activities that are duplicated when the ordering
6 and the performing physician are the same person, that could
7 take some more time, because again, that is using the RUC
8 for that process, unless you wanted to bypass the RUC and
9 have CMS do it on its own. Generally, they like to go
10 through the RUC.

11 MR. HACKBARTH: Ariel, I would note that in the
12 case of, say, contiguous body parts, there was not an effort
13 to go through all of the activities, and it was, you know, a
14 simple reduction. I think the same thing is true in terms
15 of the payment for surgical procedures. They don't try to
16 work out all of the elements. It's a simple reduction of
17 some percent.

18 MR. WINTER: Well, actually on the imagine side,
19 they did go through an exercise where they tried to take
20 into account the duplicative activities that are not done
21 for the subsequent imaging service, and they came up with a
22 range of something like -- around 50 percent. They decided

1 to phase it in. They stopped at 25. And then Congress came
2 in and said, "You have to move it to 50." So it ultimately
3 was Congress' judgment to set it to 50.

4 MR. HACKBARTH: Okay.

5 DR. CASTELLANOS: First of all, just to disclaim,
6 I want to make sure everybody understands. I belong to a
7 very large clinically integrated cancer group, including
8 medical oncologists, radiation oncologists, surgical. I do
9 not own a machine, and I have no stock in that company. So
10 I just wanted to clarify from a disclaimer point.

11 Glenn, I'd like to respond to a couple of comments
12 you made. I'm also troubled by some of the issues that have
13 been brought up, and one of the issues is the effect on the
14 beneficiary. There's no question that site of service,
15 there's cost differences in site of service, and there's
16 copayment differences in site of service. There's no
17 question there's a convenience and care coordination. But
18 this should not be bundled into a thing where we do it for
19 that reason because doctors make money. We do it because
20 it's a convenience, it's a good service to the patient,
21 there's quality.

22 Now, appropriateness, and I really want to get to

1 that a little bit. I totally agree with you, and, Cori, it
2 kind of gets back to your -- about prior authorization. My
3 personal feeling is that we do need feedback, and with prior
4 notification there is definite feedback to ever physician.
5 In other words, if you notify them that I want to do a CT
6 scan, they're going to say fine, but they're going to give
7 you feedback by saying it's not appropriate and maybe you
8 ought to think of this as a different alternative.

9 We had a presentation on this, oh, two years ago,
10 and I can bring that material back. But it's less invasive.
11 It's cost-effective. Prior authorization, maybe we need to
12 go to that on outliers who don't pay attention. But we've
13 always stressed feedback to the physician, and sometimes
14 feedback, not publicly but personally. And I think if we
15 need to go to something, I think prior notification would be
16 the first step, and then if we need to, to the people that
17 are outliers that haven't paid attention, maybe prior
18 authorization.

19 As far as inappropriate care, Glenn, you and I
20 have talked many a time on this, and it's my feeling that we
21 stress inappropriate this, inappropriate this, inappropriate
22 this. And I remember Bob Reischauer -- and I think we all

1 do. I remember him for a lot of reasons. But I remember
2 one statement he said. It really doesn't make a difference
3 where you do the study, whether it's in the hospital, in the
4 clinic, or where, as long as it's appropriate.

5 Where I'm going with this is that we had a group
6 of cardiologists here, American College of Cardiology, and
7 she made an excellent presentation on guidelines and issues
8 of that. And I think we were all very impressed with that.
9 I think it's fair to say -- I went back to my society
10 talking about guidelines and appropriateness and all that,
11 and I think it's fair to say I had a lot of resistance. A
12 lot of the urologists were on my side, but a vast majority
13 were not interested, and it appeared that maybe the society
14 didn't take it as seriously as at least I thought it should.

15 What can we do about that? Well, I think we can
16 do something. You know, when we talked about poor-
17 performing hospitals, we talked about getting them help
18 where they can increase the qualities and the issues that
19 they deal with. Well, I think we can use that same approach
20 with poor-performing medical societies or societies,
21 actually going to them and letting them know what we feel is
22 very important from a patient viewpoint, what's appropriate,

1 et cetera, you know, because I think we need to stress
2 appropriateness, because I think there's a lot of us
3 physicians that really want to do the right thing, but
4 sometimes perhaps we don't because of practice patterns.
5 For a lot of reasons we do something that's inappropriate
6 that we don't even recognize we're doing. So I think if we
7 can stress appropriateness in the approach on ancillaries, I
8 think we'd be much better off.

9 Now, Glenn, you also talked about making the price
10 right, and I agree with you. When there's outrageous
11 reimbursement, we ought to make an issue there. And I think
12 we talked a little bit about that yesterday or at least I
13 tried to on the LCA issue with Part B drugs. It became --
14 we finally got the reimbursement correctly, and it really
15 hasn't disrupted the care of the patient. So I think we
16 need to work on that also.

17 Thank you.

18 DR. CHERNEW: I think it's clear that all of these
19 are imperfect, and usually when we get these
20 recommendations, we get a more complete analysis of, like,
21 how effective we think it will be, what are the costs. And
22 so I think to really do what we're doing, that's sort of the

1 next step to think through so we can begin to weigh the pros
2 and the cons.

3 My general instinct, I think, is much the way you
4 said, Glenn, which is, you know, we don't want to do any
5 harm in preventing us from getting the system where we want
6 because we've put various rules in. And I tend to be
7 hesitant to put in a lot of rules that have sort of
8 arbitrary administrative barriers to the way people
9 organize. It somehow reminds me of -- I apologize for this
10 little folksy kid's reference, but for the sort of Brer
11 Rabbit and Tar Baby story where first Brer Rabbit hits the
12 Tar Baby in the face and gets stuck, so then he realizes the
13 problem and he hits it with his other hand and it gets
14 stuck. Then his feet are in the Tar Baby, and everything is
15 just all mucked up because he keeps creating problems, then
16 trying to fix them with some other fix. And I think that's
17 what often happens here. First, we don't want you to do it
18 in the office, but that's not working. So then we want to
19 change it so you can only do it if you're in an integrated
20 group. But now we want you to be in a big ACO, so we make
21 an exception for that. And now we're going to have to layer
22 on some extra monitoring, and before you know it, you're

1 mucked up in this incredibly complicated administrative
2 system to try and solve a problem that undoubtedly is a
3 problem, but you might have solved by going a little bit
4 slower and trying to get the incentives and sort of the
5 payment right.

6 So my general view is, although I recognize the
7 problem, I'm worried by a number of these, particularly the
8 ones that make sort of arbitrary definitions of things, you
9 know, that we think hard about doing that because there's
10 industries that figure out how to get around -- just
11 listening to your answer to the question about you can be an
12 outpatient department if you're licensed the same and within
13 a certain area and you've integrated your -- you know, all
14 those sort of administrative rules become enormously
15 complicated, and trying to get a better payment system
16 strikes me as maybe a little longer run. But from my view,
17 that's preferable than to try and do some of these other
18 things.

19 DR. NAYLOR: So I want to totally agree with
20 Mike's perspective. I think that the goal of our system is
21 integration, is integration for people, and the evidence is
22 showing that, you know, if we target populations and provide

1 them with immediate access to a team of players where a
2 team, for example, could -- a physical therapist could help
3 an individual who comes in with back pain and prevent --
4 immediate access, and prevent the use of costly tests. And
5 that was part of an earlier chapter here, that we don't want
6 to create systems that will not allow for the targeting of
7 the right population to have immediate access to the right
8 set of services that might be not in your language but the
9 least costly alternative and add more value and achieve
10 better integration for the person.

11 So I think we have, you know, this notion of
12 thinking about how we'll get to bundling or packaging makes
13 a great deal of sense, thinking about how we'll target makes
14 a great deal of sense, and certainly thinking about how
15 we'll pay for value maybe through the right kind of both
16 quality incentives packaged with the right kind of financial
17 incentives I think is right.

18 I also think that this issue of quality does
19 deserve a great deal more attention. I am concerned that
20 we're focused on technical competence in the light of
21 evidence about the critical importance of professional
22 competence in combination with technical competence.

1 MR. BUTLER: So I feel like this is fruit that has
2 been ripening for about two years, and this is the year we
3 are going to pick some of it, I hope. I agree that we ought
4 to pick -- make recommendations that are realistic, doable,
5 sellable, and advance us some, not stretch too far. I think
6 that's consistent with what we've been hearing. So I have
7 some combination of, Mike and Glenn, your two comments, and
8 I'd like to go to Slide 18 to clear more specifically so
9 that if we're going to look at more data to understand, I
10 think there may be some things that we might take off the
11 table in terms of options as we dig deeper. And I'll just
12 tell you my own preferences.

13 On the left-hand side, the exclude from in-office
14 exception for the therapy, I don't think that's going to be
15 realistic to say simply you can't own one of these pieces of
16 equipment in radiation or you can't have physical therapy.
17 I'm most concerned about the radiation being used
18 inappropriately. I'm just not sure the ownership thing is
19 the vehicle to get there. So I don't see that as a
20 realistic option.

21 Just to cover the other half of not pursue
22 further, I really don't like the same-day thing. It seems

1 kind of -- you know, to pursue that further as an option and
2 how you would really do that, I just don't see that as a
3 fruitful way to go. We could say, you know, if it's not
4 done on the same day -- if it's done on the same day, you
5 get paid. If it's not done on the same day, you don't get
6 paid. That's not realistic. So I don't see a lot of value
7 in pursuing that.

8 Then when you get to the bottom half now on both
9 sides, I do think there are opportunities. I like the
10 clinical integration option on both the therapy and the
11 diagnosis, and if only we move it above the 75th and begin
12 to be -- maybe not go to the 90th, and I don't really like
13 the IT piece. It seems a little gimmicky. But definitely
14 we could strengthen above the 75th to some level that could
15 further define what clinical integration means. I think
16 that's worth pursuing.

17 I'm a little less clear on the payment rates, but
18 I definitely think that the bundling, which is part of rate
19 setting on both sides, is a fruitful thing to look at as a
20 package of services that are coordinated for a price as
21 opposed to taking just individual payment rates and trying
22 to kind of incentivize that. I'm not as optimistic about

1 that.

2 Then, finally, on pre-authorization, certainly at
3 a threshold, because we've seen an imaging at work in the
4 private sector, why not apply something in Medicare. And
5 I'm not sure why that shouldn't also be on the left-hand
6 side of the chart, too, in terms of authorization on the
7 treatment, not just the diagnostic side. So that if you had
8 pre-authorization for physical therapy or radiation in some
9 fashion above what's done now, I think it could be in both
10 columns.

11 MS. BEHROOZI: I agree with a lot of what Peter
12 said, and actually you had said, Glenn, also. Everywhere it
13 says exclude or even reduce payments, you run the risk of
14 throwing out the baby with the bath water, where, you know,
15 there are good providers who -- you know, whether we're
16 talking Vanguard or individual physicians or whatever -- who
17 are trying to do the right thing, and, you know, why we
18 would want to make it difficult for them or their patients
19 or reduce payments when, you know, they're doing the right
20 thing. You know, it seems to constrain our ability to do
21 what we really want to do, which is to address the
22 misalignment of incentives, or whatever you want to call it.

1 I think that one of the things that I really
2 focused on in your paper, Ariel, was not just the number of
3 MRIs. I mean, you know, okay, it's inconvenient to have to
4 go for an MRI and, you know, lie there in the machine or
5 whatever. They're making it more convenient, stand-up MRI
6 or whatever. But you highlighted an example of physicians
7 who were paid more generously, blah, blah, blah, for
8 chemotherapy drugs, prescribed more costly chemotherapy
9 regimes for certain types of cancer patients. Not only can
10 that have a dramatic economic impact on the beneficiary, but
11 maybe they're getting a regimen of treatment, chemotherapy,
12 that's a lot more than inconvenient, that maybe isn't the
13 best thing, isn't necessary at this point. And I don't
14 think that payment levers really are sufficient to address
15 what has become kind of ingrained -- with some people they
16 may not particularly realize the way the incentives are
17 working on them, or maybe they are trying to game the
18 system, those outliers. But I just don't know that the
19 payment levers are enough to really get at those incentives.
20 And it reminds me of the conversation yesterday when we were
21 talking about the three-day stays and the observation -- a
22 three-day stay in the hospital being required for SNF

1 payment and the observation days not being counted. And
2 people were talking about MA plans, well, they don't require
3 the three-day stays, and everybody's response right away
4 was, well, they've got prior authorization and other
5 management techniques.

6 Maybe that's one of those things we're supposed to
7 be learning from the private sector that we need more
8 management techniques than just these rules about payment
9 that people learn ways around or adapt themselves to. And
10 so in support of prior authorization and prior notification
11 -- not that none of the rest of it is appropriate. By the
12 way, with bundling, we also -- with those people who tend to
13 be somewhat, you know, not so positively influenced by
14 payment levers with bundling as we've discussed in other
15 contexts. There's the risk of stinting, that people won't
16 get the regimens of care that they need or the diagnostic
17 tests that they ought to have, right? So it's not that we
18 shouldn't go to bundling, but it won't really work unless
19 you have robust quality measurement and enforcement and all
20 of that, and we're a long way from that.

21 So whether it's an interim step or something we
22 build in forever, I would support prior notification and

1 prior authorization. I think maybe it's for -- I don't know
2 at what level, you know, how many standard deviations or
3 whatever, it's appropriate to all somebody an outlier, at,
4 you know, the 90th percentile and above or 80th percentile
5 and above. I think they absolutely should have prior
6 authorization. I think we're far enough down the road. And
7 like I said, concern about the dramatic impact on
8 beneficiaries, I think we really do need to intervene.
9 Perhaps prior notification for, like, the 60th to 80th or
10 60th to 90th percentile would be a good thing, not just for
11 those physicians who find themselves in those bands at that
12 time, but a sentinel effect for everyone.

13 And just, you know, to clarify a couple of points,
14 prior authorization, it's not an anonymous bureaucrat or,
15 you know, a computer program or whatever. There are
16 clinicians who answer the phone and talk with the
17 clinicians. When you're talking about prior authorization,
18 one of the concerns you raise in the paper was timeliness.
19 We are in a lot of cases talking about things not provided
20 on the same day anyway, so there's plenty of time. And you
21 can get instant answers on prior authorization and prior
22 notification, and that's what we find using PA and prior

1 notification for diagnostic radiology we do now.

2 MR. ARMSTRONG: Let me just make three points, and
3 I'll try not to be too redundant.

4 First, Glenn, I would just say I thought your
5 expression or your frustration in your description of three
6 areas to focus on captured very well my point of view as
7 well. And the idea of targeted bundling, targeted prior
8 authorization, and reducing payment rates for self-referred
9 services I think are a nice combination of approaches for us
10 to evaluate.

11 By the way, I would just say I'm not uncomfortable
12 with prior authorization. I think it's less about approving
13 procedures and more about creating a kind of transparency
14 around what is it that we're doing and why. And I think
15 with that spirit we could approach that idea.

16 The second point I would make is that I love the
17 reference to Brer Rabbit, and it's sort of my version of the
18 Whack-a-Mole, and this is, you know, a perfect example of
19 where you try to affect the system in one place, it
20 sometimes predictably, often unpredictably, pops up
21 somewhere else.

22 And I think one of the risks in all this, which is

1 my third point, is that we talk about cost, we talk about
2 utilization, and we throw in a concern from time to time
3 about quality and quality of the procedures and so forth.
4 But it's been so difficult -- and I don't know how we get
5 there, but I will try to repeat this as we go forward
6 through the next couple of years -- so difficult to connect
7 these choices around policy, and payment in particular, to
8 overall health outcomes for the populations that we serve.
9 And I don't presume that just because utilization rates are
10 going up for MRIs that that's necessarily bad if it improves
11 the health and ultimately drives lower expense trends for
12 the populations that we're serving. But so far in this
13 dialogue it's very difficult for us to make those
14 connections, and I think that's a point of view that I hope
15 we can hang onto as we go forward with some of these
16 discussions.

17 MR. HACKBARTH: Could I just pick up on what Scott
18 said? As I recall the episode analysis that Mark referred
19 to earlier, you know, one of the things that we tried to
20 look at is, well, if you have increased utilization of the
21 MRI, does it result in lower episode costs? And the answer
22 there was no.

1 DR. BERENSON: I'm not going to disagree with a
2 consensus that I think is emerging here. I'm conflicted on
3 this topic because when it's done right, having the ability
4 to self-refer in a practice I think is a very positive thing
5 for patients for the practice. I mean, I can imagine --
6 well, I recently interviewed a primary care practice who
7 brings in a colorectal surgeon weekly to do colonoscopies.
8 That's partly to raise revenues and partly it's an
9 underprovided service. It seems to me that's a good thing.
10 Having a physical therapist down the hall I think can be a
11 very positive thing. An orthopedist working with a physical
12 therapist I think can be a very positive thing. It's being
13 abused, and that's the problem here. So I'm sympathetic
14 with not just the broad sweeping approaches but seeing if we
15 can be a little more targeted.

16 Let me just say a couple of things. I think the
17 results of the payment limits on MRIs and CTs and PETs give
18 confidence around the use of payment policy in this area,
19 and I think we can -- it's conceivable that just sort of
20 identifying the duplicative activities that shouldn't be
21 double paid might get us where we want to be, but it may be
22 we want to go even further if that doesn't get us there,

1 such that the payment here doesn't become a very profitable
2 business line, but it covers your costs and maybe gives you
3 a little margin, but I think we should look at how to
4 accomplish that. That would be my goal for organizations
5 that are going to be self-referring.

6 I'm sympathetic to a clinical integration
7 exemption, but, again, one of my recent interviews with an
8 absolutely integrated multi-specialty group practice of a
9 hundred-plus doctors, the executive director of it told me
10 that the way they did very well through this past decade was
11 by bringing in advanced imaging and billing the hell out of
12 it. That's what they were doing. They brought in other
13 services as well, and so even though I think they were
14 probably a great practice, they were abusing this fee-for-
15 service system. And yet I don't want to -- because I think
16 when it's done right, it is something that should be
17 encouraged. I am trying to figure out how to do this in a
18 clinical -- so prior authorization I'm attracted to. In the
19 imaging area, there are actual organizations -- I know Mass
20 General is one that does their own, they have their own
21 software with their clinical algorithms, and it may be that
22 we could do -- I mean, to me a true integrated organization

1 is not only clinically integrated but administratively
2 sophisticated. And it may be we could set up a delegation
3 opportunity for those organizations if they can adopt
4 themselves. It's not enough in my mind to just have a good
5 EHR. I mean, they've got to be using it to address the
6 appropriateness issue that Ron raises.

7 So it could be that the prior authorization is
8 there as the default and that there's an opportunity for an
9 organization to sort of demonstrate that they can manage
10 utilization and not abuse the fee-for-service system, and
11 how exactly we work that out I'm not sure. I'm not
12 endorsing the Mass General model or anything, but I believe
13 at least in clinical imaging the technology does exist for
14 organizations themselves to essentially police.

15 I'm a little more skeptical that we really know
16 what the impacts are going to be of packaging and bundling,
17 like the concern about stinting that Mitra raises, but I
18 think we should explore that. And I think it's easier with
19 lab tests and things like that than an MRI. My hunch is
20 that you would -- just like DRGs has one payment if you do
21 the surgery and a different payment if you don't do the
22 surgery, my sense is we would wind up with one payment if

1 you do the MRI and another payment if you don't do the MRI.
2 We've got to -- because a single payment isn't going to do
3 the trick, I think. So I think there are some tricky issues
4 there, but it's absolutely worth pursuing.

5 MR. KUHN: On the issue of prior authorization,
6 just a couple thoughts as we begin to think about
7 development of that as a policy option.

8 First of all, on the Medicare program, on the fee-
9 for-service side, prior authorization, to my knowledge, is
10 not used anywhere in the program except in the area of
11 fraud. And so for a management tool, this would be very
12 groundbreaking in terms of the Medicare program where you
13 would introduce prior authorization for the very first time.

14 The second thing that we really need to think
15 pretty hard about on that one is the impact on the
16 beneficiaries. Beneficiaries have never really been told
17 now when they go into a physician's office. And so, you
18 know, think of the conversation a physician would have with
19 their beneficiary that said, "Well, I think you ought to
20 have this test, but Medicare, the government, says no."
21 That could start a whole set of conversations. Plus I think
22 we need to think pretty hard about what is then the appeal

1 rights of the beneficiary to appeal that decision by the
2 prior authorization organization that's out there. And does
3 this go all the way to an ALJ? Or, you know, what is the
4 process here? So if we're going to go down to prior
5 authorization, I think we need to think pretty hard about
6 the impact on beneficiaries and understand specifically the
7 appeal process that's out there.

8 The second issue in terms of the pairing and
9 packaging, I was at CMS when we did both of those. I'm a
10 big fan of both. I think they make a lot of sense. On the
11 pairing, I think there were 11 families of imaging services
12 that we were able to deal with the contiguous body parts,
13 and on the packaging in '08, I thought that was a good
14 initiative to move forward.

15 Two thoughts on that, though. First, I think, if
16 I remember right -- and we can look at this, Ariel, to make
17 sure this is correct -- CMS pretty much exhausted all the
18 easy ones to do. I think what's left is going to be pretty
19 tough, and so I don't know how much more gain there is
20 there. So that would be worth looking at.

21 The other thing on the policy side we're going to
22 have to think about is what do you do if you do make these

1 changes. Under current law right now, it's budget neutral,
2 so all those dollars go back into the outpatient payment
3 system. Or do we want to make recommendations that the
4 Medicare program harvests those savings for deficit
5 reduction or whatever the case may be? So, again, that's
6 one that we'll have to think about.

7 The third area I would point to is one that Tom
8 Dean actually raised yesterday, and it was interesting. I
9 was listening to Ariel's presentation, and it just kind of
10 dawned on me. If you remember, yesterday Tom was talking a
11 little bit about a provision in the current outpatient rule
12 that's going to require direct supervision for a whole
13 series of outpatient procedures that are out there. If you
14 think about in a physician office, particularly for therapy
15 services, there's not direct supervision. So one of the
16 things as we think through this policy, would there be an
17 unintended consequence with a current regulation that's
18 going through the process right now, would that have the
19 effect of moving site-of-service changes for outpatient
20 therapy services to move from the outpatient to the
21 physician office because of that direct supervision?

22 So as we continue to think about these policies,

1 let's also look at what's going on with the active
2 consideration of that outpatient rule right now and would
3 that have the impact of a site-of-service shift that we
4 could see in the future.

5 DR. NAYLOR: I'm listening to everybody, and I'm
6 kind of going over that list, and sort of checks and then
7 scratches off of the different feasibility of the different
8 options up there. One of my concerns is what's the burden
9 on CMS and the various administrative overhead and what's
10 the kind of cost/benefit of -- you know, what will it cost
11 to implement that policy versus the Tar Baby approach, the
12 problem of getting, you know, stuck and having to get deeper
13 and deeper in the muck? So it would be helpful -- and I
14 don't fully appreciate what it would cost or what the
15 benefits are of a prior authorization program, but also the
16 potential for a very nasty interaction with the beneficiary
17 doesn't appeal to me, although sometimes it's the doctor
18 you're really trying to get to, but they can get at you
19 through the patient. So I think that is something you have
20 to be nervous about.

21 About the only thing up there that I think fits
22 right in with what we do normally is reducing payment rates

1 for tests based on the fact that there's overlap, you know,
2 that they're repeating -- they don't need to talk to
3 themselves and get acquainted with the patient again. I
4 mean, that one, as long as it's not too hard to do, I think
5 should happen. But I'm kind of worried about diverting a
6 whole lot of attention to the short-term -- kind of where
7 you guys were, to the short-term fixes for things that could
8 -- will probably be fixed ultimately by this whole issue of
9 bundling and ACOs and medical homes. I mean, one hopes that
10 over -- there should be a lot more effort put into the
11 longer-term solution than into the sort of short-term
12 stopgap. You know, it's obviously a trade-off, but I'd
13 favor doing less now in the short term in order to do more
14 in the long term.

15 Then my last thought is on the outpatient therapy.
16 I mean, radiation therapy is one thing. That's a big piece
17 of equipment, and I can't imagine people giving radiation
18 therapy unnecessarily, but it's kind of scary to think
19 about, but maybe they do and that's really where you do need
20 appropriateness screens. But on the physical therapy and
21 the OT and all that, I don't really think there's huge
22 synergies to having it be in a doctor's office. And as I

1 understand it, the profession doesn't either -- at least the
2 professional association doesn't either. And I guess I'm
3 wondering why that's grown so much. It really has grown a
4 lot in the last few years, and maybe that's the one place
5 where there's just no real reason to have it owned by a
6 doctor. You know, there's no reason a physician can't work
7 with other physical therapy practices in their community and
8 say, you know, I'm an orthoped, here's the things I like to
9 see happen with my knee replacements. But I just don't see
10 any value, really, to having a physician own a physical
11 therapy practice myself. I guess I'd like to know more
12 about what the APTA has said about that. I know they
13 haven't been happy with physician-owned practices and the
14 volume that that's generated. So maybe that's the only one
15 maybe we should just automatically exclude unless there's
16 some really good reason for physician ownership.

17 DR. STUART: Well, first off, I'm going to add my
18 vote to my peers in saying, yes, the Hippocratic Oath is
19 right. The first thing we should do is not do any harm.
20 And what I hear is all of the ways that we might do some
21 harm in terms of unintended consequences. But it comes back
22 to the issue of we're not sure what we're buying here. And

1 I'm reminded of the conversations that we had around the
2 home health care benefit in the sense that it -- in one
3 sense it's almost the same when we're talking about
4 therapies. We're not sure what these therapies are actually
5 doing for the patient, and this is what prompted my first-
6 round question about what do we know about what we're buying
7 here and whether that differs from the services in another
8 setting.

9 In the home health area, we had a number of
10 conversations about pay for performance and about outcome
11 measures that we could tie to payment. And I would think
12 here that that's something at least that we should be adding
13 to the list. I don't know how much we know about this, but
14 we have learned about the productivity of therapies in terms
15 of reducing physical functioning -- or improving physical
16 functioning, rather, and so that's a way we might go. We've
17 already talked about some areas that seem fairly well
18 established. MRIs for lower back pain is a no-no. There
19 are some things that clearly ought to be done that I think
20 we might at least think about developing a list for -- if
21 not pay for performance, you know, some offshoot of PQRI,
22 something that focuses on outcomes in terms of what we're

1 actually buying here.

2 MS. HANSEN: Well, first of all, I'd say that
3 colleagues on the other side of the table here have pretty
4 well expressed the key points, and I also would probably
5 condition my comments also relative to the background that I
6 bring since I lived under full capitation for 25 years, had
7 collocated services from physician services to dental
8 services to make it, again, easier for the beneficiary who
9 would be frail, just to make their life better, but we
10 didn't have financial incentives to create more services.
11 In fact, just as an anecdote about being cautious about
12 standards of care, I still remember actually going toe to
13 toe with the State of California over the standard of
14 expectation of an air contrast barium enema for a woman who
15 was 63 pounds and 93 years old and just saying that that's
16 not something we would do because that isn't necessarily
17 quality practice, even though it was on the books at the
18 time.

19 So it brings me back to the whole comment that
20 several of you have brought up about quality, and I think it
21 was raised initially by Herb and then also by Kate and
22 others of you on the other side. If we could really have

1 that as part of the context, I think about access, value,
2 and quality, especially with the whole question of the
3 amount of radium that people are exposed to sometimes
4 overusing CT scans as a frequency as compared to sometimes
5 routine X-rays. So if we could just begin to bring some of
6 that literature in, coupled with the work that we did back
7 in 2008, that would be great.

8 Thank you.

9 MR. GEORGE MILLER: I agree with Jennie that most
10 of what I've been thinking has been said already, so I do
11 want to echo that, you know, I think part of our
12 responsibility is to look out for the beneficiary to make
13 sure there's quality and value and access.

14 I am drawn to the statement made in the reading
15 that you shared, though, that we are concerned about the
16 mispricing of services because of the fee schedule and the
17 fact there's inequity in the payment system and somehow we
18 have to address that. But then I'm reminded with Michael's
19 example that we've got to be careful in how we try to fix
20 that, whether it's through prior authorization, which has
21 some appeal, or bundling, as you mentioned, Glenn, which I
22 think has some appeal.

1 I think that the problem is we do have abuse in
2 the system, abuses because of the fee-for-service system.
3 We just don't know where that abuse is specifically and how
4 to address it. So I certainly would like to see more
5 studies so we can be very, very definitive. But the current
6 fee-for-service system does create an opportunity to
7 generate additional revenue, not necessarily because of
8 quality but because you can generate more revenue. So I'd
9 certainly like to see that addressed before we make
10 decisions on what's the best course of action to take.

11 MR. HACKBARTH: Okay. We are about 10 minutes
12 over time. This is not the last time we're going to talk
13 about this topic, so if you can really keep your comments
14 focused, I'd appreciate it.

15 DR. BAICKER: That's a lot of pressure to say
16 something important.

17 MR. HACKBARTH: Yeah, right. That's exactly how
18 it was intended, Kate.

19 [Laughter.]

20 DR. BAICKER: I'm rattled now.

21 In thinking about the incentives that we're
22 creating, I agree with everyone that the goal is to foster

1 appropriate use of care, and we should in some respects be
2 neutral about where that's delivered. We don't really care
3 if it's appropriate and we want to create incentives ideally
4 such that the provider is choosing to provide the service if
5 and only if it's appropriate. And the challenge there is,
6 you know, that clearly highlights the advantage of
7 eliminating overlapping payments. If it's more lucrative
8 for a provider because he or she is getting double paid for
9 essentially the same thinking, we want to eliminate that.

10 The challenge is that there's no bright line of
11 appropriate versus inappropriate, and what we struggle with
12 is surely there aren't a lot of providers saying, well,
13 radiation here is not warranted at all, but I could make
14 some money so let's do it. I don't think anyone's doing
15 that. I think there's a very gradual diminishment of
16 appropriateness, and people are drawing the line in
17 different places. And that's really hard to price
18 appropriately because it's so subtle and continuous, and our
19 pricing is not continuous.

20 So as a first step to thinking about that, I would
21 love to see more information on appropriateness as measured
22 by differences in patient characteristics either pre-

1 existing utilization in health or other predictors of the
2 probability of a patient getting this particular service and
3 how that -- given his or her existing characteristics, and
4 how that varies across providers who have an ownership stake
5 and who don't have an ownership stake. And if you see a big
6 gradation in the appropriateness of the patient on a
7 continuous scale across these different settings, then
8 that's a flag that we have an even bigger problem in terms
9 of incrementally too much being done versus the incentives
10 being small enough that it's an issue of overpayment but not
11 an issue of changing inappropriateness.

12 As a side note, the intriguing thing about the
13 targeted prior authorization is -- I think it would have a
14 very strong psychological effect not just on the marginal
15 services of those physicians who are subject to the prior
16 authorization, but on physicians who don't want to suddenly
17 fall into the bucket requiring prior authorization, that
18 interactions with private sector research partners suggest
19 to me that those incentives can be just as strong as the
20 financial ones. You don't want to be labeled as the
21 overuser who has to call Medicare every time you want to do
22 something, and that might provide some social stigma that

1 could be very productive in terms of modulating provider
2 behavior.

3 [Off microphone] There, I'm done.

4 MR. HACKBARTH: And it was important. Thank you.

5 DR. DEAN: I agree with everything that's been
6 said.

7 [Laughter.]

8 DR. BORMAN: The way I would think about this a
9 little bit is that we've got three things going on: we've
10 got increasing volume, we've got the issue of the influence
11 of ownership, and we've got the problem of appropriateness.
12 It would appear to me that on just purely the volume side,
13 we've kind of done some of the payment -- pulled some of the
14 payment levers, and I'm a little concerned that we don't
15 know yet the entire fallout of that as evident by the data
16 we don't have and the things we can't tease out. So I'm a
17 little more reluctant to say doing more of that before we
18 know those answers is a good thing.

19 In terms of the conflict of interest piece,
20 frankly, I think in the end that these things, Glenn, as you
21 point out, kind of hit everybody and that our work on
22 conflict of interest and disclosure in the end is probably

1 the more fruitful place that we're going to get to deal with
2 some of that ownership overlap issue. I think payment can
3 be helpful in that and can be a secondary lever, but I think
4 we need to recognize that for what it is as a piece of the
5 conflict of interest, the whole big issue.

6 So that sort of leaves us with the appropriateness
7 piece, and that's where I guess I would deviate a little bit
8 from the enthusiasm for prior authorization, and I'll come
9 back to why in just a minute. But I first would suggest
10 sort of the Nick Wolter idea that we need to look at in
11 terms of target high volume, high use, high cost. Pick out
12 the five things that cost Medicare the most and figure out
13 where in each of those there's one of these kind of
14 challenges and try and deal with those in a very targeted
15 way, and that may mean packaging in one place and some other
16 modality in another. But let's do it in a way that's driven
17 at the things that -- the conditions that cost Medicare the
18 most, because then we have an opportunity to combine
19 appropriateness and cost, maybe.

20 My personal concern with prior authorization
21 relates to my own experience when laparoscopic
22 cholecystectomy was a new procedure, and our North Texas

1 Medicare intermediary actually instituted a prior
2 authorization program, and we had to call Austin. It was
3 not staffed 24 hours a day, so if you needed to do a
4 cholecystectomy for acute cholecystitis at 2:00 in the
5 morning, there wasn't anybody to talk to, it was a little
6 bit of a problem.

7 There were also issues that the person we were
8 talking to, other than the persons that Mitra describes in
9 terms of being peers and knowledgeable people, appeared to
10 be at best a high school dropout a fair amount of the time.
11 And we all fairly quickly learned that there were a couple
12 of buzz words that you could say that would make the person
13 on the other end of the phone sort of short-stop the
14 conversation and say yes. And when they analyzed the
15 program, something like 95 percent or more were being
16 approved, and it really was not very helpful.

17 So I would just caution that prior authorization
18 has to be done in a very carefully crafted way to get the
19 kind of outcomes that you want; otherwise, it's very easy to
20 get to a wrong place. So I would just say before we
21 necessarily say that's a great thing, maybe look at the
22 high-volume, high-cost diseases and say is that a technique

1 we could apply to those.

2 MR. HACKBARTH: Okay. Thank you, Ariel.

3 As we shift --

4 [Recording equipment failure, Mr. Hackbarth's
5 comment was not recorded - approximately two minutes.]

6 MR. HACKBARTH: -- just part of the weighing that
7 needs to be done.

8 Okay, David, lead the way on accountability for
9 DME, home health and hospice.

10 MR. GLASS: Thank you.

11 In this presentation, we'll pull together some
12 findings from our work on geographic variation and from our
13 sector-specific analyses related to accountability for three
14 services: DME which is shorthand for Durable Medical
15 Equipment, orthotics, prosthetics and supplies; home health
16 and hospice. Today is an introductory discussion. If the
17 Commission wishes to consider specific recommendations,
18 those would probably be developed in detail in the specific
19 sectors.

20 So why are we looking at these three sectors?

21 And let me say that first of all we are not
22 disparaging these sectors. They could all be of tremendous

1 benefit to beneficiaries, and they play an important role in
2 the Medicare program. So we're in no way minimizing their
3 importance.

4 They also may not be the only services we should
5 look into in this way. For example, we're just beginning to
6 investigate Part D, and there may be similar concerns there.

7 But today we're looking at these three sectors for
8 the following reasons: First of all, they share some
9 characteristics that contribute to vulnerability for fraud,
10 abuse and overuse, and we'll get into those shortly. They
11 show patterns of aberrant service use. And in high use
12 areas, these services do not appear to substitute for other
13 services, or, more technically, they're all positively
14 correlated with the use of remaining services.

15 So our hypothesis is that greater accountability
16 could decrease inappropriate use and slow Medicare spending
17 growth.

18 So let's look at some of the characteristics.
19 First of all, physicians prescribe, but others generally
20 deliver the care in these areas. For example, a physician
21 prescribes a home health episode. Nurses, therapists, home
22 health aides deliver the care. The physician does not have

1 to be involved. It does not require continuous physician
2 involvement or any of the physician's time. Hospice can
3 have more physician involvement depending on the
4 circumstances.

5 They also require little capital investment in
6 facilities. So entry is not constrained by the need to
7 raise large amounts of capital as would be necessary for a
8 hospital or other facility.

9 Services in these sectors are delivered at the
10 patient's home for the most part, not at a facility, with
11 some exceptions for hospice. In the extreme, DME suppliers
12 at one point could operate from a post office box. They now
13 need 200 square feet of storage area and a business address
14 that one could visit during business hours, but still very
15 limited capital is needed for entry.

16 On the cost-sharing side, DME has 20 percent cost-
17 sharing although supplemental insurance often covers it,
18 which is why the ads on TV always start out "If you have
19 Medicare, this is of no cost to you." There is no cost-
20 sharing for home health, and hospice has very little.
21 Specifically, patients who receive respite care are liable
22 for 5 percent co-insurance, and hospices may choose to

1 charge co-insurance on drugs not to exceed 5 percent or \$5
2 per drug.

3 The point is that these services generally do not
4 need physicians' time, so they aren't constrained by the
5 supply of physicians. Their supply is not constrained by a
6 need for capital, and beneficiaries have little incentive
7 not to use the service. Taken together, these
8 characteristics may make these sectors vulnerable to
9 overuse.

10 One interesting thing is we found in our work on
11 geographic variation that spending on these services can
12 change the pattern of overall spending, and this is somewhat
13 surprising because they are a small share of spending
14 overall, only 14 percent taken all together. But they can
15 be as high as 24 percent of spending in the top 10 MSAs with
16 high spending in these 3 services, and we also have noticed
17 that they increase relative service use most noticeably in
18 high use areas. For example, Odessa, Texas, the MSA there
19 is 18 percent above average in service use with these
20 services, but it's really only about average if you just
21 look at all other services.

22 So we can look at this graphically on the next

1 slide. To get oriented, this graph shows the percent of
2 beneficiaries on the Y axis who live in MSAs, with the
3 relative service use shown on the X axis.

4 The yellow bars are total service use, which is
5 all Medicare spending adjusted for prices, special payments
6 and beneficiary health status. This is similar to what we
7 reported last December, except we're here just looking at
8 one year of data, 2006.

9 In the right-hand detail, the 3 bars, 15 percent
10 above the average have about over 5 percent of the
11 population in them.

12 DR. STUART: The green bars?

13 MR. GLASS: I'm sorry? The yellow bars.

14 DR. STUART: The green bars?

15 MR. GLASS: Yes. Well, here they are, as if by
16 magic.

17 [Laughter.]

18 MR. GLASS: So on the green bars, we've removed
19 DME. We've removed DME, home health and hospice from the
20 total and looked at the distribution of service use for all
21 the remaining services, again price and risk-adjusted.

22 The distribution pulls in toward the middle with

1 over 50 percent of the beneficiaries now living in an MSA,
2 with use within 5 percent of the national average. For
3 example, the last green bar, which represents per capita
4 service use for beneficiaries in Miami, is just over 125
5 percent of the national average. Including all the
6 services, it was nearly 140 percent which is the yellow bar
7 at 135 plus. Altogether, only 3 percent of the population
8 is now over 15 percent greater than the national average.

9 We're looking at the extreme values because we're
10 concerned with overuse, fraud and abuse. What this is
11 saying is that spending on these services is exacerbating
12 regional differences, particularly at the high end of
13 service use.

14 When we look at variation for these services
15 individually, we see some startling patterns. So these data
16 are price, but not risk, adjusted because we did not want to
17 assume that the HCC scores that we use for risk adjustment,
18 which were designed to explain total spending, would
19 necessarily be accurate for adjusting individual services.

20 Looking at the first row, DME, most of the
21 population is between 0.7 and 1.25; that's the 10th and 90th
22 percentile of the national average. But the extreme use is

1 3.4 times the average.

2 Home health has a wider range for the 10th and
3 90th percentile, from 0.47 to 1.76, but goes over 7 times
4 the national average at the extreme, which is McAllen,
5 Texas. Some of you may remember Atul Gawande's New Yorker
6 article on Medicare spending in McAllen in the
7 entrepreneurial Medicare culture he found down there.

8 Hospice has a similar spread for most of the
9 distribution. In the extreme value, it's about 3 times, not
10 quite 3 times the national average.

11 Now for reference, total service use varies only
12 about 2-fold from minimum to maximum, and the maximum is
13 about 1.4.

14 In our report on regional variation, we noted that
15 some variation was so extreme it raised questions of fraud
16 and abuse, for example, this data from South Florida.
17 Miami-Dade is just way above its neighboring counties in
18 spending on DME per capita, 10 times as high as Collier
19 County, for example, and the national average is about \$250.
20 So, on the face of it, this is just incredible.

21 In fact, CMS has long been concerned with DME
22 fraud in general because barriers to entry are low, the

1 number of suppliers is high and prices are high. Miami, in
2 particular, has been of concern. After an anti-fraud task
3 force went to work there in 2007, which is after these data,
4 claims for DME decreased by 63 percent in 1 year.

5 Unfortunately, historically, victories over fraud
6 tend to be short-lived. When attention waivers, fraud
7 returns or those perpetrating the fraud move to other
8 sectors or cities. The HHS OIG Chief Counsel testified
9 recently that as law enforcement cracks down on suppliers
10 fraudulently billing for DME the suppliers have shifted to
11 fraudulently billing for home health.

12 So let's look at home health. Again, there seems
13 to be evidence of aberrant service use at the extremes, and
14 we want to emphasize again we're focusing on the extremes in
15 this exercise. We're not saying every area is like this or
16 that home health does not provide important benefits to
17 beneficiaries, but the extremes' use is very high as you can
18 see.

19 Now in some counties, over 35 percent of
20 beneficiaries use home health, and they can average over 4
21 episodes per user, and in some counties there are actually
22 more home health episodes than beneficiaries.

1 In addition, we note that there's high correlation
2 between the percent of beneficiaries using home health and
3 the number of episodes per user, which is another way of
4 saying that the more people using home health in the area
5 the more home health they use per person.

6 So the Commission has noted these problems, and
7 last March we recommended that the Congress should direct
8 the Secretary to review home health agencies that exhibit
9 unusual patterns of claim for payment, and Evan will review
10 how the law has changed in this sector when he talks about
11 home health later this year.

12 Hospice also shows patterns of aberrant use. In
13 general, a higher percentage of decedents using hospice is
14 looked upon as a reflection of access to the benefit. So
15 Ohio, at 48 percent of decedents using hospice, is higher
16 than the national average of 39 percent, and Mississippi, at
17 35 percent, is a bit under the national average.

18 What is somewhat surprising is that spending per
19 capita relative to the national norm is much higher in
20 Mississippi than Iowa. Digging a little deeper, we see that
21 39 percent of hospice stays in Mississippi were over the
22 180-day presumptive eligibility period versus about 16

1 percent in Iowa.

2 In addition, 55 percent of hospice discharges in
3 Mississippi were live discharges versus 13 percent in Iowa.

4 So it seems very unusual, and we can conclude that
5 the use of the hospice benefit is very different in these
6 two states and that perhaps some hospices may be admitting
7 patients before they meet the hospice eligibility criteria.

8 In response to findings of this sort, we
9 recommended a series of steps in our March 2009 report,
10 which you have in your mailing material, and Kim will report
11 on progress on these recommendations when she reviews the
12 hospice sector later this fall.

13 So who should be held accountable? Given that
14 we've demonstrated patterns of aberrant use, who should be
15 held accountable? The provider of the service, the
16 physicians who sign the prescription or certify, or the
17 beneficiary, or perhaps some combination?

18 It could be that there are different answer,
19 depending if the aberrant use is from fraud, in which case
20 the provider could be the focus and the physicians and
21 beneficiaries could play a sentinel role, or overuse, where
22 all three may need to be accountable. So let's look at each

1 in turn.

2 For sure, the provider of the service, the DME
3 supplier or the home health agency or the hospice, must be
4 held accountable, and anti-fraud efforts generally focus on
5 the provider. The OIG and the Department of Justice have
6 set up joint task forces in six cities to attack fraud, and
7 they've had some success. But they often have to chase
8 after, rather than prevent, fraud. And, as we said,
9 providers can switch either to different sectors or to
10 different regions, and it's always difficult to maintain
11 pressure.

12 Another approach is stricter rules on what
13 providers can enter the program and bill Medicare. For
14 example, CMS has progressively tightened conditions of
15 participation for DME suppliers. They now need a real
16 address, they have to be open for regular business hours and
17 have a storage area. They also have to post a surety bond,
18 be accredited and now licensed in the state as well.

19 It could be solutions will differ by market. If
20 there's a massive supply of some service, perhaps CMS could
21 put a moratorium on new entrants.

22 Another approach is through payment policy. For

1 example, as the Commission has often recommended, policy can
2 try to remove opportunities for inordinate profit by
3 bringing payment rates closer to cost. Or, change can be
4 more radical. For example, competitive bidding for DME not
5 only lowers prices but also puts more financial requirements
6 on suppliers and decreases the number of suppliers in an
7 area.

8 All these services require some physician
9 involvement at initiation. Home health and DME require a
10 prescription or plan, and PPACA requires that the physician
11 or MP or PA have had a visit within the last six months with
12 the beneficiary. Hospice requires attestation that the
13 beneficiary is eligible for the benefit by two physicians,
14 the attending and the hospice physician, and the hospice
15 physician is responsible for recertification. But the
16 physician has little incentive to rigorously review the
17 initial request or reassess ongoing use or consider
18 alternatives to the service and often has little involvement
19 after the service is ordered.

20 So could that incentive be changed?

21 It could be just making physicians aware of their
22 patients' use of these services would be helpful. Knowing

1 one's patients were using these services at very high rates
2 might changes one's habits, particularly if CMS started to
3 ask questions.

4 Or, there could be steps to require greater
5 involvement in the benefit, more frequent face-to-face
6 visits, for example.

7 Another approach to changing incentives could be
8 through ACOs or bundling. ACOs will include primary care
9 physicians who will be accountable for all spending
10 including on these three sectors, and they'll have an
11 incentive to keep spending down, so they might want to refer
12 to responsible providers. And the incentive exists because
13 if service use is high the ACO will not get a bonus, but how
14 strong that incentive will be is unproven, as we discussed
15 yesterday.

16 It could be that regulations will need to allow
17 for referrals to particular providers, for example, for home
18 health. I think now regulations prevent discharge planners
19 from saying go to this particular home health agency.
20 Instead, they have to just supply a list of nearby
21 providers.

22 So there is much to be worked out with this

1 concept.

2 Bundling would include payment for these services
3 within a larger episode. For example, a hospital admissions
4 bundle could include post-acute care. If a physician
5 hospital team is paid the bundled rate, they will have an
6 incentive to use post-acute care in combination with
7 hospital care in the most cost effective manner. In a
8 simpler example, which I guess we should call "packaging,"
9 not "bundling," perhaps a pair of crutches could be included
10 in the rate for treating broken foot, or diabetes test
11 strips and glucose meters could be bundled with treatment
12 for an episode of diabetes.

13 Beneficiaries have a role in anti-fraud
14 activities. There is a program to recruit beneficiaries in
15 the Senior Medical Patrol and to train them to scrutinize
16 their Medicare summary notice statements for questionable
17 billings. There has been some success though it's a little
18 difficult to measure. In high fraud areas, these Medicare
19 summary notice statements can be issued monthly instead of
20 quarterly to provide more rapid feedback, but then
21 beneficiaries don't like to be swamped by even more
22 paperwork, so some tradeoffs with that approach.

1 And finally, we could revisit cost-sharing for
2 some services. Cost-sharing can make a beneficiary aware of
3 the cost of a service and has been shown to decrease use of
4 services. To the extent that cost-sharing is offset by
5 supplemental insurance, it loses some of its incentive
6 power. So there could be different rules concerning the
7 first dollar coverage for some of these services. And, as
8 we've discussed, there is no cost-sharing at all for home
9 health and very little for hospice.

10 We've covered a lot of ground in what is in some
11 sense a new topic for us. Some approaches may be more
12 promising for preventing fraud and others for discouraging
13 overuse, and what works may depend on the market conditions.

14 So I leave you with these discussion questions:

15 How can payment systems be changed to decrease
16 incentives to over-provide?

17 Would more stringent conditions of participation
18 prevent entry of possibly fraudulent or abusive providers?

19 Should physicians be held accountable for use of
20 the services they prescribe or their patients receive?

21 What's the potential for ACO bundling or packaging
22 to restrain inappropriate use of these services?

1 And should we revisit cost-sharing for some
2 services?

3 Now Evan and Kim are joining me to answer any
4 questions you may have, and we look forward to your
5 discussion.

6 MR. HACKBARTH: Okay, thank you.

7 We'll start on this side this time, round one
8 clarifying questions. Karen and Tom.

9 DR. BORMAN: Just one relatively quick question,
10 do we have a sense that the patterns of use are different
11 when home health, DME, hospice result from an inpatient
12 hospitalization versus when they are prescribed or ordered
13 from an outpatient source?

14 MR. GLASS: Sorry, we haven't done that in our
15 analysis yet, unless -- have you done that? No.

16 DR. BORMAN: Because my sense is that, and maybe
17 it's because the nature of surgical practice is I have a
18 fair amount of inpatient care, but it's very easy to get
19 caught up in hospital utilization and some of those kinds of
20 things, and all these things kind of get rolled up to
21 deliver care to shorten stay. And that in the end may be
22 efficient for the system, but I just wonder if there -- it

1 seems to me there might be a dichotomous pattern. I don't
2 know that, and I think it might just be worth touching base
3 on that.

4 DR. DEAN: A question about the recertification
5 for hospice and the requirement that that be done by a
6 hospice physician, as I understand it, that requirement has
7 been there a while. I had a long discussion with a hospice
8 director in North Dakota who felt that it was really a huge
9 burden because this was a big, decentralized system that
10 covered a huge geographic area with something like 300
11 enrollees, and he was the only full-time employee, and it
12 was basically, virtually impossible. I'm not exactly sure
13 how they had been doing it.

14 But it seems to me that that presents, that
15 requirement presents an inherent conflict of interest. Has
16 that been in place for a long time? And I'm not sure how
17 these programs have used it.

18 MS. NEUMAN: Yes, that requirement is statutory.
19 So that's been in place for a long time.

20 And we, the Commission, have made recommendations
21 in March, and PPACA has adopted recommendations to provide
22 some additional accountability for recertification. So, for

1 example, it is the hospice physician that recertifies the
2 patient. But the Commission recommended, and beginning in
3 January of 2011, physicians will need to do a visit for
4 long-stay patients before recertifying, either a physician
5 or a nurse practitioner.

6 And in addition, the Commission recommended a
7 medical review targeted at hospices that have very long
8 stays of long-stay patients, and that has also been adopted
9 in PPACA.

10 So there have been some additional steps to bring
11 accountability around that piece.

12 DR. DEAN: I remember those changes. Was there
13 any discussion about why it should be an employee of the
14 hospice program?

15 MS. NEUMAN: I don't know the history of why that
16 was put in place. I do know that depending on the
17 circumstances a hospice physician may be the one who is
18 monitoring a patient's care once they move to hospice.
19 Sometimes the attending physician from the community will
20 continue to follow them, but often a hospice physician will
21 be, or the medical director will be, the one following them.
22 So there could be some practicality considerations, but I'd

1 need to do some digging to find out the rationale for that.

2 DR. DEAN: Because that was the problem here.

3 These patients were all being cared for by local physicians,
4 and they only had one hospice physician that covered a large
5 area, and so it was really presenting -- and it was the
6 visit part. That's the part I had forgotten about. That
7 was the part that was really going to create a problem, and
8 I don't know how they've gotten around it.

9 MR. HACKBARTH: So what you're saying is in the
10 circumstances that you described, of a sparsely population
11 area and long distances, that you could get two benefits
12 with one change. Having a non-hospice physician responsible
13 for recertification would get you out of the conflict of
14 interest and maybe make it easier to do.

15 DR. MARK MILLER: Just to reinforce, we often
16 heard that the opposite situation was really what was
17 present on the ground. The community physician kind of
18 drops out of the picture after the hospice referral. So we
19 definitely heard the other side of the argument pretty
20 strongly in other parts of the country. Kim, right? Right.

21 MR. GEORGE MILLER: Have you had the opportunity
22 to talk with any national organizations about this issue and

1 did they provide you any feedback or comments, particularly
2 about some of these outliers in different states that you
3 pointed out?

4 MR. HACKBARTH: Which service, George, or just on
5 any of them?

6 MR. GEORGE MILLER: All three, all three services
7 through national organizations.

8 DR. MARK MILLER: The way I would answer that is
9 that throughout the work that we've done on home health in
10 this set of recommendations we went through with you the
11 last few rounds, and the hospice recommendations, when we
12 went through that there were extensive conversations.

13 And I think both the home health and the hospice
14 industries, less so on DME, and we haven't had a lot of
15 focus on DME in the last few years here, but both of those
16 groups have said, you know, what we would prefer is that if
17 you're going to take a look at our industry in this way,
18 that you have targeted approaches that go in after certain
19 actors. I mean all of them acknowledge that there are
20 certain actors out there. So the kinds of things that they
21 feel more comfortable with are things like when you make
22 recommendations, for example, in hospices, on hospices with

1 100 consistent patterns, they're more comfortable with that
2 than other types of approaches.

3 MS. HANSEN: Yes, two questions. One is since
4 this is under the overall umbrella of thinking of fraud and
5 abuse, what is the amount that I think that the GAO had
6 originally scored for during health care reform as to how
7 much savings might come about if we took on the topic of
8 fraud and abuse, and then what subset does this potentially
9 represent from that, if we know that?

10 MR. GLASS: I don't know the answer to that. We
11 can look into it.

12 DR. MARK MILLER: We can come back.

13 MS. HANSEN: Sure, just because I know that on the
14 topic level it's a very popular topic, and it also resonates
15 with the public in terms of doing this. I mean I think even
16 60 Minutes did another story in the past month or so.

17 And related to that is the Medicare or the Senior
18 Patrol program. Is that a CMS program? And you said there
19 are some mixed results. I was just wondering if you could
20 describe that a little bit more.

21 MR. GLASS: Yes, I believe CMS runs it, and the
22 idea is to train Medicare beneficiaries to look at the

1 statements, the summary statements, and notice whether this
2 is something that they didn't have that, they didn't get it,
3 whatever. And they tell them what to do if they find that
4 out. They give them a number to call and that sort of
5 thing. And we can give you some statistics on what the
6 success has been.

7 DR. KANE: I guess I was going to go back, similar
8 to what Jennie was asking about the beneficiary involvement.
9 Do they get any reward if they find anything? I guess
10 that's one question.

11 Then another is, as Ron knows, I've actually --
12 the families often hear things that just don't sound right,
13 like laser surgery will cure your father's spinal stenosis,
14 and there's nowhere to go easily to put down your concerns.
15 You know. You really have to be very persistent about it to
16 find a place to put a complaint in about a provider. So I
17 guess is there any place where beneficiaries and/or their
18 families can go to lodge complaints, that's easy to find and
19 doesn't require 16 calls and being well placed to find them?

20 MR. GLASS: I think there are fraud hotlines to
21 call if you think it's absolute fraud. If it's something,
22 if someone is claiming they gave you a wheelchair and you

1 didn't get one or something like that.

2 DR. KANE: No, no, I'm talking like treatments
3 that are really inappropriate or totally bogus.

4 MR. GLASS: Oh, that, yes. Again, I don't know on
5 that.

6 DR. KANE: Yes. I mean it seems to me there are a
7 lot and not just for the DME, but there are fraud issues,
8 and that families might pick up on that. But it's pretty
9 hard, especially if you're not right there, to figure out
10 how to get them to the attention of the right people who
11 will actually act on it. I just wondered if there were
12 programs around that.

13 MR. GLASS: We can look into.

14 MR. KUHN: On that last point, the Office of
15 Inspector General does run a fraud hotline that's a very
16 good program and works very well.

17 A quick question on Slide 12, on the first dot
18 point, particularly for the prescription for DMEPOS that you
19 have there, if I remember right, it was about 4 or 5 years
20 ago that CMS made a pivot from the old CMN, the old
21 Certificate of Medical Necessity, to the prescription. Do
22 we know, do we have any information, that that change from

1 the old CMN to the physician prescription, has that made a
2 difference in terms of compliance or improvement overall in
3 terms of DMEPOS activities?

4 MR. HACKBARTH: Could you, Herb, explain what the
5 difference is between Certificate of Medical Necessity and a
6 prescription?

7 MR. KUHN: Yes. The Certificate of Medical
8 Necessity was a standard form, kind of a template that CMS
9 had prepared but sometimes by the actual DME suppliers, that
10 they could supply to the physician where they could check
11 boxes and sign, and it was part of the compliance process,
12 ultimately in lieu of a prescription. CMS, I think through
13 a national coverage determination, got rid of the old CMN
14 and then moved to the actual physician writing a
15 prescription, hoping that would be better compliance, better
16 physician engagement in the process that was out there.

17 And I'm just curious if we know if that's
18 materially, if that's borne out what CMS thought at the
19 time, if that would be that much better.

20 MR. GLASS: I don't know. We can get back to you.

21 MR. KUHN: Okay.

22 MR. GLASS: What date did you say it was?

1 MR. KUHN: I think it was about four or five years
2 ago when that change had occurred.

3 DR. BERENSON: I'm interested in a question around
4 dual eligibles for the home health benefit. Do we know
5 anything about the interaction between whether states have
6 home and community-based waiver programs, the generosity of
7 those programs and how much then Medicare and the Medicare
8 home health provision? I mean with the theory that maybe in
9 some cases Medicare is used as a replacement for states that
10 aren't providing that. Or, you could argue the other way,
11 that maybe they're both being -- what do we know I guess is
12 the question.

13 MR. CHRISTMAN: A while back, I did take a look at
14 that, and there has been a little bit of work done on that,
15 but I just don't remember what it said. I'll have to get
16 back to you.

17 MR. HACKBARTH: Round one, Mitra?

18 MS. BEHROOZI: Thanks. It's actually on this
19 slide. I should know this. The last major bullet point
20 says "could try to change incentive by." I'm forgetting
21 what the incentives are for the physicians who are
22 ostensibly separate from the service or the product they're

1 ordering. What is the incentive for the physician?

2 MR. GLASS: I guess what we're saying is right now
3 there's very little incentive to question the use.

4 MS. BEHROOZI: Essentially, it's just to make
5 their patients happy. I mean that's like why not? Or, I
6 mean are they allowed to own stock?

7 MR. GLASS: Well, I don't want to speak for
8 physicians, but presumably right now if the -- well,
9 actually, I was talking to a physician, and he said he does
10 a lot of tracheotomies, and there's some DME that is
11 provided for care of that. He kept getting these from DME
12 suppliers, asking for prescriptions well after the
13 tracheotomy was removed and the patient was fine and all
14 that sort of thing, and they just kept appearing for him to
15 sign. The easiest thing to do of course is just sign the
16 stack of paper that comes to your desk. But he has little
17 incentive to question it, but he of course questioned each
18 one and didn't sign it.

19 But I guess that's what we're referring to. Right
20 now, there's very little incentive for the physician to put
21 in the extra effort to question some of this stuff, and it's
22 easier to just sign it. That's why we thought the feedback

1 might be of help.

2 MS. BEHROOZI: But no particular incentive to
3 order something, that's my question.

4 MR. HACKBARTH: One of the things you asked was
5 the ownership and how the historic rules apply. Physicians
6 cannot have ownership interest.

7 MR. GLASS: Yes. Presumably, they couldn't self-
8 refer. It wouldn't be an in-office ancillary or anything
9 like that.

10 MR. HACKBARTH: Yes, go ahead.

11 MR. KUHN: I want to think that I don't think
12 there's any ownership. I think the one limited exception,
13 but I could be wrong here, is that if someone gets an IOL
14 and the ophthalmologist can have eyeglasses there or
15 something like that for the convenience of the patient. But
16 I think other than that it's a pretty good barrier.

17 MR. GLASS: And I think physicians can have
18 crutches in the office and can have a supply closet.

19 DR. MARK MILLER: Isn't there, and this is truly a
20 question, isn't there one other angle? I mean if the person
21 is sort of getting a medical director, either as part of a
22 home health or a hospice or an arrangement. I mean there

1 could be things like that, where it's not ownership per se.

2 MR. CHRISTMAN: Yes. Hospices and home health can
3 hire medical directors. And I believe this, sort of: You
4 do not run afoul of Stark as long as the financial
5 arrangement does not reimburse the physician on the basis of
6 the volume or value of their referrals.

7 MR. HACKBARTH: Round one, Mary?

8 DR. NAYLOR: I think this is a really important
9 area of focus, and I'm wondering if it is also like
10 everything else in our system, a moving target. So we have
11 lots of things going on since the competitive bidding, as
12 you reported, that started in 2009, and really major changes
13 in incentives and disincentives that are happening as a
14 result of the Affordable Care Act that will target these
15 areas.

16 My question then is what are the advantages and
17 disadvantages toward a targeted review? I mean to focus on
18 review as the solution, meaning those that are outside in
19 terms of performance, to really just target efforts in the
20 short term on those providers that appear to be overusing or
21 maybe misusing, abusing.

22 MR. GLASS: I think that's what we did do in home

1 health and hospice. Is that correct? Yes, our last set of
2 recommendations.

3 DR. NAYLOR: So that's been done. Okay.

4 MR. CHRISTMAN: I guess I would just add sort of
5 two pieces to it, which is that the targeted review, kind of
6 you have to know what to target. So you have to have some
7 idea of what you want to go after.

8 And I think the other thing that frequently comes
9 up is people want ways to prevent bad actors from getting
10 into the program, and the changes in the Health Reform Act
11 do do some things that do raise the scrutiny that new
12 providers are going to face. So I think those are some of
13 the other pieces.

14 MR. GLASS: I just wanted to add on the
15 competitive bidding. You know that went into effect, and it
16 was stopped, and not it is supposed to start again in 2011.
17 They started. They've had the competition, but the
18 contracts go into effect in January of 2011. So it hasn't
19 happened yet.

20 DR. NAYLOR: The fundamental question is: Is
21 there anything else that could be done in terms of improving
22 reviews and actions on, that we should consider as this

1 field is rapidly unfolding?

2 DR. MARK MILLER: Yes, and I mean we've tried to
3 make -- if you think about some of the recommendations we've
4 made, we've tried to make recommendations in the payment
5 system to try and take some of the accuracy and incentives
6 out of it. We've made recommendations about profiling
7 providers and then trying to look at the tail of the
8 distributions and try to make changes on the part of
9 accountability for ordering the services.

10 I think there are still areas that even within
11 those boxes we could continue to think about. For example,
12 the interaction between the nursing home and the hospice is
13 an area that I think still there are some behavior and some
14 multiple payments that might be looked at.

15 I think another question to ask ourselves here is
16 what about the beneficiary because we're sort of focusing on
17 the physician and the provider. Does the beneficiary
18 provide another point of view and place to have an impact?

19 And I would say at least on DME there is sort of
20 this sense of yes, we'll do competitive bidding. Maybe.
21 Okay. If that doesn't, if that horse doesn't look like it's
22 going to leave the line, do we want to come back and say,

1 okay, if that's not going to happen, what should we be doing
2 there?

3 That's at least some ways to think about what's
4 happening here in front of you.

5 MR. HACKBARTH: Could I ask about the competitive
6 bidding for DME point? We all know the history of that
7 having been blocked, but Congress did reauthorize it via the
8 Affordable Care Act. Yet, I detect some skepticism about
9 whether in fact that will happen. Is that just general
10 wariness or is there something specific that you know?

11 DR. MARK MILLER: The former.

12 MR. HACKBARTH: Okay.

13 And the discussion we had yesterday, I think we need to be
14 reminded that only applies -- what is it -- 10 MSAs where
15 the competitive bidding.

16 DR. BERENSON: If I could just say something.

17 MR. HACKBARTH: Yes.

18 DR. BERENSON: The discussion we had yesterday, I
19 think we need to be reminded that only applies to, what is
20 it, 10 MSAs, where the competitive bidding --

21 MR. GLASS: It's nine now, but we'll expand that.

22 DR. BERENSON: Nine now. So there's the rest of

1 the DME world which needs attention as well.

2 DR. CASTELLANOS: Weren't there some changes in
3 the PPACA concerning fraud and abuse, and would any of these
4 changes or issues addressed in PPACA help here?

5 MR. GLASS: Yes, there's a long list of them in
6 fact, and presumably they will help indeed. We can get into
7 more detail if you want.

8 MR. CHRISTMAN: I mean I guess most of those
9 things were in areas you would kind of recognize as
10 additional reviews, screening of new providers and things
11 like that.

12 I think, just like Mark said earlier, the one that
13 it didn't do is make any changes to sort of what the
14 beneficiary might be able to do in some of these situations.
15 There weren't any changes on the beneficiary side.

16 MR. HACKBARTH: Did the Affordable Care Act do
17 anything to change the funding stream for fraud and abuse
18 activities?

19 MR. CHRISTMAN: It increased funding for the
20 administrative activities associated with it, and I think
21 that was the big one.

22 MR. HACKBARTH: Is that via using trust fund

1 dollars, or?

2 MR. CHRISTMAN: It was appropriated, yes, yes.

3 DR. MARK MILLER: Those are appropriated or from
4 the trust fund?

5 MR. CHRISTMAN: I believe it comes from the trust
6 fund, yes. I'm sorry.

7 MR. HACKBARTH: Okay. Any others?

8 Okay, round two comments. Karen.

9 DR. BORMAN: I want to talk mainly about home
10 health because to me the increase in that, at least in my
11 own clinical practice over the last 15 years, has really
12 been striking.

13 One of the things is surgeons make wounds. So my
14 most frequent interaction with home health relates to wound
15 care for patients that are being discharged. And the whole
16 notion now is almost if you have an open wound, no matter
17 how small or superficial or easy to get to it is, you get
18 home health visits. It's sort of whether it's discharge
19 planning rounds, suggestions from very good nurses, whatever
20 it may be, there is this impetus of the notion that the
21 patient and family can't possibly cope with any kind of open
22 wound.

1 And I think we have to be sensitive to what scares
2 people. Wounds are less scary to me than perhaps they are
3 to many of you sitting around the table. But the reality is
4 that lots of wounds that 15 years ago we would have had the
5 family come in, be instructed, say, get one those little
6 attachments for your shower and hose this off, use a mild
7 soap like Dial or Ivory, pat it dry and then put on a clean
8 dressing, now is a twice-a-day home visit for the first two
9 weeks of their discharge.

10 So I think that to me that says several things.
11 Number one, is there an opportunity to re-engage families
12 and beneficiaries? That sort of translates to number one or
13 the bottom one, revisit cost-sharing, because I think that
14 has kind of been lost in the shuffle, and maybe Medigap kind
15 of makes it to where it doesn't matter. But if the new
16 insurance plans and so forth come in, I do think we need to
17 think about that because there is this default now of
18 providing home health.

19 Another thing is migration of the home health
20 service a little bit. When I eventually get the full-form
21 initial prescription, it has a lovely, very elegant, very
22 comprehensive patient assessment about a whole bunch of

1 things that to me don't relate to the home health that I'm
2 authorizing, and it wants to engage in a whole bunch of
3 things about their anti-hypertensive meds or whatever, and
4 monitoring their blood pressure and stuff, which wasn't a
5 problem. The problem is this person has got a wound, and
6 maybe it's a wound on their bottom they can't see, and they
7 don't have anybody to help with. So home health is
8 perfectly legit here as a service, but kind of all this
9 other stuff that ratchets up the complexity and the
10 frequency of the visits, related to all these other stable
11 conditions. I'm not sure exactly how we get to that, but I
12 think there is something about targeting to a purpose of the
13 home health that maybe could lead to better value.

14 And then that leads me also to the forms. The
15 forms are there are a lot of things crowded into a little
16 bit of space, and given the volume of paper and/or drop-down
17 screens that physicians and nurse practitioners and
18 everybody else now encounter every day the impetus is to
19 kind of move that paperwork, move those screens. So I think
20 in terms of the feedback piece that would help stop the home
21 health that goes on for 52 weeks for a wound that should
22 have healed in 3 would be maybe the reminder, or the query

1 piece, was a very simple form and single drop-down screen:
2 Your patient is still getting home health for this wound.
3 When were they last seen by you or have you discharged them
4 from care, or something -- because the forms that I get
5 typically come pre-filled out with 99 years.

6 There's not a place where they can say forever or
7 until the patient's death, but there is this 99-year box.
8 Okay. And they're always -- when they come to you, they've
9 got the 99-year box filled in.

10 So I think that simplifying forms, maybe putting
11 in some shorter initial certification periods and maybe
12 revisiting the cost-sharing would be ways to potentially
13 come at it, at least the home health piece.

14 And I don't mean to pick on home health. It's a
15 wonderful activity, does lots of great things for patients,
16 but we can do it better.

17 DR. DEAN: This is very interesting because my
18 problem, as the staff already knows, is just the opposite of
19 what Karen described. I mean, I live in an area where home
20 health is not available, and in the whole upper Midwest
21 area, the access to these services has been declining rather
22 than increasing. I think I probably mentioned this before.

1 I know I've talked some about it. There's at least 13
2 counties in Minnesota that have no access to home health. I
3 haven't got an exact number. I think it's something similar
4 in the Dakotas and Montana.

5 And so, I think it just reflects the fact that
6 clearly we don't have the prices right. I mean, we're
7 losing services in some areas, we've got over-supply of
8 services in other areas, and I'm not exactly sure what the
9 answer is. But clearly, we have a problem and it's a
10 concern.

11 With regard to the prescriptions, those are a real
12 problem for us, especially some of the DME things because,
13 for instance, the ones that I have the most trouble with are
14 prescriptions for lift chairs and prescriptions for scooters
15 and things. These are things that there's a wide range of
16 people could benefit from; and yet, we know that they're not
17 going to meet the Medicare criteria and that may well be
18 appropriate because virtually everybody with some arthritis
19 in their knees could probably benefit from a lift chair.
20 And yet, the Medicare criteria is much more restrictive than
21 that.

22 So, Herb, I think what happens, we're actually

1 doing both. We write the prescription, but then we get the
2 questionnaire from Medicare that lists these things and the
3 criteria, at least for a lift chair is, is the patient able
4 to get out of an ordinary chair without assistance.

5 Well, if you can't get out of an ordinary chair
6 without assistance, for instance, you can't live by
7 yourself, for one thing, and that really limits the thing.
8 But when I sign that, and if I sign it honestly, then I'm
9 the bad guy and it really puts us in a bind. As it came up,
10 there's really no incentive for us not to sign it unless
11 we're worried about somebody is going to come and really
12 check, which isn't very likely, but it does create an
13 ethical dilemma because we know that in a lot of these
14 cases, people really could benefit from these. And yet,
15 from a technical point of view, they don't meet the
16 criteria. So it really creates a difficult issue.

17 I guess finally, I'm interested in the idea of the
18 Senior Patrol because I think I've mentioned before that
19 I've certainly had patients that come in and complain about
20 getting things they didn't order, and I didn't realize -- I
21 have some patients that would be happy to get involved in
22 that, but I didn't even know it existed. Do you know how

1 widely that's been promoted? Because I didn't even know it
2 existed, but I think the concept makes sense because some of
3 these folks don't like to see things wasted and they can be
4 pretty tough sometimes if they had a mechanism to do that or
5 to respond.

6 MR. GLASS: Yeah, I'm pretty sure it's in all 50
7 states, but I can check.

8 DR. DEAN: I'd be interested to know because I
9 think it hasn't been promoted very much.

10 MS. HANSEN: This is just a really short one to
11 build on the last aspect because I think there's always been
12 the question of how the beneficiary role is going to perhaps
13 play into understanding Medicare costs. I think this is a
14 really prime example of something that is very personal for
15 people, and to even look at bills -- because normally
16 they're transparent and you don't have any cost sensitivity.

17 So this may be a natural opportunity to really
18 look at the effectiveness and perhaps amp up its ability to
19 engage people to have greater awareness of costs and what
20 things are charged about, because otherwise, everything is
21 just totally transparent if you have a supplemental plan.
22 So it just is an example of a way to start engaging the

1 beneficiary with a vested interest in sometimes a very,
2 probably, investigative interest in terms of not seeing that
3 Medicare money "is wasted."

4 DR. KANE: Yeah, I think we're kind of dealing
5 with two separate issues here and they obviously are
6 continuous variables as, Kate might say, between fraud and
7 inappropriate use. I think it is hard, and I think for
8 inappropriate use, payment systems can do something. For
9 fraud, people are purposely trying to circumvent the system
10 and it's a lot harder to use legitimate means to try to deal
11 with illegitimate behavior.

12 But I think the use of the -- that the beneficiary
13 and their families should really be more engaged. I don't
14 think cost-sharing is the answer there, so much as rewarding
15 them financially when they find something, or giving them
16 some share of what they recover or prevent from being spent.

17 So that would be -- instead of saying, "We're
18 going to penalize you with more cost-sharing," I would say
19 reward you for actively seeking out inappropriate billings
20 or inappropriate approaches to use services you don't need,
21 and that's what I was talking about when there needs to be a
22 web site for people coming up and hovering around these

1 senior villages in Florida and saying, you know, having
2 little lunch meetings to sell services that are
3 inappropriate to somewhat unsuspecting seniors.

4 So reporting those people and then getting some
5 kind of reward for it, because it does take time and effort
6 and, you know, you think twice about what kind of reputation
7 you might be generating for yourself if you turn people in.

8 The other area that it seems would be interesting
9 to look into is what is direct to consumer advertising
10 doing? I've seen a commercial for every type of medical --
11 wheelchairs and chair lifts. They play those commercials
12 all the time. And what's that doing to demand and should it
13 taxed or monitored or somehow controlled? Because I think
14 it is -- people are probably going to Tom after they've been
15 watching the TV and they would never have thought of it
16 until someone says, "This is free to you, Medicare will
17 pay," and well, that kind of gets you interested.

18 So I think the whole -- I mean, what are they
19 saying in these commercials? How well are they being
20 monitored? Are they appropriate? Are they really adding
21 public interest, public value, or are they just jacking up
22 demand that then puts the doctor in an awkward position of

1 having to say no or say something inappropriate.

2 So I think that for fraud, I think there's things
3 outside of payment that we really should be thinking about.
4 For inappropriate use, we've got the usual tools that we
5 would use for any service, but fraud, I think, is different.

6 MR. KUHN: Yeah, on the issue of fraud, I mean,
7 it's pretty clear from the evidence here and the news
8 stories, there is a lot of fraud in this space in particular
9 areas of the country and it's just unconscionable that
10 people are stealing from the federal government and stealing
11 from the Medicare program this way, and also, I think,
12 abusing some seniors across the country in this effort
13 that's out there.

14 And so, one area that we might want to think about
15 on a go-forward basis is to make sure that or look at the
16 enrollment process, the accreditation process, the bonding
17 process to make sure those are as tight as they can be. And
18 another set of recommendations we might want to think about
19 is any area that we can encourage or help CMS think
20 differently about data mining to help spot this stuff sooner
21 than later.

22 As I think you said in the presentation, pretty

1 much in a pay and chase scenario, and if there's a way that
2 with now the new MACS and the Medicare Administrative
3 contractors, and the DMACS, the Durable Medical Equipment
4 contractors and those that are out there, hopefully data
5 feeds from their contractors can come more quickly and they
6 can start to cite these things like the home health outlier
7 issue we saw in south Florida, some of the DME spikes that
8 are out there.

9 So we might want to look at better surveillance
10 and sophisticated tools that could be used to help that.

11 The other area we might want to think a little bit
12 about is the perennial problem of mispricing. And we talked
13 a little bit about DME competitive bidding, and the results
14 are staggering. The first round that ultimately Congress
15 overturned across the ten product categories, they got a 26
16 percent reduction. And then on the second time, they're
17 over 30 percent. It's north of 30 percent. So there is
18 some opportunity there.

19 But the current pricing scheme that Medicare uses
20 for DME is called gap filling, and basically when a new
21 technology comes in with a current manufacturer price, the
22 fee schedule says that CMS needs to use 1986 dollars. So

1 what CMS does, through this gap-filling process, is they
2 deflate the product over the past two-and-a-half decades and
3 then re-inflate based on the updates that Congress has
4 granted in order to kind of put us in place where it needs
5 to be.

6 I think that the fact that we've got a base on
7 1986 dollars and that we deflate and re-inflate through this
8 gap-filling process is terribly antiquated, and I think
9 looking at that would be appropriate.

10 MR. HACKBARTH: That piques my curiosity. So
11 where does the 1986 come from?

12 MR. KUHN: I think that's based in statute and
13 it's never been updated since.

14 MR. HACKBARTH: It is?

15 MR. KUHN: Yeah. It's extraordinarily difficult
16 for CMS to do, and you might have years where there were
17 freezes that were less than updates, so that has to be
18 taken. So it's very arcane.

19 DR. BERENSON: I want to pick up where Karen was
20 talking about that patient who had a wound. The other side
21 of the story is what sometimes happens is the patient has
22 hypertension and diabetes and a bunch of other things and

1 the home health nurse calls the surgeon who ordered the
2 wound care who says, "Don't talk to me, talk to the
3 internist." And so, I get the call and, amongst other
4 things, would find that the list of medications that's
5 probably been memorialized is wrong, that they either were
6 wrong when the patient was discharged or I've been seeing
7 the patient and have changed the medications, and there's a
8 real need here for coordination. This is not the time to
9 talk about the medical home and that stuff, but I do think
10 we do need to look more into the role of the doctors. In
11 this case, it may not be the individual doctor, but sort of
12 the -- or the team of professionals. I won't even say
13 doctors. In many cases, it might not even be a physician.

14 And we were going down this road last spring, as I
15 remember, and Nancy wisely cut us off because we were going
16 down -- we were sort of -- it was an undisciplined
17 conversation we were having. I think we need to get back to
18 it.

19 And what I would suggest, perhaps as a place to
20 get some guidance in this area, would be the medical groups
21 who contract with Medicare Advantage plans. The Medicare
22 Advantage plans have to provide the Medicare benefits, the

1 home health and the DME benefits, and those groups, if
2 they're capitated, have every reason in the world to figure
3 out how to not just automatically sign the thing, but to
4 actually sort it out.

5 So in your kind of a place or some of the IPAs in
6 California, I think, we might be able to see how this could
7 work well on the ground and then figure out how to translate
8 it back into a fee-for-service environment. But I think we
9 might get some information from those -- from a few of those
10 places.

11 MR. ARMSTRONG: Particularly given what you just
12 described, Bob, I think the only comment I would make would
13 be that in our markets -- unlike, Tom, yours -- there are
14 plenty of providers. But we are very assertively trying to
15 increase the use of hospice and increase the use of home
16 health, particularly for certain populations of patients who
17 are not getting access and whose health and outcomes would
18 be better if they had more access to these programs. So I
19 offer that only to reinforce the suggestion that you made.

20 There may be ways in which we can think a little
21 bit differently about this by looking at how, in a different
22 payment structure, some of these solutions are discovered.

1 MS. BEHROOZI: Just to continue the last
2 discussion into this one a little bit, I feel like we should
3 be thinking about prior authorization or prior notification
4 as a potential tool here. It's maybe not for exactly the
5 same reasons in terms of the question I asked about
6 physician incentives, but maybe -- and of course it couldn't
7 be high school drop-outs who could help with this, but if
8 you have clinicians available at the other end of the line,
9 then maybe in places like McAllen, Texas, where the doctors
10 are like, "Well, you know, every patient expects that I'm
11 going to sign them up for one of these home health agencies
12 that's been out there recruiting, and whatever, and nobody
13 says no so I'm just going to go ahead and sign it."

14 It's not about disciplining them, but giving them
15 some advice. You know, the standards everywhere else are a
16 little different than they are there. Shaping behavior, not
17 necessarily punitively, but just to add it to the list.

18 MR. BUTLER: So while I think we can make
19 contributions on commenting on co-pays or physician
20 involvement, I think our principal value is in payment
21 accuracy. I think that we've done a pretty good job on
22 that. I'd just remind us that because the costs of entry

1 and exit are small, we shouldn't be timid, therefore, about
2 making adjustments in a given year, where in some services
3 we like to phase it and be gentle. Even if we make a
4 mistake in a recommendation, it's one of those areas where
5 you can correct it.

6 I think that the where and how much is provided,
7 for example, in home health, has changed dramatically based
8 on payment. So there's no reason we shouldn't use that as
9 the principal tool.

10 Now, as Nancy pointed out, the other issue is the
11 fraud and abuse, which is really a little bit independent of
12 this issue. The only thing that's curious to me is why it
13 has popped up. I wonder what we could learn about why it --
14 what is it about the climate and the environments of the
15 places where it has emerged? What would we learn from that?
16 Because it's not across the whole country and I'd be kind of
17 interested in what were the characteristics of those
18 communities or whatever that permitted it. Is there a
19 pattern beyond what the IG might find on their own?

20 DR. NAYLOR: So I'd like to echo Bob's and Scott's
21 comments about we have learned a great deal in the last
22 couple of decades about how to more efficiently and

1 effectively care for high risk Medicare beneficiaries. And
2 I hope that we would use the opportunity that's unfolding as
3 we think about creation of Accountable Care Organizations or
4 transitional care services that are really richly based in
5 evidence to more efficiently and effectively address the
6 needs.

7 I agree, we found, in one of our clinical trials,
8 that 50 percent of the people that we identified as at high
9 risk for poor outcomes and were subsequently shown to have
10 an early re-admission had not received home care services
11 because they were not perceived as in need.

12 So there's a lot of work that needs to be done,
13 both in terms of targeting the right individuals and
14 matching them to the right services, and I think the
15 Affordable Care Act offers numbers of opportunities with the
16 Transitions Act and incentives and disincentives.

17 So the best, I think, opportunity right now is to
18 engage the beneficiaries. They want to be engaged, their
19 families do, they don't have a sense often about where to
20 call. So this hotline, et cetera, that, I think, just
21 letting them know how it is that they could help the program
22 with communication of information, I think, could be very

1 helpful.

2 DR. CHERNEW: I agree that engaging the
3 beneficiaries is important in a number of ways, but I think
4 that actually in this case, some cost sharing is probably
5 important here. There's a lot of cost sharing. We charge
6 people if they have a heart attack for an inpatient
7 admission. We charge them a lot of money. Some modest
8 amount of money to pay for some durable medical equipment,
9 for example, or other types of services, I think, could be
10 useful in an area where it's very hard to know what the
11 appropriate amount of the service to provide is.

12 I think it's going to be very difficult to solve
13 through payment policy, although I think bundling is a good
14 thing. I think bundling could help. But for just getting
15 the price right, I think, is very hard because I think the
16 bad providers might be lower cost, and we very much run the
17 risk of driving out the good providers and just keeping the
18 bad providers when we try to get the price right in this
19 area, more so than some other sets of services.

20 So while I think we've done a number of
21 recommendations in some of these areas about how to get the
22 price right, and I think some of the competitive bidding

1 things show that we were not very close. We've gotten a lot
2 better. I do think for a lot of these services to figure
3 out what's in the social contract with people, you know, how
4 good of a wheelchair are we actually really going to make
5 sure you have for free.

6 I'm all for a whole series of things, but I think
7 we need to think through exactly what that social contract
8 is, and I do think this is an area where, in some cases,
9 some patient cost sharing is valuable to help control
10 demand, which is really very difficult to control in very
11 difficult situations. And I think the problem with bundling
12 is it does create this conflict between the provider and the
13 patient for things the patient perceives as free, for
14 something the provider is not getting paid for. I think
15 some patient input is important because there's so much
16 discretion and heterogeneity in cost.

17 MR. HACKBARTH: Okay. Thank you very much. We
18 will now have out -- oh, I'm sorry, Tom.

19 DR. DEAN: Just a really quick comment about the
20 whole concept of hospice. The Atul Gawande article that you
21 sent out, I think, was really -- it was an eye-opener for me
22 and really made me start to rethink some of this whole idea,

1 because I thought they made some very important observations
2 in there. I think that we shouldn't lose track of that.
3 The whole structure of the program and eligibility and all
4 those things may need some deeper thinking. I just didn't
5 want to lose track of that because I think that was very
6 important observations that they made.

7 MR. HACKBARTH: Thank you. We will now have our
8 public comment period, so let me briefly review the ground
9 rules. Please begin by introducing yourself and your
10 organization and please limit your comments to no more than
11 two minutes. When this red light comes back on, that will
12 signify two minutes are up.

13 And I would remind people that this is not your
14 only opportunity to provide input to the Commission or even
15 your best one. The best way to do that is through our
16 staff. In addition to that, there is an opportunity on our
17 website to provide comments.

18 MS. SAPHIRE-BERNSTEIN: Hi. I'm Inger Sapphire-
19 Bernstein with the American Urological Association and I'd
20 like to comment on the discussion of growth of ancillary
21 services in physician offices. We've been following this
22 issue with MedPAC for several years now and we have

1 submitted written comments four times, including comments on
2 the June report to Congress.

3 The staff report today stated that rapid volume
4 growth of imaging and other ancillary services contributes
5 to Medicare's growing financial burden on taxpayers and
6 beneficiaries and it also implied that some office-based
7 ancillaries are not clinically appropriate. The AUA does
8 not agree that growth of in-office ancillaries, particularly
9 imaging, has been demonstrated to have a significant impact
10 on Medicare's financial burden. Especially since
11 implementation of the Deficit Reduction Act, growth in
12 imaging paid under the Physician Fee Schedule has slowed
13 significantly and it fell below the growth of physician
14 services. This slowing continued in 2008, 2009, and we have
15 no more current data to indicate that that situation has
16 changed.

17 Payment for imaging under the Physician Fee
18 Schedule has been cut significantly, as staff noted, through
19 the Deficit Reduction Act, through changes of payment for
20 practice expense, and other cuts, and CMS has proposed
21 additional cuts to the Physician Fee Schedule for imaging in
22 2011. We appreciate that staff examined growth in the

1 number of imaging services and payments under the Medicare
2 Physician Fee Schedule and under the hospital outpatient
3 department. We note that payment per beneficiary was higher
4 in the outpatient department and that the number of imaging
5 services provided in the hospital outpatient department
6 cannot really be determined based on the change in the
7 packaging policy noted in 2008, and that graph that was
8 provided clearly did not note that and it ought to be
9 changed if that graph is going to be used in the future.

10 We recognize that use of imaging and other
11 ancillaries has been growing in all settings and some
12 component of that use may be inappropriate. The burden on
13 Medicare expenditures is caused by inappropriate use in all
14 settings, not by physician self-referral per se. And so an
15 overhead use of ancillaries is only warranted if the use is
16 unnecessary. The report to Congress in June did note some
17 incidents of inappropriate imaging. However, that imaging
18 was not only linked to self-referral and, in fact, it was --
19 it seemed those studies cited the highest level of
20 inappropriate use was by primary care physician referral.

21 We also want to state that we object to the
22 assumption that physician investment in ancillary services

1 automatically leads to higher volume. We do not feel that
2 any evidence has been provided to demonstrate that
3 physicians order imaging that produces potentially dangerous
4 radiation without medical necessity just to generate
5 revenue, and we see this assertion frequently and it's very
6 harmful to our members.

7 In our letter of August 3, we cited a study from
8 the Journal of Oncology, the Journal of Urology that
9 documented physician acquisition of imaging equipment had no
10 impact on imaging utilization in a large urology group, and
11 I believe that data has been shared with staff.

12 So just to wrap up here, we feel MedPAC should
13 address the problem of inappropriate use in all settings
14 rather than focus narrowly on self-referral, and the AUA is
15 making strides in this direction and we're looking at
16 clinical guidance on appropriate use. Thank you.

17 MS. NUSGART: Good morning. My name is Marcia
18 Nusgart and I'm Executive Director of a number of different
19 coalitions of medical devices used in the home care setting,
20 such as in wound care, respiratory care, enteral nutrition.

21 First of all, I wanted to commend Commissioner
22 Kuhn. I would totally agree that gap filling needs to be

1 able to be certainly fixed. But one other area that I would
2 consider or ask MedPAC to consider for greater
3 accountability of the use of DME could come by the reform of
4 the HCPC coding process.

5 The current process is not transparent,
6 understandable, or predictable, and the current HCPC code
7 set includes broadly defined codes that are ambiguous and
8 imprecise. What does this lead to? It leads to improper
9 payment accuracy for payors and difficulty in tracking
10 outcomes research as well as looking at utilization.

11 In addition, inadequate coding creates target
12 codes, which you were talking a little bit about today in
13 terms of the fraud and abuse, and it has a potential impact
14 on it. Examples are broad and all-inclusive codes provide
15 these opportunities when the lowest-cost item in a code
16 provides a disproportionately high margin of profit for the
17 supplier. An adequate reimbursement for codes is a barrier
18 which also could lead to fraudulent billing, billing the
19 item used in a code, and oftentimes that's a miscellaneous
20 code that would certainly provide the needed reimbursement.
21 Having an imprecise coding system and using miscellaneous
22 codes creates serious audit issues for the Medicare program.

1 Since the Medicare program wouldn't be able to prove what
2 code is used for an item, it can't prove they're reimbursed
3 appropriately, and decreases the ability to write
4 appropriate coverage policies.

5 I'm one of the members of an alliance for HICPIC2
6 coding reform, which is comprised of over 25 key law firms,
7 lobbying firms, associations, coalitions, medical device
8 companies, and reimbursement consulting firms with expertise
9 in HCPC coding who recognize the need to take action to
10 reform the HCPC coding system. We've had the opportunity to
11 meet with MedPAC staff last year and have also disseminated
12 our fact sheets and significant concerns at one of the
13 MedPAC meetings last year. We would submit that this is an
14 important issue and respectfully request that the MedPAC
15 Commissioners to include HCPC coding reform in a future
16 meeting and a future report to Congress. Thank you.

17 MR. FRIEDMAN: Hello. My name is Alan Friedman.
18 I'm a board-certified pathologist in anatomic and clinical
19 pathology, and I would like to speak about the subject of
20 over-utilization in laboratory testing.

21 It seems to be that that's the concern of the
22 committee and it seems that much simpler than changing the

1 system of reimbursement or changing systems is simply to
2 monitor utilization, which can be simply done, I think, and
3 is a much simpler process than changing the whole system and
4 coming up with all these rules and acts of Congress.

5 If you simply look at, in pathology, the number of
6 biopsies per patient, that would be a very useful data point
7 to look at. You could look at an in-house lab versus an
8 outsourced lab. You can look at practices that at first had
9 no in-house laboratory and how many biopsies per patient
10 they were doing at that time and then look later to see if
11 that increases significantly. That would be a measure of
12 over-utilization. And rather than changing the system, why
13 not treat over-utilization as a type of Medicare fraud and
14 punish it, and thereby the specter of punishment would
15 decrease over-utilization.

16 So I haven't heard much to that suggestion and it
17 seems a lot simpler than changing the whole system of
18 reimbursement and studying all these different methods of
19 measuring. In the field of pathology, you simply measure
20 the number of biopsies per patient. Now, different
21 practices will have different standards, but they can be
22 measured in different areas and for different types of

1 practices and specialties and it's a very simple measure to
2 do. It doesn't take much work at all and it wouldn't cost
3 much, either.

4 The only other thing is to know whether you're
5 dealing with an in-house or an outsource laboratory and you
6 could have coding in the billing for that, as well.

7 So I just wanted to make some of those suggestions
8 to point out how much simpler it could be and trying to
9 address over-utilization could be much simpler, and thank
10 you.

11 MS. SHEEHAN: Hello. I'm Kathleen Sheehan. I'm
12 Vice President of Public Policy for the Visiting Nurse
13 Association, representing nonprofit home health and hospice.
14 And I just want to address briefly the question of what's
15 the climate in terms of what's happening with fraud and
16 abuse.

17 I think if you look at Certificate of Need, if you
18 did a division of Certificate of Need States versus States
19 where there is not a Certificate of Need, you'd probably see
20 a lot of differences in terms of some of the problems that
21 we've looked at today, and I would encourage you to perhaps
22 do an analysis along those lines.

1 I also want to mention that nonprofits are very
2 concerned about fraud and abuse. We actually have on the
3 home health side 33 recommendations, which we'd be delighted
4 to work with MedPAC and with Congress in terms of looking at
5 those recommendations. We're also developing it right now
6 for hospice.

7 One thing I want you to think about as you think
8 about bundling and all kinds of other things is really
9 patient choice. One of the difficult areas that we see
10 right now, and I'll give you a specific example, is you have
11 a patient who's been receiving home health from a community-
12 based local provider that they have a relationship with and
13 they know well, and by the way, nonprofits do a lot with
14 education of patients and family members. That's one of the
15 areas where they really excel. But you have a person who's
16 associated with a home health agency. They go into the
17 hospital. At that point, a determination is made that they
18 need to get hospice. And in many instances, they lose their
19 ability to make a choice. They're basically shuttled from
20 the institution into whatever the hospice is that has been
21 selected by the institution.

22 So I think as you look at financial relationships

1 between institutions and you look at bundling and other
2 kinds of things, please remember that patient choice is very
3 important and having a relationship with a community-based
4 provider that works with the family and works with the
5 patient, whether it be home health or hospice, makes a
6 tremendous difference.

7 So we look forward to working with you, and it is
8 true, I will say, that sometimes the providers that are not
9 doing the right thing may have lower costs and you need to
10 look carefully at preserving a nonprofit delivery system
11 that really serves not just Medicare patients that you sort
12 of take off the top, but that you look at a delivery system
13 that is serving Medicare, Medicaid, and also charity care
14 patients. You want to be sure -- I think that MedPAC has
15 indicated in several instances they are very concerned about
16 the rapid growth of for-profit delivery systems and we are
17 concerned about the survival of the nonprofit delivery
18 systems. So I ask you to look at that in your analysis.
19 Thank you very much.

20 MS. TOWERS: I'm Jan Towers with the American
21 Academy of Nurse Practitioners and I'd like to pull you out
22 of the box just a little bit and make a comment about the

1 fact that much of the focus that has been placed on fraud
2 and abuse has created some unintended consequences in that
3 it actually is putting us in a position of being prohibited
4 from doing the kinds of things that we could do in relation
5 to home health care and hospice in terms of authorization
6 for services.

7 One of the things we talk about is physicians who
8 are signing these things and not looking at the patient, and
9 part of that is because they're so busy that they don't
10 really have time to do that, and yet we will not utilize
11 nurse practitioners who would be able to actually do
12 evaluations and perhaps make better judgments in terms of
13 who needs care and who does not care [sic] that are highly
14 qualified, so I would ask you to think about that as a
15 solution to part of your problem.

16 MR. HACKBARTH: Okay. Thank you.

17 We are adjourned.

18 [Whereupon, at 12:12 p.m., the meeting was
19 adjourned.]

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