MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Tuesday, January 9, 2007
9:49 a.m.

COMMISSIONERS PRESENT:

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

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

2 MR. HACKBARTH: Good morning everyone. This
3 morning we have two sessions. The first our final
4 discussion of the SGR report and then one session on payment
5 adequacy and update recommendations on hospitals.

6 So on SGR, Kevin, Dana, who's leading the way?

7 MS. KELLEY: Good morning.

8 This will be our final presentation on MedPAC's
9 mandated report to the Congress on the SGR. Today, Kevin
10 and I will summarize the main points to be covered in the
11 report.

12 What we need from you is assistance in identifying
13 points that we have omitted or parts of the report that are
14 unclear or need to be beefed up our toned down. We'll take
15 your written comments, along with today's discussion, and
16 revise the draft for publication on March 1st.

17 Before I begin, I want to acknowledge the staff
18 members who aren't up here today but whose efforts have been
19 integral to this work: Niall Brennan, Cristina Boccuti,
20 David Glass, Scott Harrison, Megan Moore, and Jennifer
21 Podulka.

22 The Deficit Reduction Act of 2005 requires that we

1 report on mechanisms that could be used in place of the
2 current SGR system for updating physician fees. The report
3 must do several things: identify and examine alternative
4 methods for assessing volume growth; review options to
5 control the volume of physician services while maintaining
6 beneficiary access; examine the potential for volume
7 controls using five alternative types of target tools, group
8 practice, hospital medical staff, type of service,
9 geographic area, and physician outliers, and consider the
10 administrative feasibility of each; and finally, identify
11 the appropriate level of discretion for the Secretary of
12 Health and Human Services to change payment rates or take
13 other steps to affect physician behavior.
14 In addition to the analyses of the five mandated
15 alternatives, our report will provide background information
16 on the SGR system and a detailed discussion of MedPAC's
17 vision for improving the value of the services Medicare pays
18 for. The report will also lay out issues that cut across
19 all the mandated alternatives and will explore additional
20 options for addressing expenditure growth.
21 Our report will begin with an introduction
22 outlining the key issues. First, since 2000 Medicare

1 spending for physician services has climbed to 9.4 percent
2 per year. Spending has grown largely due to increases in
3 volume, the number of services furnished, and the complexity
4 or intensity of those services.
5 Medicare's fee-for-service method of paying for
6 physician care itself contributes to volume growth, and some
7 observers have hypothesized that physician volume growth is
8 spurred by new technology, demographic changes and shifts in
9 site of service. Change in disease burden may also play a
10 role. But analyses by MedPAC and others have found that
11 much of the rise in volume is unexplained. Moreover, it's
12 difficult to determine whether volume growth is improving
13 the health and well-being of Medicare beneficiaries.
14 Further, rapid expenditure growth directly affects
15 beneficiaries' out-of-pocket costs through higher Part B and
16 supplemental insurance premiums and copayments. And just as
17 important, rapid expenditure growth increases the burden on
18 the American taxpayer.
19 At the same time, it's well established that many
20 Medicare beneficiaries do not receive services that are
21 known to improve health and perhaps reduce the subsequent
22 need for more expensive services like hospital admissions.

1 The challenge for Medicare, as well as for private
2 purchasers, is to encourage the optimal mix of services. On
3 its own, a formulaic approach is unlikely to accomplish this
4 goal.
5 Under current law, the Congress has only one
6 expenditure control lever, the Medicare physician payment
7 rate. That rate is calculated each year under the SGR
8 system. Expenditure growth has been so high in recent years
9 that the SGR system has calculated substantial reductions in
10 the physician payment rate, but the Congress has repeatedly
11 overridden the SGR system and prevented those reductions.
12 As a result, the cumulative SGR formula calculates even
13 larger payment cuts the following year and results in a
14 longer period of negative updates.
15 The Medicare Trustees project that the SGR would
16 dictate fee cuts of 5 percent per year for a long period
17 into the future, cuts that the Trustees consider unrealistic
18 because the Congress is unlikely to implement them. But the
19 budget baseline includes the large fee cuts, making it
20 costly in terms of budget scoring even to maintain fees at
21 their current level.
22 The fundamental question for the Congress is

1 whether it wants an overall limit on Medicare spending for
2 physician services. Some argue that if properly designed
3 and allowed to function, expenditure limits can effectively
4 control volume and expenditure growth. Others believe the
5 value of an expenditure limit lies in the fact that it
6 forces annual attention to the issue of Medicare spending
7 which, if allowed to increase unchecked, will require
8 reduced spending elsewhere in the budget, higher taxes, or
9 larger deficits.
10 Others are opposed to formulaic approaches,
11 contending that they cannot distinguish between good and bad
12 care, provide little incentive for individual providers to
13 control volume, and penalize providers who use health
14 resources conservatively.
15 If the Congress determines that expenditure limits
16 are necessary, the Commission has concluded that such limits
17 should not be borne solely by physicians. Rather, they
18 should ultimately be applied to all providers. This will
19 encourage providers of all types to work together to keep
20 costs as low as possible while increasing quality.
21 Congress may also wish to apply whatever limits
22 are used on a regional basis. Risk-adjusted Medicare

1 spending per beneficiary varies at the state level and even
2 more when measured at the level of hospital referral areas.
3 Moreover, high spending areas often have lower, not higher,
4 quality of care.
5 The Commission recognizes the desire for control
6 over rapid increases in Medicare spending but wise
7 stewardship of the program goes beyond controlling its cost.
8 Regardless of whether Congress explicitly limits expenditure
9 growth, it's imperative that Medicare increase the accuracy
10 of its payments and create new payment policies that reward
11 providers for efficiency, quality and coordination of care
12 across sites.
13 These improvements will require a much larger
14 investment in CMS, both dollars and administrative
15 flexibility. CMS will need to develop, update and improve
16 information systems and quality and resource use measures,
17 as well as contract for specialized services. In the long
18 run, failure to invest in CMS will result in higher program
19 costs and lower quality of care.
20 Our report will then consider alternatives to the
21 SGR. As required, we assessed the pros and cons of the five
22 alternatives mandated by Congress and then we also

1 considered some other options.

2 As you'll recall from previous presentations, the
3 geographic alternative would apply an SGR to sub-national
4 geographic areas, setting different fee update amounts by
5 region, acknowledges the fact that regional practice
6 patterns vary and contribute differentially to overall
7 volume and volume growth. Use of different regional updates
8 could help reduce geographic variation over time. However,
9 it's not clear what the optimum geographic unit would be.
10 Choosing the unit involves tradeoffs between physician
11 accountability, year-to-year volatility, and administrative
12 feasibility. Using smaller units, such as counties, would
13 create target pools that might increase physician
14 accountability, for example, but would increase year-to-year
15 volatility and be difficult to administer.

16 Using different regional updates would not
17 entirely addressing the inequities of the current system.
18 For example, a physician who practices conservatively in a
19 high-volume region would still be penalized. Using
20 different regional updates could also create wide
21 disparities in payment rates across areas. Border crossing
22 by physicians and by beneficiaries would also be an issue.

1 A type of service SGR would set expenditure
2 targets for different types of services, as was done by the
3 VPS system. This alternative recognizes the fact that
4 volume growth differs by type of service. Using service-
5 specific targets could allow policymakers to shift resources
6 from types of services that are considered to be of lesser
7 value to those that are considered to be of greater value.
8 This alternative could also be used to try to boost payments
9 for physicians providing primary care.
10 But service-specific targets present a number of
11 difficulties. One is that such targets ultimately undermine
12 the integrity of the RBRVS. Under service specific targets,
13 payments would vary not only because of differences in RVUs
14 but because of differences in conversion factors. In
15 addition, because setting service-specific targets requires
16 choices among services, using such targets could put
17 policymakers in the position of determining what represents
18 good care. That would likely involve ongoing and
19 contentious debate.
20 Congress also asked MedPAC to analyze an
21 alternative to the SGR that might adjust payment based on
22 physicians participation in group practices, since studies

1 suggest that physicians in multispecialty group practices
2 may be more likely to use care management processes and
3 information technology and to have lower overall resource
4 use.

5 But considering the low share of physicians in
6 multispecialty groups and that not all group practices
7 engage in activities that improve quality and manage
8 resource use, payment policies that focus solely on group
9 status may not effectively elicit desired behavior.
10 Further, using separate targets for groups and non-group
11 physicians would be inequitable since efficient physicians
12 in smaller or solo practices would be ineligible for the
13 presumably higher group payment updates. In addition, rural
14 physicians might have few, if any, opportunities to join
15 group practices.

16 Establishing payment incentives for performing
17 specific activities associated with better care and lower
18 resource use would probably be more effective than using
19 separate targets based on group practice status.

20 A hospital medical staff SGR alternative would use
21 Medicare claims to define hospital medical staffs by
22 assigning physicians and beneficiaries to the hospitals they

1 use most. Using these extended hospital medical groups
2 could better align incentives to control expenditures.
3 Although the size of the groups would vary substantially,
4 each of them would be much smaller than the current national
5 pool. Individual physicians could therefore more readily
6 see a link between their own actions and their group meeting
7 its target. These groups would also increase incentives for
8 physicians to monitor the behavior of their peers. Over
9 time this alternative could increase care coordination and
10 reduce expenditures.

11 But there are significant barriers to this
12 alternative. Some argue that hospital medical staffs are
13 not currently functioning well and are unlikely vehicles for
14 change. Physicians may resist being assigned by Medicare to
15 an entity to which they may feel little or no affinity.
16 Physicians who rarely refer patients for hospital care may
17 be particularly resistant. There would also be legal
18 obstacles to this option.

19 Finally, Congress asked MedPAC to look at outliers
20 as an option for reforming the SGR system. An outlier
21 policy could be used to identify physicians with very high
22 resource use relative to their peers. CMS could first

1 provide confidential feedback to physicians and then, once
2 greater experience and confidence in outlier measurement
3 tools were gained, Medicare could use the results for more
4 aggressive interventions such as public reporting, pay for
5 performance, or differential updates based on outlier
6 status.
7 The major advantage of this option is that it
8 would treat those physicians with high relative resource use
9 differently from other physicians. It would promote
10 individual accountability and would enable physicians to
11 more readily see a link between their actions and their
12 payment.
13 However, there are a number of issues that would
14 need to be resolved. Implementation of an outlier system
15 based on episode groupers may prove difficult if physicians
16 cannot be convinced of the validity of episode grouping
17 tools. There would also likely be considerable controversy
18 around initial physician scores, as some physicians realized
19 that their practice patterns were not in line with those of
20 their peers.
21 In addition to the mandated alternatives we
22 considered a few others. First, we looked at using

1 specialty-specific expenditure targets. Under such a
2 system, specialty groups could be a source of peer influence
3 that could induce behavior change. Such a system would also
4 create incentives for specialty groups to promote efficiency
5 and develop standards for quality and appropriateness.
6 However, a major obstacle to such a system is that
7 physicians self-designate their specialty. Without
8 administrative controls, a specialty-specific target system
9 could lead to physicians changing their specialty to avoid
10 reductions in payment rates or to seek higher payment rates.
11 Specialty-specific targets could also undermine efforts to
12 promote more collaboration among physicians of different
13 specialties.
14 We also considered a reconfiguration of the
15 current national target. For example, the current system
16 could be changed to eliminate the cumulative aspects of the
17 spending targets.
18 Another option would be to implement an additional
19 allowance corridor around the allowed spending target line.
20 Both these options would result in more favorable updates
21 but, of course, would increase total expenditures.
22 I'll now turn it over to Kevin, who will discuss

1 an additional alternative to expenditure control.

2 DR. HAYES: We return now to the question of

3 whether to retain an expenditure target for physicians. The

4 draft report discusses two paths that Congress could follow

5 in answering this question.

6 Pathway number one would be to repeal the SGR and

7 not replace it with a new expenditure target. Instead of an

8 expenditure target, the Congress could accelerate

9 development and adoption of new approaches for improving

10 value in the physician payment system.

11 These new approaches are discussed in chapter five

12 of the draft report. They include linking payment to

13 quality, encouraging coordination of care and measuring

14 resource use coupled with providing feedback.

15 The alternative to path one, path two, would

16 retain an expenditure target but it would differ from the

17 current SGR in three important ways: one, a new system of

18 targets would apply to all of Medicare. Two, the targets

19 could be applied geographically. Three, providers could be

20 given an array of options for sharing in gains resulting

21 from their improved efficiency.

22 Otherwise, pathway two would include the

1 approaches for improving value that would be in pathway one,
2 namely the linking payment to quality and so on.
3 If the Congress follows path two and retains a
4 target, the draft report discusses a rationale which is that
5 it maintains pressure for continual improvement. For
6 policymakers, it is pressure to improve payment systems.
7 For providers, it is pressure to improve efficiency. And if
8 there is a target the report discusses the idea of expanding
9 it to encompass all providers, not just physicians.
10 Under path two, a target or system of targets
11 would apply on a geographic basis. This would respond to
12 the findings that Medicare spending varies widely across the
13 country and that quality does not seem to increase with
14 higher expenditures. By some measures, it may be lower as
15 spending goes up.
16 Within this geographic framework, path two could
17 them accommodate alternative groupings of providers:
18 hospital medical staffs, integrated delivery systems,
19 multispecialty physician groups, and so on, to bring
20 incentives closer to those providers.
21 Even if there is a target, Commissioners have
22 discussed the importance of other reforms. These would

1 include increasing the accuracy of payments under existing
2 payment systems. For example, the Commission has
3 recommended ways to improve the accuracy of the physician
4 fee schedule by improving the review of relative values for
5 physician work.
6 Pathway two would also include rewarding providers
7 for efficiency, quality and coordination across sites of
8 care. In the draft report we site pay for performance for
9 quality as an example of a way to provide such rewards.
10 The complexity of this second path argues for a
11 phased approach to implementation. At the December meeting
12 we went over the phases in some detail. To briefly recap,
13 phase one could include adjusting the current expenditure
14 target. For example, one option is to make the target non-
15 cumulative instead of cumulative as it is now. In phase one
16 there could also be rewards or penalties for physicians
17 based on their individual performance on quality measures.
18 Phase two could start by differentiating payments
19 geographically to reward or penalize physicians and
20 potentially other Part B providers such as hospital
21 outpatient departments.
22 The expenditure target could be expanded to

1 include all of Medicare. In phase two, physicians could
2 receive confidential feedback on their resource use. Also
3 there could be public reporting on the performance of
4 accountable care organizations. These are the organizations
5 mentioned earlier, multispecialty group practices,
6 integrated delivery systems and so on.
7 In the later phases, payments could be adjusted
8 for all providers, depending on whether spending targets are
9 achieved. These could be targets inclusive of all Medicare
10 services.
11 There could also be opportunities for providers to
12 share in savings. Concurrent with the phases, payment
13 systems reforms could be underway. These could include
14 bundling, gainsharing, and other policies.
15 We conclude with a few points on the
16 administrative burden for CMS. For both path one and path
17 two the draft report reiterates the importance of increasing
18 substantially the investment in CMS.
19 For the payment system reforms contemplated under
20 both pathways, there has been some progress already. CMS
21 has a number of efforts underway right now, including the
22 physician group practice demonstration and the physician

1 voluntary reporting program. In addition, the Agency has
2 taken steps to improve the accuracy of existing payment
3 systems, including the one for physician services as well as
4 those for inpatient hospital care and post-acute providers.
5 The report discusses the importance of accelerating the pace
6 of such improvements.
7 CMS would bear a further administrative burden if
8 the Congress adopts path two and CMS must then implement the
9 four phases.
10 For all of this, a way to ensure an investment in
11 CMS is with dedicated resources. Previous reforms have had
12 a large impact on resources. Two recent examples, in the
13 Medicare Modernization Act the Congress made available to
14 CMS and the Social Security Administration $1.5 billion to
15 administer the new drug benefit.
16 In the Tax Relief and Health Care Act, passed just
17 last month, the Congress made available $60 million for
18 fiscal years 2007 through 2009. This is to implement the
19 Act's provisions for physician payment and quality
20 improvement programs. This amount is separate from a
21 physician assistance and quality initiative fund established
22 for 2008.

1 That's all we have. That's all of our
2 presentation. We look forward to your comments on the draft
3 report.
4 MR. HACKBARTH: If I could, I'd like to just add a
5 few comments to what Dana and Kevin presented, saying much
6 of the same thing but in my own words.
7 I think through our deliberations we've reached a
8 couple conclusions on which there is broad agreement. One
9 of those is that expenditure targets like the SGR do not
10 create appropriate incentives for providers to improve care,
11 to improve efficiency, defined as lowering cost and
12 increasing quality. They are too far removed from day-to-
13 day practice.
14 Indeed, the SGR has probably created as many or
15 more perverse incentives than positive incentives when
16 viewed from the perspective of the daily practice of
17 medicine or the provision of health care. An example of
18 that would be through focusing on physician fee constraint
19 alone, encouraging physicians to expand their practice by
20 imaging equipment in order to strive to have an economic
21 basis for their practice that is sustainable.
22 So expenditure targets, per se, are not going to

1 move us in the right direction for Medicare. I think there
2 is broad, even unanimous, agreement on that point.
3 To change the behavior of health care providers,
4 whether it's physicians or hospitals or post-acute
5 providers, there is no alternative but to change the payment
6 systems at a detailed level that apply to those prospective
7 groups, improve our ability to measure performance, assess
8 quality, move towards bundled payments of various types that
9 create a stronger incentive for reducing resources consumed
10 in providing appropriate high-quality care. And chapter
11 five, briefly summarized by Kevin, lists a number of
12 initiatives that we think are critically important in
13 getting payment systems right and actually helping to
14 improve care.
15 In order to do that work in chapter five, we need
16 a much larger investment in resources in CMS. We have made
17 some progress in terms of improving payment systems. We've
18 got some promising demonstrations underway that CMS has
19 organized. The problem is that the cycle time for
20 improvement is dreadfully slow and not at all in keeping
21 with the urgency of the task facing the Medicare program and
22 the country. On that point, I think we also have unanimous

1 agreement among the Commissioners.

2 Where we don't have unanimous agreement is

3 whether, in addition to doing that sort of work to improve

4 the nitty-gritty of payment policy, an aggregate expenditure

5 target could be a useful supplement. And to be very pointed

6 about it, the goal of such an expenditure target would not

7 be to change the behavior of health care providers but

8 rather to change the behavior of health care policymakers

9 and establishing greater discipline in that policymaking

10 process, including updates for providers. Other things as

11 well, but updates in particular.

12 And there we have a division of views. We don't

13 have consensus on whether expenditure targets could be a

14 useful complement to the payment reform discussed in chapter

15 five.

16 I think we do have broad agreement though that if

17 Congress were to elect to retain some sort of expenditure

18 target mechanism that a couple of things need to be

19 addressed. One is that such a mechanism should apply not

20 just to physicians but should apply to all health care

21 providers. Medicare does not just have a physician cost

22 problem but rather a total cost problem.

1 And second, that in some fashion expenditure
2 targets should be adjusted to reflect the large disparities
3 in Medicare expenditures per beneficiary across the country.
4 Not all areas of the country contribute equally to the
5 expenditure problems that Medicare does have.
6 I think there is consensus on those two points,
7 that it ought to be broader than just physicians and there
8 ought to be some effort to geographically adjust so that
9 pressure is applied greatest in the areas that contribute
10 most of the cost problem.
11 That's my summary, a very brief summary, of our
12 discussions. That then leads to the two paths that Kevin
13 and Dana presented, path one being repeal SGR, not impose
14 any new expenditure target, then get on with the work of
15 developing detailed reforms and various payment systems.
16 Path two would retain an expenditure target, albeit in a
17 modified form, but also focus principally on the changing of
18 payment systems.
19 So that's my personal summary of where we've been
20 to this point.
21 DR. CROSSON: Thanks, Glenn. I think I'd have to
22 first start out with congratulations to you and to the

1 staff. As I was listening to all the staff members who
2 worked on the report, I was trying to figure out who hadn't
3 worked on this particular item actually, which I think is a
4 testament to how complex it is.
5 And congratulations to you for really leading the
6 synthesis of what is, I think, primarily agreement as you've
7 described, although there are probably some areas of
8 disagreement about exactly how to get to where I think
9 everybody would like to get to.
10 This is one of the most complex, as you mentioned,
11 items that we've discussed at least in my time on the
12 Commission. It's also, I think, one of the most vital
13 things that we'll discuss because I have the notion in here
14 that somewhere in here is one of the important keys to
15 Medicare's sustainability over time as it relates to both
16 moving towards bringing physicians and hospitals closer
17 together, creating incentives for that, and creating, I
18 think, a different set of payment dynamics than Medicare has
19 right now, many of which don't appear to work very well.
20 It's also been a difficult discussion because of
21 the contentiousness around the current system of physician
22 update payment and the use of the SGR. The word itself is

1 sort of now emotionally charged. It's a complex idea
2 because it stands for a lot of different calculations and
3 notions within it. I think that's made it difficult. And
4 it has also made it a bit of a struggle for some of us to
5 try to put words to what I think we think ought to happen.
6 And as we have these discussions, we kind of
7 realize we're all sort of thinking the same thing but we're
8 using different words in some circumstances.
9 Having said that, I think what I'd like to say is
10 that I think that the target in the end, to me anyway, the
11 target or the use of targets is in the end going to be less
12 important than the dynamic that is created by the payment
13 system because the target really just addresses the amount
14 that's paid -- the update to the target addresses the amount
15 that's paid for a unit of service. Whereas I think many of
16 us believe that it's the numbers of units of service, at
17 least in some areas of medicine, and in some cases the
18 inappropriate use of services that is technology driven in
19 part, that is one of the major props that we're dealing
20 with.
21 I do think that in some parts of the report the
22 projection of the number of targets that would be required

1 in some of the examples may be administratively impossible.
2 So I have less interest or concern about the
3 target as a starting point and what that ought to be than
4 the nature of the dynamic. I think I'll just give an
5 example of what I think might be something that illustrates
6 that. And I'm not saying this is the only way that this
7 could be done.
8 But least what I have in my mind is something like
9 -- and I don't know whether this means adjusting the SGR,
10 changing the name of it, repealing it, pretending it never
11 existed, or starting over, or whatever.
12 But starting with some basis for next year's
13 payment that would be either based on reasonable input costs
14 or perhaps, in some circumstances, less than that based upon
15 what we think we can afford as a country, taking that number
16 and perhaps modestly adjusting it regionally. Let's say we
17 ended up with a number of 2 percent as a starting point, and
18 we could arrive at that number by a number of different
19 means.
20 Maybe that number gets adjusted by one point,
21 broadly geographically based on the fact that we have these
22 broad differences and we'd like to see them change over

1 time.

2 But then within those broad geographies, so let's
3 say we have geographies now that are at one and we have some
4 that are at three, that based on utilization -- and
5 utilization could be narrowly defined. It could be just
6 physician utilization. It could be physician and hospital
7 utilization, which is what I would believe is right. It
8 could be for all services or it could be a subset of
9 services.

10 But it would be some measure of utilization of
11 services, targeted maybe at the most inappropriate areas.

12 But then, within those environments, entities that
13 would be created -- and we list in the report ideas of group
14 practices, accountable organizations which would include
15 physicians and medical staff physicians in hospitals --
16 would essentially work sort of in competition with each
17 other around that number. And there would be a range around
18 that number of reward or loss based on that. Say you had
19 the one in three I was talking about, you might end up with
20 a 3 percent range on each side. And so you could have
21 within each geography some entities that ended up with a
22 couple of points minus and some that ended up with 4 or 5

1 percent positive.

2 The point of this is again that the starting point

3 or the target is less important than the competitive dynamic

4 that's created because over time it becomes in the interests

5 -- relatively quickly I would think, in a few years -- it

6 becomes in the interest of entities to be created to be part

7 of this process and then to learn from each other or learn

8 within their own competitive entities what are the areas of

9 efficiency that can be created, where can quality drive

10 better outcomes as well as lower cost, and the like.

11 So I think that's just broadly my sense. It's

12 that again I think the focus on targets, particularly at the

13 micro level, may drive an administrative complexity that

14 isn't necessary. The focus on targets in the end is less

15 important than the dynamic that's created by the incentives

16 that could in the end reverse what the problem is, which is

17 on the utilization side. And it's not just a physician

18 problem, as has been mentioned. This is an entire system

19 problem.

20 DR. SCANLON: I agree with much of what Jay just

21 said, although I think the idea of in trying to create

22 something that's simpler, simplicity is a relative term and

1 we're still going to be dealing with something that's
2 complex.
3 I think that the staff did an incredible job in
4 terms of this report, in capturing the difficult situation
5 that we're dealing with. Your characterization of the two
6 goals that we have, the two disciplines, certainly the
7 current SGR doesn't meet those. But at the same time I
8 guess there's a question of whether targets can meet those.
9 And I think in terms of the report, trying to work through
10 how targets can be improved to try and help with both of the
11 disciplines that it just does a fantastic job of talking
12 about those.
13 What comes across for me is both the information
14 needs that would be needed to maintain any system that we
15 adopted, but also the information needs to choose a system
16 to adopt and the fact that today we're not at a point where,
17 in some of the trade-offs that were discussed, that we can
18 say exactly where we are with respect to those trade-offs
19 because we don't have enough information to understand them.
20 And that really needs to be sorted out in terms of making
21 choices.
22 There's a few things that I guess I'd like to

1 underscore. The one that I think is critical is that we
2 start with a payment system that's sound, that the relative
3 fees are in the correct proportions, and that they're for
4 the units of service that make sense. Which leads to an
5 issue of not having the fragmentation we have, but to bundle
6 things that are more appropriately bundled.
7 The critical importance of this is because I think
8 that there is the potential that even with the right targets
9 and the right structure that if the fees are wrong, there's
10 the potential that you can do better as an individual by
11 being a bad apple, by just ignoring what the incentives are
12 for an accountable units, and saying I'm going to go my own
13 way because that's the best way for me. We've seen that
14 today and we could see it again unless we get relative fees
15 right.
16 This goes, I think, to what Jay mentioned in terms
17 of the competitiveness of the situation will produce a
18 dynamic that's positive. I worry about the heterogeneity of
19 markets across this country, that in some of our markets
20 there isn't enough competition and the potential for a
21 larger entity to be a bad actor is very real. We need to
22 think about that so that we can create the structure that

1 minimizes any damages that are associated with that.
2 We also, I think, need to recognize in terms of
3 the information needs and making choices, that we're
4 exploring new territories. When Elliott Fisher was here and
5 discussed the extended hospital staff as the accountable
6 unit, one of the things that came across for me very
7 strongly was the very great differences in the patterns of
8 use between large urban and small urban and rural areas.
9 One can easily say we just need to risk adjust for
10 that. But this is the kind of risk adjustment we haven't
11 been doing in the past because it relates to the scope of
12 services that individuals are receiving from a set of
13 providers, as opposed to just their health status. And
14 that's not something that we've got the risk adjustment
15 models for today, because we haven't been thinking in terms
16 of accountable hospital units up to this point.
17 We also need to start thinking about other factors
18 that might influence service utilization, such as the
19 composition of the patient population. We don't want to
20 create a situation where there is a particular problem for
21 inner-city hospitals versus suburban hospitals because one
22 has got a much more compliant patient population after

1 you've controlled for health status, and one is therefore
2 better than another.
3 The idea of extending this to other providers
4 makes a lot of sense in terms of Medicare having an overall
5 cost problem, not just a physician cost problem. But again,
6 the complexity of that is something that we need to think
7 about because other providers are paid in very different
8 ways. They are not necessarily rewarded in the same ways
9 for volume changes and they don't necessarily control volume
10 in the same way. Physicians are the key determinant in
11 terms of the use of many services. Think about inpatient
12 admissions to hospitals. We pay for the admission in total
13 and we pay an individual hospital on the basis of the
14 national costs.
15 So the question is, if we're trying to bring that
16 hospital into this system and give them incentives to change
17 its behavior in some way, how are we going to do that in
18 terms of the underlying payment that goes to that hospital?
19 Let me stop you. I think those are the things I
20 think that are important that we emphasize in the report.
21 Thank you.
22 MR. MULLER: Consistent with what Jay and Bill

1 have said, one, I want to commend everybody who has worked
2 on this. And also, in terms of their themes.
3 The SGR points out the difficulty of controlling
4 volume by hammering on payment rates. We've seen over a
5 course of years, not just in this discussion and others,
6 that we have a lot of increase in activity and utilization
7 in the Medicare program largely due to increases in
8 technology that advance the health of the population,
9 incentives to providers, and also beneficiary choice.
10 There's a kind of confluence of technology and beneficiary
11 preference and provider incentives coming together to
12 increase utilization quite a bit inside the program.
13 The SGR acknowledges we have this major increase
14 in utilization but says we'll hit the nail with the hammer
15 that we have, which is payment reductions. In some ways, I
16 would like that we say that that's the wrong hammer to hit,
17 because we have to take more direct steps to look at
18 utilization.
19 We'll be discussing tomorrow some modest efforts
20 towards that, in terms of bundling of payments in the
21 inpatient setting and some other changes in the outpatient
22 setting for example, and also looking at some of the bigger

1 cost areas in the inpatient setting such as heart disease,
2 respiratory disease and so forth. I think we should keep
3 moving in that direction towards greater bundling. I think
4 the comments of, again, Jay and Bill have already indicated
5 how difficult it is to make some of these changes by moving
6 the target system and the control system to other providers
7 besides physicians.

8 So I would encourage us to keep focusing on those
9 kind of modest changes that affect utilization. I think we
10 all wish they were more profound ones that we have, but I
11 think the discussion very well illustrates how difficult it
12 is to really change utilization in any kind of profound way,
13 given the very extensive discussion of the administrative
14 complexities of whether one looks at -- especially the most
15 extended discussion we have inside the chapters around
16 geographic variation.

17 Obviously, there's a lot of great attraction,
18 given the work of the colleagues at Dartmouth, to look at
19 geographic variation and have some concern that there's
20 something wrong about it. On the other hand, as to how to
21 fix it becomes, as the chapters indicate, very, very
22 complex.

1 I would, though, take one of the ideas that
2 Elliott Fisher and others have urged us and is contained
3 within these chapters, which is to keep focusing on
4 incentives for more accountable units inside the program. I
5 think there's a considerable consensus inside the Commission
6 that that's a good way to go. It's a long road to get
7 there. And that unfortunately there are many parts of the
8 health care system that can't fall easily into accountable
9 units right now. That doesn't mean that we shouldn't be
10 making efforts to move more fully in that direction.
11 Obviously, organization such as the group
12 practices, such as the one that Jay is in, have an advantage
13 in moving in that direction. I think we should commend them
14 for having that advantage and keep moving in that direction.
15 There are hospitals and medical staffs around the
16 country who could also move in that direction as well,
17 understanding that in some places that's more difficult to
18 secure, that coming together.
19 So my preference is to both summarize this by
20 saying that if we have a utilization problem we should keep
21 looking at the utilization problem and taking the kind of
22 steps we can take as best we can. And we have over the

1 course of recent years, we've looked at certain appropriate
2 standards on utilization, on imaging services for example.
3 So I don't think we have to reference all of them again, but
4 we have taken steps to try to look at utilization controls.
5 And again, tomorrow we'll be talking about further bundling.
6 But I have a very strong preference for saying
7 that if the problem is utilization, don't fix utilization by
8 cutting rates. That's wrong when you get there. In fact,
9 as I think either Kevin or Dana said in some of the
10 introductory comments, there may be this perverse effect
11 that by hammering the payment rates you, in fact, exacerbate
12 the utilization problem. I think there's evidence to that
13 effect.
14 So if, in fact, we're increasing our problem when
15 we're trying to fix it, we should at some point say let's
16 stop going at least in that direction.
17 MR. BERTKO: I, too, would like to commend staff
18 for looking at all the many details in the mandated
19 Congressional portions. And then I'd like to lend support
20 to pathway two, in particular. I'm going to follow up on
21 some of Ralph and others comments here.
22 The real target ought to be combined expenditures

1 and whether its utilization or rates or intensity and new
2 services, that all ought to be combined together, and that
3 we should be, under pathway two, encouraging formation of
4 these accountable care organizations with an emphasis on
5 care coordination.
6 I think, as Ralph said, but I'll be even more
7 explicit, this is a long-term process. This is probably a
8 10-year process, from everything from encouraging the set up
9 of these organizations, and Ron and I were talking about
10 medical education as being a part of it for new physicians.
11 One part of this that I think in pathway two needs
12 to be retained and maybe even emphasized is retention and
13 use of the target of some sort as perhaps a default that
14 says if a group or a physician or an organization does
15 nothing, they stay in something similar to the current SGR
16 or something modified along those lines. And that, in turn,
17 means that if you move into an accountable care organization
18 you have a good chance of making a change and improving the
19 amount that you're paid on this in the appropriate way.
20 The last comment is really to the report itself.
21 You've got a lot to talk about here. And having a greater
22 amount of focus, perhaps on pathway two or pathway one both

1 as defined alternative that Congress and staff could react
2 to would seem to be something that might be useful.
3 DR. WOLTER: Just a few comments. I'm not a fan
4 of continuing the SGR in any fashion. I think any benefit
5 that it has created in terms of highlighting the volume
6 problem or any blunting of reimbursement that it has created
7 has been more than overridden by the problems it's created,
8 and including some of the behaviors that are leading to
9 increased volume in other ways.
10 Another area where I think it has created problems
11 as the whole thinking about pay for performance in the
12 physician sector, which I happen to think is on a very bad
13 track. We're trying to solve reimbursement to physicians by
14 creating measures for every specialty rather than focusing
15 our thinking on pay for performance in those high-cost high-
16 volume disease areas.
17 I think in so many ways the SGR has had
18 detrimental effects. It's created a sense of a punitive
19 approach in one sector where we haven't done this in other
20 sectors.
21 I would not be opposed to something that's fairly
22 painful, which is no updates for hospitals and doctors

1 except for those who move into other accountable paths of
2 care. I think there's ways to think about this a little bit
3 differently. But if there's anything that's had a track
4 record of complete failure, I think the SGR would be near
5 the top of the list. And so I think there's other ways to
6 get at whatever the benefits of that have been, if any.
7 Another thought I've had is in the past when we've
8 seen a problem in a given sector we have said we're not
9 going to increase the update across the board. We're going
10 to try to focus on the problem in a different way. We won't
11 use the overall update as a way to do it.
12 Well, we're doing that in the other way here.
13 We're using a negative update to try to deal with a problem
14 that could be dealt with in a more strategic and focused
15 way. And that's why the recommendations that are more
16 specific around pricing, et cetera, are so important. And I
17 think if we would highlight that we need to aggressively
18 move to these strategic tactics that in the short to
19 moderate term could help us create more value, that would be
20 more useful.
21 I also wanted to mention in the outline, which I
22 thought was very well put together, in five we say improving

1 the value of the Medicare physician payment system. I think
2 we really have moved to a discussion of improving the value
3 of the Medicare payment system. And it might be better to
4 just go ahead and reflect that. Because whatever we put in
5 place in terms of cost control measures, I think there is
6 agreement here it needs to be expanded beyond the physician-
7 only sector.
8 We mentioned in executive summary, I think the
9 issue of self-referral and conflict of interest needs to be
10 added to our list. I know that's a very controversial area.
11 It's very likely to be a driver of volume, at least to some
12 degree.
13 I think when we talk about that there's so much
14 focus on the physician. But in fact I know very well that
15 there are many behaviors and hospital strategies that are
16 volume drivers, and some of those bleed into the physician
17 issues in terms of high dollar recruitments and other
18 strategies to drive volumes on the hospital side. So that
19 whole issue of where the hospital side fits into volume
20 growth probably needs more discussion and more attention.
21 Another thing I think that's important here is in
22 some ways if we could strengthen certain areas of physician

1 reimbursement so that there were appropriate incentives to
2 help us reduce hospitalization, reduce readmission, do
3 better chronic disease management. There are proposals from
4 various groups on medical home or better chronic disease
5 management. It's quite possible that physicians would find
6 involvement in those activities preferable to trying to put
7 a CAT scan or something in their office.
8 So I think, in some ways, we could benefit from
9 investment in certain areas of physician and reimbursement
10 than what we've been doing.
11 Another point I really wanted to emphasize is that
12 as I look at the report, which by the way I agree really is
13 marvelously done. It's going to take a few more iterations,
14 I think, for this to emerge in terms of what might be a good
15 framework. But we're talking about some short to medium
16 term policies that might help us really tackle the problem.
17 But we're also beginning to talk about some long-term
18 framework that's really about the reorganization of the
19 underlying health care delivery system.
20 I think if we can emphasize that that's a long-
21 term goal, because the current state of the hospital medical
22 staff clearly is not set up for what we're talking about.

1 So we have to look at this really as a transformation that's
2 going to be over the next decade or perhaps a little bit
3 longer.
4 We have administrations that change, we have CMS
5 executives that change, we have so many things that change.
6 But I think MedPAC could make a contribution by trying to
7 reiterate over time a somewhat consistent long-term vision
8 for how the infrastructure of health care delivery does have
9 to be transformed so that we can create some accountability
10 differently than what can really be handled in the current
11 fragmented system. And so that's in our report but we might
12 be able to highlight that a little bit differently.
13 I like Jay's comment this morning in the exec
14 session about maybe gainsharing is a little bit of a loaded
15 term because of its history. I was thinking about that. I
16 like the term shared accountability because really we're
17 talking about not just cost savings but quality improvements
18 and delivering greater value. I think shared accountability
19 also fits nicely with some of these long-term strategies
20 around more accountable care units.
21 I think those are my key points.
22 DR. KANE: I'm very enthusiastic about emphasizing

1 the infrastructure. Actually I think it can be done much
2 faster than we're giving the system credit for. If you
3 think about the mid-nineties, when everybody thought
4 capitation was coming and hospitals and providers all got
5 together and formed integrated delivery systems. And then
6 they just stopped because nobody did it. The capitation
7 revolution never came.
8 I noticed this a year-and-a-half ago. Suddenly,
9 we stopped mentioning the notion that we can pay on a
10 capitation basis and we've moved back to how do you balance
11 out fee-for-service with volume? Which everybody pretty
12 much knows is impossible, but capitation does do that.
13 So I guess I would just like to have the word
14 capitation reintroduced to our vocabulary and perhaps start
15 thinking again about what infrastructure enables us to pay
16 on a capitation basis, not necessarily through Medicare
17 Advantage but out there in the more general world out there.
18 I think the intermediate target should be the
19 infrastructure, not the long-term target. The long-term
20 target should be capitation with all kinds of protections
21 against underutilization as well as over-utilization or
22 inappropriate.

1 The same kind of thing that made us backlash
2 against managed care, I think we have to put the protections
3 in on the Medicare side. But we really have to think about
4 an integrated payment unit that has all services under one
5 payment and that the providers, who are frankly the only
6 ones who really know what good care is, and are fully
7 responsible for that.
8 And having Medicare policymakers trying to second-
9 guess what's good care by altering this fee and that
10 payment, it's impossible. So I think at the federal level
11 we should really be thinking about how do we try to get back
12 to a capitation-like environment, how do we encourage the
13 infrastructure that allows people to take full
14 responsibility for a population of care in a geographic
15 area.
16 I realize we're still envisioning fee-for-service
17 or bundled. But let's go all the way and call it what it
18 really is. Because then I think we can think much more
19 constructively about what we need to safeguard the system
20 from. It's not over-utilization there, it's actually
21 underutilization. We need to really take that seriously, as
22 well, and think about how do we -- I mean, gainsharing was

1 actually there as a concern, that when physicians have an
2 incentive to withhold care the beneficiary is at risk. And
3 that's still the case.
4 And bundling does the same problem. So we don't
5 talk much about what happens with underutilization in this
6 whole environment because we're worried about over-
7 utilization. I think we ought to think about really the
8 right thing to do is probably get towards a capitated
9 environment and then how do we create the safeguards and the
10 infrastructure to make it politically palatable and
11 something that both providers and the beneficiaries would
12 buy into.
13 I think the other piece that seems -- well two
14 other pieces, I guess. I guess this is still in my
15 capitation mode. We don't look at the health of the
16 population enough as part of the concern, and that maybe as
17 we think about targets, they're all based on -- we mostly
18 talk about expenditure targets. But can't we break
19 geographic areas down and also look at the health of the
20 Medicare population and have that affect either capitation
21 levels or whatever payment unit we end up with?
22 I feel Jennie speaking in my ear, that we need to

1 have some sort of concern about the health of our
2 beneficiaries out here, and that efforts to measure that and
3 have rewards based on the health of the population in a
4 geographic area could also -- not just expenditure targets
5 and volume. We're really kind of looking at the detail
6 without looking at the overall outcome, which I think could
7 guide us in what would be an appropriate way to set
8 capitation or adjust capitation.
9 And I guess my last point is that the SGR -- and
10 now I hear Arnie talking to me. There's a lot of ghosts in
11 this room.
12 The SGR is really Congress's way of saying how do
13 I make sure that the Medicare program is affordable to the
14 taxpayers? And yes, they are one-third of the people paying
15 this bill. The people paying this bill are actually
16 taxpayers, workers and employees, and beneficiaries.
17 Actually I'm most worried about beneficiaries at some point.
18 Perhaps instead of an SGR based on whether taxpayers can
19 afford it, we should tie it much tighter to whether
20 beneficiaries can afford it.
21 You've got that nice chart about where premiums
22 are going for beneficiaries relative to their Social

1 Security income. Why is the SGR just worried about
2 taxpayers? So in a way I feel like the affordability issues
3 are not fully articulated and they're looking at the one
4 group and there's actually three groups of payers, employers
5 and employees -- who by the way can't even afford their own
6 insurance right now. And then there's the taxpayers, who
7 can afford the most perhaps, although we're in deficit so
8 obviously we're not paying our bill. And then there's the
9 beneficiary.
10 So I don't know, even thinking about what's
11 affordable to me, if you're going to really go into SGR and
12 say it should be there to discipline policymakers. We've
13 taken a pretty one-sided view of what's affordable. So if
14 affordability and putting the discipline of affordability on
15 policymakers is part of this process we need to maintain a
16 discipline, I would throw in the other two parties who are
17 involved here and talk about whether that's affordable to
18 them, too, as a way to keep the discipline on the
19 policymakers.
20 So I don't know, it's a lot of different thoughts.
21 But it's just a little bit different twist on the way we've
22 presented it here. I just think we've presented it as

1 probably the most complex and hardest way to visualize
2 what's going happen, by going at payment, volume, episodes,
3 down to the nitty-gritty. I think we need a broader view at
4 this level that's much more feasible to envision.
5 But I did like the report and I thought it
6 addressed Congressional requests very well.
7 DR. HOLTZ-EAKIN: At the risk of letting the staff
8 get too full of themselves, I guess I have to also
9 compliment to on the -- nah, I'm not going to do it then.
10 No, this is a wonderful report in that it
11 highlights to the Congress just how difficult a question
12 they've asked an answered to. It really is hard. And
13 living through this report is getting a crash course in the
14 Medicare system for sure, but American medicine as well.
15 I just want to say that, in the final version I
16 want to also put in a plug for pushing the second path and
17 say a little bit about how this ties in with some other
18 things we've been concerned about.
19 The first is the sustainability. SGR's first
20 letter is sustainable growth rate mechanism. We know that
21 that's not true because the current system and the current
22 medical system is not on a sustainable trajectory. And to

1 repeat the things that are easy to forget, if we simply
2 repeat the history and go forward as things currently stand,
3 this program will grow to more than half the size of the
4 current government or the current size of the federal
5 government over the next five decades. It is something that
6 is truly beyond belief.
7 And at the same, if we don't change this system,
8 we will sit around this table, or our successors will, and
9 be unhappy with the affordability of the care to
10 beneficiaries, their access to care in some dimensions, and
11 the quality of care that they get. So that it is incumbent
12 upon everybody involved to change the nature of the Medicare
13 system and the health system that's underneath it.
14 That's an observation that I think just can't be
15 lost.
16 As part of that, the report contains, and the
17 discussions of this group have illuminated, an enormous
18 number of ways that we could do business better. The
19 current system provides just ample examples of bad
20 incentives for bad apples and inadvertent or deliberate
21 overuse of particular therapies and pieces of modern
22 medicine. So it is important to move down the path that

1 involves higher quality care, coordination of care,
2 understanding what we're getting out and not just paying for
3 what we put in and how often we do it. All of that is
4 essential.
5 However, in the absence of a demonstrated way to
6 do that and a demonstrated success in doing that and
7 bringing the cost trajectory under control, I think it is
8 essential to retain an expenditure target in the system.
9 And I say that knowing that the current expenditure target
10 has produced all sorts of problems. Certainly it has
11 produced some perverse incentives at the provider level, in
12 part because it's too narrow.
13 So the second part of that path that I want to
14 essentially endorse is a broader expenditure target
15 mechanism that brings in, in particular, the hospitals. I
16 think you've got to get the hospitals and the doctors
17 together on this. Those are some of the low hanging fruit
18 for getting costs and quality to line up the way we want.
19 It is however, I think, important to recognize
20 that a lot of the problems that are attributed to the SGR
21 are not the SGR's fault. I want to talk for a moment about
22 the language used in the draft report and make sure we're

1 careful in how we talk about concepts like baseline budget
2 scoring, as if those are exercises in fantasy accounting
3 that aren't real.
4 In fact, if the Congress were to waive the SGR, we
5 would spend more. That's not fantasy. And beneficiaries
6 would pay more and taxpayers would pay more and outlays in
7 the federal government would go up. Waiving that is not
8 something that somehow waives a fantasy accounting. It's
9 embracing a cost that the Congress has been regularly
10 avoiding the bill.
11 That's all there is to it. This is not an SGR
12 problem. This is a Congressional behavior problem. So one
13 of the things that I think is valuable about the expenditure
14 targets and why any new system should both retain an
15 expenditure target as an affordability gauge but also as a
16 discipline on the policy process so that when we create
17 dynamics of competition at local levels, something we all
18 believe is an imperative in a transformed system, there is
19 not an out. And that out is go to the Congress, relieve
20 yourself of the burden of competing with people who are
21 doing a good job, and get your money anyway. That can't be
22 cheap, it can't be easy and must be transparent when that's

1 going on. I think expenditure targets help to take care of
2 that. I think that's one reason why path B is, in fact, the
3 way to go.
4 DR. CASTELLANOS: Like the rest of the
5 commissioners, I really congratulate the staff. I think
6 they've done an excellent job on this, as usual.
7 I think under the two pathways, I think there's a
8 lot of similarities in the pathways. I think the biggest
9 dissimilarity is the SGR or the expenditure target. I have
10 a very difficult time accepting to continue a problem that
11 hasn't worked. As we all agreed, and Doug as you said, it
12 perpetuates ugly behavior.
13 I'm going to step away and think about something a
14 little different. One of the things that we said under both
15 targets was to develop and adapt a new approach for
16 improving value. I think we all agree we need to change the
17 system. We need to have a more improved valued system.
18 Glenn, you mentioned that one of the things we
19 need to think about doing is changing the behavior of the
20 provider. One of the ways to do it is to change the payment
21 policy.
22 What you're really trying to do here is to change

1 the practitioners' pattern of practicing medicine. That's
2 what you're really doing. You're changing how I, as a
3 practitioner, practice medicine.
4 I will tell you, because I talk to a world's
5 expert every day, my wife will tell you that it's going to
6 be very difficult to retrain me. But it's possible.
7 One of the things that, after looking at this
8 report and the different spin I'd like to put on it, it's
9 about a 200-plus page report. There was one paragraph with
10 three sentences that talked about education, and they talked
11 about continued education. I know it's expensive to do it
12 but we have a beautiful opportunity and perhaps making some
13 recommendations to Congress to implant that. And Nancy, in
14 the past you've talked about education, too.
15 We have this medical student who in the next 10
16 years is going to be the basis for our medical community.
17 And if we start not at the doctor level where I am, and
18 working down, but if we start at the medical school level
19 and start a course of medical education for cost efficiency,
20 evidence-based medicine, coordination of care, if we can
21 train a new generation of physician faculty where these
22 medical students have the model to identify with, the

1 person, their mentor. And if we can expand that into the
2 residency program a lot of these problems of education and
3 changing behavior will be automatic.
4 It's sort of like the computers. To teach me how
5 to do a computer is going to be difficult, but my grandkid
6 does it. And he does a good job by teaching me how to do
7 it. And I think the same philosophy can be said here.
8 I'm a little embarrassed to say that I see nothing
9 in this report about education. I would strongly emphasize
10 that we, as a Commission, make some recommendation on an
11 educational basis starting at the medical school level.
12 MS. BEHROOZI: Yes, just to add my comment, thank
13 you Glenn, for helping us to distill all the various
14 thoughts of the commissioners into these two paths. And
15 thanks to the staff for pulling all of those things that
16 we've been talking about, all of which was new to me a few
17 months ago, but to see it all put together in one place with
18 an outline and everything, it's really very helpful. It's
19 really great.
20 Just two comments. It does seem like there's a
21 reason to retain targets because just the pricing obviously
22 doesn't work on its own. The responses to the pricing have

1 the opposite of the intended effect sometimes, as you lay
2 out in the report. So it does seem that targets are
3 necessary.
4 But to have one overall target that has such
5 draconian effects, part of which is because of the
6 cumulative nature, I think while it's true, Doug, then
7 people have to kind of go with hat in hand and say so maybe
8 you want to take care of me even though I'm not doing so
9 well.
10 On the other hand, when the punishment seems so
11 severe then I think it elicits a response that is not
12 necessarily tailored to the best policy judgments but rather
13 to how big a whack, how blunt the instrument seems to be, as
14 people have said.
15 So I do think that in crafting the target it's
16 important to look at some of these different areas that
17 Congress has asked us to look at or the staff has brought up
18 to try to tailor better the targets to the goals and then
19 not create such an incentive for a general override. The
20 fairer the system the more likely it is to be upheld.
21 In terms of some of those choices, those policy
22 choices, the staff has identified in the report some areas

1 where there might be political backlash or thresholds of
2 acceptability, or whatever that might be, kind of high like
3 with respect to the type of service notion that it could put
4 policymakers in the position of determining what represents
5 good care. And Nancy thought that wasn't such a great idea.
6 But the other hand, at the very beginning you
7 identify some of the key issues, encouraging the optimal mix
8 of services. Even when we're talking about quality and
9 talking about -- throughout the report there are other
10 places we talk about things like cost-effectiveness. We
11 might not all agree on those, but I would suggest that it is
12 actually a function of policymakers to decide what is good
13 quality, what's an optimal mix of care, and to some extent
14 then what is good care. And so that might not be low-
15 hanging fruit in terms of what you'll get policymakers to
16 agree on or get the public or providers to all accept all at
17 once. But that doesn't mean we shouldn't try.
18 Nick referred to the longer-term contribution of
19 MedPAC to the policy debate, and I think we shouldn't back
20 off of pointing out that if Medicare is going to be a
21 purchaser of services really -- I mean the way it's worked,
22 particularly in fee-for-service is just to be the back-end

1 payer and let providers and beneficiaries choose the
2 services.
3 But really if you look at the Medicare program as
4 a purchaser of services I think that we need to start
5 thinking more like the government when it purchases other
6 services, when it uses procurement rules and things like
7 that, what's the best value. I think a lot of the comments
8 from different perspectives and in different ways move us
9 towards thinking about value, which means we have to start
10 getting Congress and the public ready to recognize that yes,
11 there might be some decision making at some level by some
12 authorities about what is good care, what is quality care,
13 what's worth paying for, and what's worth paying more for,
14 what's worth paying less for it.
15 It's the kind of thing that obviously there's been
16 backlash against it in the managed care setting. But I deal
17 with it every day in my day job, trying to get buy-in from
18 our population of beneficiaries. When we tell them look,
19 there's just not enough money to pay for everything in
20 unrestricted amounts, so we are going to take into account
21 your concerns, the professionals' concerns, your providers'
22 concerns. But in the end we can only pay for a limited

1 amount of things and so we're going to try to make the best
2 choices with your constant input.
3 I think that means that we also have to recognize
4 that when we talk about looking at value or at what
5 represents good care, we constantly have to include Jennie's
6 voice and say that there must be beneficiary input and
7 review and responsiveness to the interests of beneficiaries
8 all along the way in making those judgments.
9 DR. HOLTZ-EAKIN: I just wanted to react to
10 something you said and also what Nick said, and one last
11 piece on how I think this second path should play out.
12 Nick described the current SGR as a complete
13 failure. I think that's too strong. If you take an
14 expenditure target at face value, its goal is to constrain
15 expenditures. And the SGR has done that. We have less
16 spending than we would have in the absence of that
17 mechanism. I don't believe that you can make a compelling
18 scientific argument to the contrary. So it's done part of
19 what it was supposed to do, which is control spending.
20 We're not happy with some of the other things it's
21 done. I'm willing to agree with you on all of those. But
22 it has done part of what it was supposed to do. That's

1 point number one.

2 Point number two is I think it's important to
3 recognize that the minus 5 percent updates and all the
4 things that are in the formula are not actually where I
5 think the appropriate attention should be. The appropriate
6 attention is on what the Congress has done in deciding
7 affordability on an annual basis. The way this is working
8 at the moment is that Congress every year says okay, what
9 can we afford?

10 That's not an unreasonable thing to ask of our
11 Congress regarding a major program like this. I actually
12 don't think that's wrong. And that's why I think an
13 expenditure target is an appropriate thing to include in
14 path number two.

15 We just want to have an expenditure target that
16 works better toward controlling expenditures, so it should
17 be broader. And that doesn't mean it's a substitute for the
18 other things that we need in the program. It's a complement
19 to the appropriate pricing and the whole plethora of things
20 we've discussed about getting the quality and cost of care
21 to line up right.

22 And so I don't want somehow the experience with

1 the current SGR to somehow damage the notion that it is
2 sensible, in the absence of demonstrated success on low-cost
3 high-quality care, to in a sense have an affordability
4 check. And that's what an expenditure target gives you.
5 DR. WOLTER: I haven't had so much fun with
6 point/counterpoint for awhile, Doug.
7 DR. HOLTZ-EAKIN: I'm not done.
8 [Laughter.]
9 DR. WOLTER: I'm sure you're not.
10 But I do think you could make a very logical
11 argument that, in fact, the current baseline budget is a
12 fantasy budget. I believe that there are a lot of things
13 about it that are so unrealistic, and that we haven't held
14 ourselves to, that any person used to doing their own
15 monthly budget would look at this and say this is a pretty
16 unrealistic situation. I think even some of the reports
17 we've recently reviewed would say that.
18 I also think you could make a fairly logical
19 argument that one of the effects of the SGR has been
20 behaviors that have actually increased expenditures in the
21 Medicare program. Not within the update to physicians, but
22 within many the physician/hospital joint ventures, the

1 movement to physician ownership so they can get technical
2 fee. And I think that it's quite possible that if we could
3 do an analysis of that, we would find that we've driven
4 costs up because of behaviors in response to the SGR. That
5 would be at least a reasonable premise to explore.
6 DR. REISCHAUER: So Doug, a tag team here. We
7 have the same DNA structure that we're reflecting.
8 I don't think Doug is saying that the baseline
9 budget, assuming an effective SGR, is realistic. It's not.
10 But the question is where is the expenditure vis-à-vis a
11 situation in which there were no SGR at all and we were
12 giving MEI updates each year.
13 What he and I are saying, and I said before is, it
14 would be somewhat below.
15 Nor are we saying that there aren't areas in which
16 the incentives, the perverse incentives in the SGR haven't
17 caused a net increase in that component. But overall there
18 is some dampening effect, not as great as the Congress
19 intended but some dampening effect. And that's worth
20 something.
21 DR. WOLTER: Could I just respond quickly?
22 There's been a dampening effect within the sector

1 to which SGR has been applied, possibly overruled by the
2 fuels that have been created in other sectors. I think that
3 needs to be recognized. I don't think it has been
4 recognized.
5 I think that the inability to move beyond the SGR
6 discussion to true tactics that might help us get control of
7 this situation is an issue. It's definitely an issue.
8 Here's where I think there's common ground on
9 this. We need a pressure point. The question is what's the
10 best pressure point? Is it a formulaic approach that
11 applies to only one sector? I would agree with Doug, that
12 doesn't work. If we need a pressure point, it should go
13 across the program.
14 But is it to use this current baseline or is it to
15 be realistic and say where we are, we're going to do
16 something fairly disciplined about how we look at updates.
17 Maybe it's zero percent for a while until we get some of
18 these new behaviors in place while we introduce these other
19 tactics.
20 I just would like us to get to a realistic set of
21 strategies that can help us deal with the issue.
22 MR. HACKBARTH: I would like to jump in here for a

1 second on behalf of Arnie and Karen, neither of whom is here
2 for reasons beyond their control. I had promised each that
3 I would try to offer some comments on their behalf. I think
4 Arnie would have his hand up at this very moment, wanting to
5 leap in.

6 Arnie would strongly support the view that we need
7 to maintain some form of expenditure target. Indeed, he
8 would take the added step of opposing any forgiveness of the
9 existing debt, believing that we need a very strong tool to
10 encourage providers to change behavior.

11 His notion of how that would work is that if you
12 want to get out from under this threat of not just constant
13 fees but declining fees, you need to reorganize yourselves
14 and create a variety of different paths for doing that.
15 Whether it's an accountable care organization that's built
16 around a group practice or integrated system, or something
17 that's more suitable for physicians in solo or small group
18 practice, he wants the threat of cuts in fees to be there as
19 an inducement for shaking up the way care is delivered in
20 the U.S. not just for Medicare beneficiaries but in general.

21 He would strongly agree with Nancy's points about
22 concern about the impact of all of this on Medicare

1 beneficiaries. He, too, believes that that gets too little
2 emphasis. Taxpayers are important but what concerns him
3 equally, if not more so, is what's happening to the ability
4 of Medicare beneficiaries and other workers to afford health
5 care. We are rapidly, in his view, making health care
6 unaffordable to Medicare beneficiaries and workers who are
7 not at the upper end of the pay scale. And that is a matter
8 of great urgency, in his view.
9 Given all that, his biggest reservation about path
10 two as described in the draft report is it's not nearly fast
11 enough. The time line, from his perspective, is glacial in
12 its pace. And he thinks that we need to be much faster,
13 much more demanding, and ought to be working hard to get
14 Medicare caught up, in his perspective, with tools that have
15 been in place in the private sector and shown to be working
16 there.
17 Finally, Arnie would also agree with Ron's
18 comments about medical education. All of you will recognize
19 this as a theme of his, that one of the things that we need
20 to be doing is changing the pipeline both of terms of the
21 type of physicians we're producing. An example he's often
22 cited there is way too few geriatricians. But also not

1 educating the broader class of physicians in the skills that
2 they'll need to practice successfully in the 21st century.
3 And so that is a matter of concern to him, as well.
4 Let me then turn to Karen's comments on SGR. She
5 strongly believes that the current SGR is so flawed that it
6 should be abandoned and she would like to see that flavor
7 come through more strongly and repeat some of the things
8 that MedPAC has said in the past about that.
9 She said if we choose to offer a path with some
10 other form of expenditure target, for heavens sakes let's
11 call it something else other than SGR. I think there she
12 agrees with Jay that sometimes these terms have such bad
13 historical connotations that the terms ought to be
14 abandoned.
15 She said let's explain very clearly why this new
16 alternative would be better than the old SGR and not subject
17 to the same flaws.
18 In the same vein, she's concerned about the use of
19 the term outlier as one of the mandated options. She
20 understands why people are inclined to use that term but she
21 thinks it's a very loaded term and one that almost condemns
22 the idea.

1 You know, from Karen's previous comments, that she
2 thinks it's very important to provide physicians with
3 information about how their practice patterns compare to
4 their peers. And so she doesn't want to see the idea
5 condemned with a bad label. She suggests that we not call
6 it outliers but something like clinical resource
7 consumption, clinical resource measurement and the like.
8 So those are some comments from Karen and Arnie.
9 Before we go on to other comments, let me just
10 address one other thing that may be on the minds of the
11 audience, if not of Commissioners, and that is why not a
12 vote on what to do with SGR.
13 Instead of a vote, as we've discussed repeatedly
14 now, we are saying here are a couple of alternative paths
15 that the Congress might pursue. I've thought long and hard
16 about whether it would be appropriate to do a vote, and Ron
17 raised this question earlier today. That would allow
18 observers, including the Congress, to see exactly how we're
19 divided. I think it's evident to everybody in the world
20 that we are not of one mind on this topic.
21 So yes, a vote would accomplish that. But I think
22 that that advantage would be overridden by the disadvantage

1 that a lot of these ideas are still too abstract for us to
2 fully understand what it is we're voting for or against. I
3 think that to the extent that MedPAC is valuable to the
4 Congress, it's because we tend to be pretty careful about
5 things like that. We don't just abstractly recommend
6 things, for the most part. We try to be more disciplined
7 than that and have a pretty concrete idea what we're talking
8 about, what its pros and cons are, so we can speak to those.
9 Here, due to the time constraints that we've had,
10 we are far short of that point, to be able to say with
11 confidence we know exactly how path two would work and we
12 can assure Congress that the advantages will outweigh the
13 disadvantages. I don't think a serious person can make that
14 assessment at this point. So my judgment is the best thing
15 to do is to say here are paths that might be pursued and
16 developed further.
17 Now we can go back to other comments.
18 DR. CROSSON: I'll reiterate a little bit and
19 point out that I think in the end the work and the effort
20 that we devote to the target or the not target probably
21 should be about 10 percent of the effort. And the effort
22 that gets devoted to creating the dynamic or the set of

1 dynamics that will lead to appropriate utilization and
2 quality is where the effort ought to be.
3 I think whether you want to call it a target or a
4 baseline, talking about updates, there has to be some
5 starting point. That starting point could very well be
6 input costs, or it could very well be the perspective of the
7 Congress as to what is affordable. And that, in any
8 particular moment, might not be input costs.
9 But then what really does matter is what you do
10 about creating incentives and who those are for and how
11 they're organized and how they're gaited and the like. And
12 I think if I were involved in trying to take this report at
13 some point and begin to build it into something that could
14 work, that's where I'd spend 90 percent of my energy because
15 I think that's where the gain really is. If the SGR has
16 saved money over time, it probably has because if there had
17 been no target of that nature there probably would have been
18 more spending than there was.
19 But yet this type of target in itself doesn't
20 solve the problem. So I just think it's just a question of
21 where the mental energy and the design energy out to be
22 devoted. And it's not really to a finer and finer

1 discussion of what the baseline or target ought to be.

2 I don't agree though, having said that, with
3 Arnie's putative idea that keeping in place the current SGR
4 pit of minus 35 percent or minus 95 percent or whatever it
5 works out to be is either necessary nor effective. I think
6 it, in fact, is generally widely believed is unbelievable or
7 unmanageable or unworkable and therefore can be dismissed by
8 people.

9 Whereas a system of slow inexorable competition
10 with 2, 3, 4, 5 percent differentials year-to-year figure is
11 very believable because it would be experienced at the local
12 level and it would, in fact, create the dynamics that we're
13 interested in.

14 I also believe what Nancy said, which is although
15 I am in no way underestimating the complexity of this, I
16 think were this type of dynamic to be created, as we saw in
17 the early 1990s, things would get moving a little faster
18 than what people might think.

19 Now having said that, a lot of these efforts were
20 clumsy and didn't work. But some did. It was abandoned
21 relatively quickly before I think there was an opportunity
22 for learning to take place.

1 So I really don't believe that this is 10-plus
2 years. I think it could occur a good deal more quickly.
3 DR. REISCHAUER: A comment on Arnie's hair shirt
4 approach and then on Jay's comments.
5 With respect to Arnie's view that in the long run
6 the desirable course of action should not forgive the sector
7 for its "overspending" in the past. I think we'd have to
8 sit down and ask whether a premiere accountable health care
9 organization, one that coordinates care and mixes and
10 matches inputs and resources in a way that isn't bound by
11 traditional roles such as the one Jay works for, could live
12 and provide high-quality care to Medicare beneficiaries for
13 -- I think the number is 23 percent less than what they're
14 getting now.
15 I don't know the answer but Jay maybe does.
16 [Laughter.]
17 DR. CROSSON: You're mixing up policy issues.
18 DR. REISCHAUER: I kind of suspect that the answer
19 to that is no because of the way things have evolved over
20 the last 10 years have hanged the practice of medicine even
21 within your organization.
22 So the question we're really left with, it strikes

1 me, do we think the incentives in pathway two are sufficient
2 so that within 10 years or so we will get a change in the
3 delivery system and the emergence of some kind of
4 accountable entities for which capitation, pseudo-
5 capitation, whatever, can be applied.
6 I guess I'm very skeptical about that, and I
7 wouldn't look back to the earlier period unless you knew
8 some way of enlisting the active participation of the non-
9 Medicare world in this effort. It was the non-Medicare
10 world that brought this about, the employer world, in the
11 early 90's. You'd have to have both Medicare and that group
12 on board for a change like this, I think, to bring about.
13 And I think there would have to be more active
14 incentives and models for the creation of these entities
15 rather than just we're going to jigger around with some of
16 this stuff and the actors out there will do it on their own.
17 I don't believe they will. I think they will resist, which
18 is another approach when policy doesn't go in your
19 direction.
20 MR. HACKBARTH: Can I just pick up on this on
21 Arnie's behalf? In fact, let me just issue a general
22 apology.

1 DR. REISCHAUER: Maybe I won't come. My views
2 will be better expressed and more frequently if I wasn't
3 here.
4 [Laughter.]
5 MR. HACKBARTH: Let me start with a blanket
6 apology to everybody whose views I am presenting. I'm not a
7 worthy advocate.
8 [Laughter.]
9 MR. HACKBARTH: Having said that, I know, based on
10 my conversations with Arnie, that there are a couple of
11 points that he would want to make. One is about the urgency
12 of system reform. And he would absolutely agree with what
13 you said, Bob, about the need to better coordinate and
14 synchronize the efforts of the public and private sectors on
15 this. That if either public or private acts alone, the
16 effectiveness is going to be greatly diminished. He thinks
17 much more attention needs to be done and provided to that
18 synchronization.
19 The second thing that I think that Arnie might
20 mention with regard to what's achievable is that I think he
21 believes that people haven't really thought seriously about
22 what might be achievable. One of the reasons that he pushed

1 hard for us to have the panel on reengineering health care
2 delivery, including the CEO from Virginia Mason, is he fears
3 that there are way too few health care providers who are
4 thinking about this in the right way, which is let's go back
5 to square one in how we design these systems to improve
6 efficiency. We need to take them apart. Just as so many
7 other American businesses have been taken apart to deal with
8 global competition. And that health care has been way too
9 complacent. We have asked way too little of health care
10 providers. And that is because it's a lot easier for them
11 to lobby and get higher payment.
12 So he thinks that the amount of pressure needs to
13 increase dramatically to force a fundamental rethinking of
14 how services are delivered. I think all of you will
15 recognize Arnie's voice in that statement.
16 Now we are down to our last five or 10 minutes.
17 MR. MULLER: I think the negative updates just
18 have such a pernicious effect on behavior. While I think we
19 all understand, based on the studies from Joe Newhouse on,
20 that technology is the biggest driver of expenditure
21 increases. I think when you look at some of the themes that
22 we've looked at the last years, the growth of imaging, the

1 growth of specialty hospitals, the growth of ambulatory
2 surgery centers, of diagnostic centers, of LTCHs, the growth
3 in outpatient.

4 I think part of the behavior you see on the part
5 of physicians when they keep seeing negative updates being
6 held out there is they start looking, as Nick and others
7 have said, for other ways in which to maintain and have
8 access to income.

9 So while I should be hesitate to debate with two
10 former directors of the CBO forecasts of expenditures, I
11 just think that there's at least pretty plausible evidence
12 that the physician behavior that is in part incentivized by
13 the five, six, seven years of forecasting negative updates.
14 So even though, as we say, each year somehow the Congress
15 takes the step that Doug has described, I think it has this
16 pernicious effect on the whole system. And in my mind
17 therefore it is a plausible argument that it is driving up
18 expenditures.

19 Again, I think technology is the biggest driver of
20 that, so I don't want to then put the cause on this. But I
21 think it does have the effect of causing them to enter into
22 arrangements that the fee-for-service system tends to reward

1 and therefore incentivize that really drive up the cost to
2 the system.
3 Now there are other parts of our provider economy
4 where we give updates of 1, 2, 3, 4 percent. I'm not
5 suggesting that when you give updates of 1, 2 or 3 percent
6 it somehow mitigates utilization increases. But I do think,
7 given the central role of the physician in driving health
8 care expenditures, there is just too may opportunities the
9 last four or five years, exacerbated by capitalists coming
10 in from the equity markets and private equity and so forth,
11 to get into these businesses where they get a share of the
12 facility fee. And I think we are just deluding ourselves by
13 not noticing that the incentives have very much moved in
14 that direction in the last four or five years. I say, we
15 have seven or eight sectors that we have discussed at length
16 in the last three or four years where I think the behavior
17 is going on.
18 So I would argue that the ongoing prospect of
19 negative updates foster that kind of behavior. Not the
20 biggest cause of it, but foster that kind of behavior. And
21 I would argue therefore drive up the expenditures more than
22 they otherwise would.

1 So I do think that our expenditures -- you know,
2 it's hard to prove something in the absence of it happening.
3 I think it has, in fact, driven up expenditures more than it
4 would have been in a world where we had -- if we had the MEI
5 recommendations that MedPAC has been behind at least four or
6 five years, I think that might have mitigated some of that.
7 MR. HOLTZ-EAKIN: Briefly just one more time
8 around on this. The only difference between Arnie and I is
9 he's nicer than me.
10 I understand why he doesn't want to waive this
11 cumulative debt. The reason is if you just waive it, you
12 make it free to Congress. And remember, Congress created
13 this. This is not something that came out the SGR. This
14 sis something that came out of Congress. Each time they
15 gave more than the SGR would permit, they weren't honest
16 about the fact that they had done it and pretended that they
17 were going to take it back.
18 So this is something they did. And to waive it
19 and make it free to them is, I think, not desirable because
20 it's not going to be free to everyone else.
21 The money will actually get spent then, if you
22 waive this, and beneficiaries are going to be on the hook

1 for it. If you just get rid of the SGR and forget the
2 overhang, you're talking about $1,000 for every Medicare
3 beneficiary. They're going to really pay that. And I don't
4 think that Congress should do that casually or lightly.
5 It's producing pernicious incentives. Agreed.
6 But the Congress should recognize that it's worth it to put
7 it on the books and pay this bill to get rid of bad
8 incentives.
9 And the last piece on Arnie's incentives, if you
10 can then find an alternative mechanism, one that comes
11 faster, pushes harder, reengineers more quickly, and gets
12 the 25 percent reduction the SGR would have, you net zero
13 anyway. And he wants that incentive.
14 MS. BURKE: This was not my point, but at the end
15 of the day Congress isn't paying a thing. At the end of the
16 day, it's essentially the taxpayer and the beneficiary and
17 everybody else who's paying it. I think the reality is
18 they're going to have to contend with it from a bunch of
19 perspective one way or another. Either it's through the
20 Medicare program or through some other mechanism.
21 So at the end of the day yes, Congress has chosen
22 to do it. At the end of the day, we're not punishing

1 Congress. We're ultimately having to make a decision as to
2 what makes sense over the long term.
3 I think it does create pernicious incentives and I
4 think it has been a failure in a variety of ways. It
5 achieved maybe some dampening effect. But I would agree
6 with Nick, I think at the end of the day it's been a
7 failure.
8 But I wanted to go back to the point that you made
9 at the beginning, Glenn, and then the point that Bob
10 continued on. I think you are wise not to take this to a
11 vote. And I think for the reasons that you, in fact, state
12 which is there is not, I don't think at the moment, the
13 detail available to us to really understand how one might go
14 down one path of the other. I think there are the seeds of
15 a number of alternatives and options that we might consider.
16 Having been on the receiving end of these kind of
17 reports for 20 years, I think the upside is I think the
18 staff have done an extraordinary job of helping to
19 articulate what the pros and cons are of each of these
20 individual pieces, notwithstanding the fact that we really
21 don't know how fully they would understand. In fact, if I
22 were asked to vote, I don't where I would go because I

1 fundamentally am opposed to the SGR. I don't know that I
2 would agree necessarily with all the pieces of path two.
3 To Bob's point, I think there is a great deal of
4 complexity, as has been identified, as to how one might do
5 any one of these things. I do think that, if anything, the
6 end result of this ought to put some pressure on the
7 industry to begin to understand how does one retool. This
8 might be one area where I might, in fact, agree with Arnie,
9 which is not often. But I do think there is pressure that
10 has to be borne by the industry to understand how to begin
11 to retool.
12 But I am concerned that even in pulling together
13 all of these options, which I think again the staff did a
14 great job at doing, I think further understanding -- I mean,
15 the instinct will be like a menu, let's take that one and
16 that one and that one. I think there ought to be a
17 cautionary note throughout this, which I believe there is
18 certainly the foundation for, of the complexity of every one
19 of these options.
20 The geographic cap, for example. The specialty
21 cap, for example. How one might create groupings. In rural
22 areas in particular, this will be enormously complicated.

1 Among certain specialties who don't tend to refer to
2 hospitals and tend not to do a lot of hospital-based care,
3 enormous complexity.
4 I think if there was anything that, in fact, the
5 staff as we can continue to refine this and send it to the
6 Hill, it is to underscore that complexity, that we really
7 don't understand how it will play out. But there really
8 does need to be a fundamental rethinking of how we organize
9 care and how we create these incentives. And the faster we
10 can do that the better we will be.
11 But again, I think your point that we really don't
12 yet know enough, I think there's work to be done. I think
13 the question of how we can help CMS and invest in CMS to
14 give them the tools to begin to help us understand how one
15 might go about doing this, the data upon which these
16 decisions will be based will be critical so they are viewed
17 as fair by providers, I think will be very important.
18 But again, I think underscoring that complexity,
19 understanding the need for change, understanding the need
20 for investment now in CMS to begin to gather those tools
21 together, I think would be the one message if nothing else.
22 I mean, we can't choose among these. We don't really know

1 enough to do it.

2 But clearly, the SGR is the wrong direction. But
3 some kind of pressure that helps us force that kind of
4 decision making, I think, makes a great deal of sense.

5 MR. HACKBARTH: Okay, thank you.

6 I appreciate all the work that you've done, Kevin
7 and Dana, on this.

8 Next up on the agenda is the update for hospitals,
9 and we're doing an audience rotation here with the physician
10 people moving out and the hospital people moving in. So
11 we'll just take a minute to let them get settled before we
12 start up.

13 Okay, we're on to hospital updates. Jack.

14 MR. ASHBY: Good morning. We would like to begin
15 this morning by returning to the issue of DSH payments and
16 uncompensated care, and we will bring back the draft
17 recommendation on uncompensated care data that we discussed
18 at the November meeting.

19 Then we're going to briefly review our findings on
20 IME payments and on overall payment adequacy. Both of these
21 were discussed at the December meeting. And we will finish
22 up with draft recommendations on IME payments and on updates

1 for inpatient and outpatient payments.

2 Once again, I'd like to take just a moment to
3 acknowledge the input of several staff members whose help
4 was integral in preparing our chapter. That would be Tim
5 Greene, Dan Zabinski, Julian Pettengill, Jeff Stensland,
6 David Glass, and Anne Mutti.

7 Turning to our first topic, the DSH adjustment,
8 and beginning with a little bit of review. DSH spending is
9 $7.7 billion and about three-quarters of all PPS hospitals
10 get a DSH adjustment. Our analysis estimated that there
11 were about three-quarters of all DSH payments, or $5.5
12 billion, represent a subsidy because this portion of the
13 payment is above the empirical level of measured impact of
14 low-income patient care on Medicare costs.

15 And finally, our analysis found little if any
16 evidence of a relationship between hospitals' uncompensated
17 care share and the size of their DSH add-on or their IME
18 add-on.

19 As an alternative to the DSH adjustment, we talked
20 at the November meeting about options for a federal payment
21 to protect access to care by offsetting a portion of
22 hospitals' uncompensated care costs. The payment could be

1 organized outside of Medicare and financed through a broad-
2 based revenue source such as general revenues or a dedicated
3 provider tax, or it could be designed as a Medicare payment
4 mechanism, in which case the funding would come from the
5 current DSH payments.

6 Regardless of which of these approaches is taken,
7 we established the principle that the payments should be
8 distributed on the basis of each hospital's total
9 uncompensated care costs, which means that it would not be a
10 per case payment.

11 An uncompensated care payment, of course, requires
12 accurate data on hospitals' uncompensated care costs.
13 Congress directed CMS to begin collecting uncompensated care
14 data from all PPS hospitals and a form for this purpose was
15 added to the Medicare cost report in 2003. But there have
16 been numerous problems with this data collection effort.
17 Some of the specific improvements that we think are
18 necessary are detailed in the chapter and I won't spend our
19 presentation time to go into that detail again.

20 This leads up to our first draft recommendation,
21 which is that the Secretary should improve the form and
22 accompanying instructions for collecting data on

1 uncompensated care in the Medicare cost report and require
2 hospitals to report using the revised form as soon as
3 possible.
4 This recommendation would have no impact on
5 spending and would cause a small increase in hospitals' data
6 collection burden.
7 We'll hold this draft recommendation for the end
8 and go on now to IME.
9 MR. LISK: Moving on to review the findings on the
10 IME adjustment, we founded that in 2004 Medicare spent about
11 $5.5 billion on the IME adjustment, roughly 6 percent of
12 Medicare PPS payments. The IME adjustment is set so that in
13 fiscal year 2008 per case payments increased about 5.5
14 percent for each 10 percent increment in teaching intensity.
15 30 percent of hospitals receive IME payments and the
16 payments are largely concentrated in urban hospitals and
17 teaching hospitals with larger residency training programs.
18 Our analysis of costs in teaching hospitals found
19 that per case costs increased about 2.2 percent for each 10
20 percent increment in teaching intensity, compared to the
21 payment, which is 5.5 percent. Thus, the current payment
22 provides a sizable subsidy to teaching hospitals, $3 billion

1 more than is empirically justified. That is, these payments
2 more than exceed the higher patient care costs associated
3 with training residents.
4 We also found that teaching hospitals would
5 benefit from severity of adjustment system.
6 The IME adjustment contributes to wide disparities
7 in financial performance between teaching and non-teaching
8 hospitals. As you can see in the overhead, there's a 12
9 percent difference in the overall Medicare margins between
10 teaching and non-teaching hospitals. This difference would
11 narrow to 10 percentage points if the IME adjustment were
12 reduced by 1 percentage point to 4.5 percent. It would
13 narrow further to 5.5 percentage points if the IME
14 adjustment were reduced to the empirical level. The current
15 DSH adjustment contributes only a small amount to this
16 disparity in financial performance between teaching and non-
17 teaching hospitals.
18 At the last meeting, we also discussed three
19 potential uses for the funds above the empirical level. One
20 is returning them to the base rates to improve payment
21 equity across providers. A 1 percentage point reduction in
22 the IME adjustment to 4.5 percent would result in roughly a

1 1 percentage point increase in base rates for all providers.
2 Alternatively, these funds could be used to
3 support a pay for performance fund for all hospitals,
4 providing higher payments to hospitals that perform better
5 on quality measurements. A 1 percentage point reduction in
6 the IME adjustment would support about a 1 percent payment
7 pool for such an initiative.
8 A third potential use of these funds is to help
9 support innovations in residency training.
10 We're now going to move on and talk about payment
11 adequacy and will return to the recommendation on the IME
12 adjustment later.
13 MR. ASHBY: Turning to overall payment adequacy,
14 most of our indicators are positive. First, access to care
15 remains strong, as indicated by more hospitals opening than
16 closing since 1999. In fact, the annual number of closures
17 has dropped by more than 60 percent since 1999. And the
18 share of hospitals offering a set of inpatient, outpatient
19 and specialized ancillary services remaining stable or
20 increasing. The number of Medicare discharges and
21 outpatient services has been steadily increasing, although
22 the rate of increase slowed in 2005 and into 2006. The

1 complexity of both inpatient and outpatient services has
2 also been increasing.
3 Quality of care is generally increasing with
4 mortality and process measures showing nearly uniform
5 improvement and mixed results on the rate of adverse events.
6 And finally, access to capital is good. In fact,
7 by some measures it's at an all-time high.
8 On the rate of cost growth, the weighted average
9 increase in Medicare inpatient costs per discharge and
10 outpatient costs per service has fallen from 5.3 percent in
11 2003 to 3.7 percent in 2005. That 3.7 percent figure is
12 only a few tenths higher than the operating payment update
13 in 2005.
14 But we have preliminary evidence, from a survey of
15 about 600 hospitals that we cosponsor with CMS and from six
16 for-profit chains, that the rate of increase may be up as
17 much as a percentage point in 2006.
18 Key factors in the escalating rate of cost growth
19 appear to be a substantial increase in capital costs, and
20 that's certainly related to the 30 percent increase in
21 hospital construction we saw in 2006, and the fact that
22 hospital employment rose faster than volume in the first

1 half of 2006, which may be a temporary phenomenon related to
2 slowing growth in discharges and outpatient services.
3 MR. LISK: Let's move on. This leads us to an
4 estimate of overall Medicare margins which includes all
5 lines of service provided to Medicare patients in the
6 hospital. Our estimate for 2005 was minus 3.3 percent, 0.2
7 percentage points lower than it was in 2004.
8 The projected margin in fiscal 2007, accounting
9 for 2008 payment policies, is estimated to be minus 5.4
10 percent. The decrease is largely due to the expected higher
11 cost growth in 2006 and 2007 that Jack just mentioned a
12 moment ago.
13 Returning to some of the other findings we had on
14 financial performance presented at the December meeting, we
15 found that hospitals with consistently low Medicare margins
16 have higher cost and higher cost growth than other
17 hospitals. Hospitals with consistently low margins do not
18 appear to be under as much cost pressure as hospitals with
19 consistently high margins. The non-Medicare ratio of
20 revenues-to-cost, the measure of financial pressure, is very
21 different between these hospitals, hospitals with
22 consistently low and high margins.

1 This ratio stands at 1.16 for the low margin group
2 compared to 0.99 for the high-margin group. The low-margin
3 group may face less pressure to control their Medicare costs
4 as non-Medicare revenues greatly exceed costs and they can
5 rely on these excess revenues to offset their Medicare
6 losses. In fact, these hospitals have actually seen
7 revenues grow faster than costs, another sign that this
8 group is facing less financial pressure.
9 The ratio non-Medicare revenues to cost for
10 hospitals with consistently high margins is only 0.99, which
11 means these hospitals are almost breaking even on their non-
12 Medicare business and that they need to do well under
13 Medicare in order to perform well. Thus, lower cost and
14 cost growth for this group appear to be associated with the
15 financial pressure that they're under. Hospitals with
16 consistently low Medicare margins are also not competitive
17 in their markets compared to their competitors.
18 In a related analysis, we found that hospitals
19 with consistently high costs pull the industry-wide overall
20 margin down 3 percentage points.
21 Jack and I are now going to walk you through the
22 recommendations on the IME adjustment and the hospital

1 update. The recommendations are interrelated in some ways,
2 so you may want to consider them as a package for improving
3 the payment system.
4 Now we return to the draft recommendation on the
5 IME adjustment. There's a slight change from what's in your
6 report to what's here, and I'm going to go by what is
7 generally in your written material.
8 So reading what the recommendation is: concurrent
9 with implementation of security adjustment to the DRGs, the
10 Congress should reduce the indirect medical education
11 adjustment in fiscal year 2008 by 1 percentage point to 4.5
12 percent per 10 percent increment in the resident-to-bed
13 ratio. The funds obtained from reducing the adjustment
14 should be used to fund a quality incentive payment system.
15 The spending implications for this recommendation
16 are none, since the proposal is budget neutral. Under
17 beneficiary and provider implications, this recommendation
18 would reduce IME payments to teaching hospitals but would
19 redistribute payments to hospitals that perform well under a
20 quality incentive program including teaching hospitals.
21 We must also note that our analysis shows that
22 teaching hospitals will benefit from the implementation of

1 severity adjustment to the PPS rates. With funds from
2 reducing the IME adjustment used for pay for performance,
3 there is the potential for improved quality of care for
4 Medicare beneficiaries.
5 We make this recommendation because the IME
6 adjustment is set considerably above what is empirically
7 justified, leading to substantial disparities in financial
8 performance under Medicare between teaching and non-teaching
9 hospitals. These funds are provided to teaching hospitals
10 without any accountability for how they are to be used.
11 Teaching hospitals will also benefit from the
12 impending implementation of severity adjustment to the DRGs.
13 The Commission believes a credible severity adjustment
14 system is necessary to help improve the accuracy of the
15 payment system.
16 This recommendation would also provide the initial
17 funding for a quality incentive program for all hospitals,
18 including teaching hospitals, which the Commission
19 previously has recommended.
20 In 2005, the Commission recommended the
21 implementation of a quality incentive program. The
22 Commission recommended that the program be funded with a 1

1 to 2 percent payment pool. Our IME recommendation would
2 fund about a 1 percent payment pool. If we wanted the pool
3 to be closer to 2 percentage points, the added funds would
4 need to come from the base rates from all hospitals. Some
5 of the underlying principles of the Commission's
6 recommendation included that the programs would reward both
7 attainment and improvement in quality performance and that
8 the pool should be expended with funds redistributed back to
9 hospitals that perform well on quality measures.
10 The Commission also thought that this program
11 should be implemented as quickly as possible, but it has
12 been two years since we made our recommendation and a system
13 wide quality incentive program for hospitals has not yet
14 been put in place.
15 The quality incentive program would replace the
16 current pay for reporting system, which reduces payments by
17 2 percentage points for hospitals that do not report quality
18 data.
19 MR. ASHBY: Now we turn to our update
20 recommendation. In considering the appropriate update, on
21 the one hand our indicators of payment adequacy are almost
22 uniformly positive, as I mentioned earlier. But on the

1 other hand, Medicare margins remain low and recent cost
2 trends suggest that they are likely to be lower in 2007.
3 At the same time though our analysis of hospitals
4 with consistently high costs and low margins suggest that
5 there's wide variation in cost and financial performance and
6 that a fairly small minority of hospitals -- less than a
7 fifth -- have caused the negative aggregate margin for the
8 industry.
9 So balancing these considerations, our draft
10 recommendation, which will apply to both inpatient and
11 outpatient payments, is for an update of market basket to be
12 implemented concurrently with the pay for performance
13 program.
14 This recommendation differs from the one we put up
15 in December, which was market basket less than half of
16 expected productivity growth, which we had carried over from
17 last year as a starting point for discussion.
18 The implication of this recommendation is that if
19 a 2 percent pool were used to implement P4P, for example,
20 with part of the pool coming from the IME change and the
21 rest taken from base payments, then quality performance will
22 determine the net increase in payments that hospitals

1 receive. Poor performers would have a net increase of less
2 than market basket while good performers would likely have a
3 net increase of more than market basket.
4 Now just to be clear, the P4P program would
5 operate completely separately from the update but it would
6 be the combination of the update and the hospital's
7 performance in the quality arena that would determine it's
8 net change in payment for the coming year.
9 At this point, we can open up discussion on each
10 of our three draft recommendations.
11 MR. MULLER: Glenn, I appreciate the sensitivity
12 you've displayed in trying to come to a reasonable consensus
13 on these recommendations. But I want to speak to the
14 payment adequacy findings first, because I find it
15 inconsistent, almost perverse, that we say that the
16 indicators of performance are positive. That's largely
17 based on what's happening in the market outside of Medicare.
18 It's because of the higher payment rates in the private
19 market.
20 And by and large, as a Commission, we've said
21 we're going to look at Medicare margins, not at total
22 margins. So for the sake of our arguments inside the

1 Commission we look at Medicare margin, not at total margin.
2 But then we really, in a sense, look at total margin as a
3 way of justifying payment adequacy because it's really the
4 payment rates outside of Medicare that allow us to come to
5 the findings.
6 If you could go to page 10, Jack, slide 10. If
7 you look at slide 10 in terms of access to care, volume of
8 services, quality of care, access to capital, a lot of that
9 is arguably driven by the higher payment rates in the
10 private sector.
11 Now Arnie and others around the table might say we
12 should also be looking at the payment rates in the private
13 market, as opposed to Medicare. But I would argue that it's
14 highly inconsistent for us to say let's just look at
15 Medicare margins, which are projected to be more than 5
16 percent negative in the upcoming year, and then use the
17 payment practices in the private sector which allow this to
18 happen to say that access is good.
19 So I just find that highly inconsistent. I
20 understand why we look at Medicare total margins, for the
21 reasons that have been well articulated over the years. But
22 then I don't think we should say that there's adequate

1 payment in the Medicare program. There aren't. I
2 appreciate the fact that we're recommending a full update as
3 a result, but I think it's hard to find that Medicare leads
4 towards adequate payments because I think there's clear
5 evidence that it does not.
6 Secondly, on the IME, I think having the
7 recommendation -- I think I understood you, Craig, that it's
8 going to be amended to say that concurrent with the
9 implementation of the severity -- so I think with the
10 severity adjustment system, which should have a positive
11 effect on the hospitals that have higher acuity patients to
12 be served, this is a fair and appropriate recommendation to
13 make that have that kind of balance.
14 I do think in our ongoing discussion of the
15 empirical factor and whether the payments are above the
16 empirical factor, to constantly say that the payments are
17 adjusted for the costs of residents is a little misleading.
18 The costs are for the cost of a teaching hospital. We
19 measure, as a proxy factor, the size and scale of a teaching
20 program by looking at the number of residents. But we have
21 a long history, both inside this Commission and in other
22 forums, that the role of a teaching hospital is not just

1 measured by the number of residents. It's a proxy measure
2 thereof.
3 I think the chapter does a good job of pointing
4 out some of the other things in terms of anchoring regional
5 care systems, providing standby capacity in terms of part of
6 the issue in the last four or five years, terrorist attacks
7 and so forth, being an anchor in a whole variety of ways to
8 the care program of communities that teaching hospitals
9 provide. So I do think there's a broader role that has been
10 well established in policy, just like we have well
11 established policy justifications for critical care
12 hospitals and various provisions in rural care for policy
13 exceptions to the empirical factor.
14 So I do think we should perhaps lighten up a
15 little bit on the fact that it's just the cost of residents
16 that is driving this empirical factor, that in fact there's
17 other unspecified roles that the teaching hospitals play
18 that drive this higher payment we make in IME.
19 But by and large I think the recommendations we
20 have come up with are fair, balancing with the kind of
21 concerns that the Commission has expressed over the course
22 of the last few months. But I couldn't help but note that

1 we are highly inconsistent in the fact that we use total
2 margin to justify accuracy and then we deny that we use
3 total margin -- that we can look at the total margin at
4 other times.
5 DR. KANE: I had some questions in the way the
6 data was presented that I'm not quite sure I understand
7 what's going on. When you do on page 12 the overall
8 Medicare margins -- and you said that's for all lines of
9 business, inpatient and outpatient and then also any post-
10 acute or home health. But we're only recommending an update
11 for the inpatient and outpatient.
12 It would be helpful to me to not put the other
13 pieces in there if that's possible so we can separate --
14 because we're not recommending an update for the other
15 pieces of the business. I don't know if it's a huge
16 difference or not. It probably isn't huge but it's
17 confusing.
18 MR. ASHBY: Two responses to that, just to get on
19 the table. The inpatient margin is minus 0.9 and the
20 outpatient margin is minus 9.4. But the reason that we have
21 looked at the overall Medicare margin is because we don't
22 really have confidence that the measures of the individual

1 components are an accurate representation of those services.
2 And to capture the interplay, we need to look at all of the
3 services so that we can be confident that it's accurate at
4 that level.

5 DR. KANE: I think we have that problem but this
6 is useful to have the break down because -- I mean, this
7 might suggest a differential update between in and out.
8 Minus 0.9 is roughly a break even, versus the outpatient of
9 minus 9.4. Granted, they can allocate overhead but there's
10 a point where we have two separate programs and we're
11 recommending updates on that basis. I just think it would
12 be useful to keep it to the underlying detail.

13 The other question I had is if we're recommending
14 a severity adjustment for the DRG system and we know that
15 that is going to -- that's budget neutral, I assume. What
16 would be the impact on the disparity between the teaching
17 and non-teachings once you do that? Because we now have a
18 12 point spread. And if we don't ask to have a reduction in
19 the IME, aren't we making the disparity even greater by
20 doing the severity adjustment?

21 And I know there was another adjustment, or I'm
22 not sure it was ever implemented, simultaneously around

1 reweighting based on costs rather than charges.
2 These all sort of came together. Do they all
3 affect the disparity? What's the end result? It would be
4 helpful to break that down as well, just so we understand
5 what we're really doing here if disparities between non-
6 teaching and teaching are important to keep an eye on.
7 My concern remains that when you do give a funded
8 non-mandate such as the IME or the DSH or a tax exemption,
9 you do create a competitive advantage to the ones who get
10 it. So the disparity, even though it ma not be an equity
11 issue between the teaching and the non-teaching, it is a
12 competitive issue and it really can upset certain markets
13 pretty badly. You know which market I'm from, which is one
14 of the most upset. But I think New York, California, it's
15 not just an equity issue. When you just hand out money
16 without an accountable piece for it, you can create
17 competitive advantage and disadvantage. Some would view
18 that as inequitable but I agree there's inequities across
19 the board.
20 But I think we do want to keep track of these
21 disparities, whatever we want to call them, and understand
22 the impact of the policies that we recommend on that

1 disparity. Because in the real world we are creating
2 competitive advantage and disadvantage in some markets.
3 I think I'll stop there, but I just would like to
4 keep some of these things more broken out than they are in
5 this presentation, just so I understand them better.
6 MR. HACKBARTH: The other major question was the
7 impact on teaching hospitals, severity adjustment, and other
8 payment refinements. Do you want to address that, Craig?
9 MR. LISK: Severity adjustment by itself, keeping
10 the rest of the payment system in place, would increase
11 payments to teaching hospitals by a little more than 1
12 percentage point. It would reduce payments to other
13 hospitals.
14 The other refinements overall, if we look at -- in
15 this analysis we're looking at weights created with 2002
16 data, implemented on 2004 data, which is a little bit
17 different than what Julian had presented earlier in the
18 year. We see actually basically total payments about the
19 same both for teaching hospitals and non-teaching hospitals,
20 in terms of if you think of the full refinements the
21 Commission recommended, you see teaching hospitals and non-
22 teaching hospitals about the same.

1 DR. KANE: So no increase in the disparity with a
2 reweight?
3 MR. LISK: About the same. There may be a few
4 tenths difference, but I know on teaching hospitals, for
5 instance, the difference with going to 2004 weights was
6 basically a zero change within that, with all the
7 refinements.
8 DR. KANE: Also then the last thing is given that
9 we think that the hospitals that lose money on Medicare are
10 losing money purposefully because they've increased their
11 cost because they have payment-to-cost ratios in the private
12 sector that allow that, is that kind of what you're getting
13 at?
14 MR. ASHBY: I'm not sure I'd put in terms of doing
15 it purposely, but they have some freedom to absorb a higher
16 rate of cost increase because they do have the additional
17 revenue coming in on the other side. That pattern is pretty
18 consistent.
19 DR. KANE: So would it be helpful to look at the
20 margins of what we would consider Medicare efficient
21 hospitals, as opposed to the total? I want to get at
22 Ralph's point a little bit, but I want to make it a little

1 fairer.

2 The private sector has largely backed off from

3 heavy-duty payment constraints ever since the late 90's.

4 And I agree that you are incentivized to be more efficient

5 if you can't just shove it over to the private pay. And

6 when you can shove it over to the private pay, you're

7 creating affordability issues.

8 It would be helpful to see the margin on the

9 hospitals that do not have the opportunity to cost shift

10 over to the private pay. Instead of saying -- what's the

11 inpatient margin and the outpatient margin for those

12 hospitals that can't cost shift? Because those are the

13 efficient hospitals to whom we are trying to hold everybody

14 to that standard. Those are the costs we're trying to

15 cover.

16 MR. HACKBARTH: Let me leap in here and I'm not

17 going to answer your question specifically but talk about

18 this general issue, the significance of the Medicare margin

19 for the update recommendation.

20 As I think I said at the last public meeting, over

21 time in my mind, and I won't pretend to speak for the whole

22 Commission here, but in my mind the margin figures have

1 become less important to what the right policy is over time.
2 And I look at the declining Medicare margin for hospitals
3 and like everybody else at one level it gives me a little
4 bit of anxiety, and my stomach churns a little bit as I see
5 it.

6 On the other hand, I think the real question for
7 the Congress, not just for MedPAC, is what to do about cost
8 trends. It our goal in setting updates to accommodate the
9 underlying increase in costs and thus stabilize margins or
10 hit some target margin? Or should the update be driven by
11 the need to improve the efficiency of not just hospitals,
12 but this applies to all Medicare providers, and force
13 bluntly providers over time to change the cost trends and
14 reduce the cost trends?

15 Now the task is complicated by the fact that in
16 recent years, since the managed care backlash, private
17 payment rates have become relatively generous. And that's
18 due to a number of different factors. In some cases a
19 factor is consolidation within the hospital market, and
20 you've talked often about how that's an issue in Boston. In
21 other cases, it's because of the design of health benefits
22 programs and options with tight restrictive networks became

1 less popular and bigger networks became more popular. Now
2 that pendulum is swinging back a bit now.
3 But the dynamics on the private side have changed.
4 Lots of the flow of dollars into hospitals from the private
5 side has become much more generous in the last five or six
6 years than it was previously. And hospitals have said we've
7 got the resources and we're going to spend them. It's a
8 largely not-for-profit industry and they exist to spend the
9 money, not distribute it as dividends to shareholders.
10 So when the revenues go up, predictably they will
11 spend, whether it's on capital investment, expansion, new
12 imaging facilities, more staff, whatever. They will spend
13 it.
14 And so Medicare faces this problem that private
15 payment policy is influencing hospital behavior and now it
16 shows up as Medicare cost increases and Congress needs to
17 decide how much of that to accommodate.
18 I don't think that in that complex world, dynamic
19 ever-changing world, looking at a margin and saying well,
20 the margin is at this level, therefore the right update
21 figure is X, that there's some sort of formulaic response.
22 I don't think there can be.

1 DR. KANE: I actually wasn't suggesting that there
2 should be, but I do think both Ralph and the industry
3 document that was faxed, FedExed, and handed to us today
4 goes back and says well, look at the Medicare margins.
5 And I think that the response should be to clarify
6 that, that yes, there is a negative margin in effect on the
7 outpatient side that's really negative. But perhaps we
8 should clarify the fact that we feel the efficient provider,
9 or the one that doesn't have the private pay cost shift
10 available may have a better margin and make that argument.
11 Just burying it in a broader number makes it
12 harder to make that argument. It's really more of if that's
13 one of the factors, let's clarify it for this sector because
14 it can easily be buried in this minus 9 percent.
15 MR. HACKBARTH: In various ways, we have tried in
16 the last couple of years to look at the industry not as a
17 whole but rather in parts and how do hospitals in different
18 situations respond? What happens with their cost trends,
19 their average length of stay, their Medicare profitability?
20 In fact, it's a complex situation. But a
21 consistent factor is that hospitals that face more financial
22 pressure through a combination of Medicare and what happens

1 on the private side tend to have lower cost increases. Many
2 of the hospitals that are consistent losers financially tend
3 to be in a situation where frankly they deserve to be
4 losing. They've got low occupancy, they're not very
5 competitive within their existing markets. There are the
6 hospitals that are nearby alternatives to them. And I don't
7 personally lose a lot of sleep over them.
8 DR. KANE: All I'm asking is if we could show the
9 margin that way, as opposed to an overall, as a way to help
10 people understand what you're saying.
11 DR. MILLER: I do want to jump into this for a
12 second and just give you more of a mechanical answer.
13 So far everything that you've mentioned, with
14 perhaps one exception, is presented in the chapter. And
15 most of it was presented in the last meeting. A couple of
16 things in the chapter, we do make the separate margins known
17 in the chapter, and I believe that was presented in the last
18 meeting. We also go through extensive discussion on this
19 issue of cost and how it has an effect on different
20 hospitals. We have an extensive discussion on the poor
21 performers, the point that Glenn is making.
22 The only place that we haven't done exactly what

1 you've said is that when we talk about the poor performers,
2 what we present are more things like their cost, their cost
3 growth, their occupancy. It's the margin that sort of
4 divides them into the groups that we look at. And that's
5 the one piece of information that is somewhat different.
6 In this instance, and I just want other people to
7 understand this. It's not that this information is in here.
8 We also have to make a decision when we come up to this
9 meeting to get down to 10 or 15 minutes to give you guys the
10 time to talk. We tend to try not to repeat information
11 that's gone through in the previous meeting.
12 But virtually everything you've said has either
13 been presented or is in the chapter.
14 DR. HOLTZ-EAKIN: Glenn has anticipated a lot of
15 what I was going to say, and said it better than I could.
16 I've struggled with the process to come to this
17 particular recommendation. In the way that I laid out my
18 thinking the day has passed when the starting point can be
19 accommodating what's gone on. So it's struck me as sensible
20 to sort of think of market basket minus productivity as a
21 benchmark against which you would begin weighing different
22 factors. And the factors are the ones that the staff has

1 walked through. You look at access, which seems quite good.
2 You look at services, which are increasing. You look at the
3 quality of care, which is going up. Everything seems fine.
4 One of the things that struck me, in thinking
5 through our job today, is that if this were the doctors
6 that's all we'd know and we'd be done. And we'd say, okay,
7 it's market basket minus productivity, things are in good
8 shape, let's move on.
9 But in this case, we have this other thing called
10 the margins. And now suddenly you have to figure out what
11 these margins are, and it's fraught with all sorts of
12 problems. First of all, there's the genuine measurement
13 difficulties that make it difficult to isolate lines
14 accurately. There is the difficulty that these are
15 projected margins, and I want to emphasize that the
16 projections are fraught with all sorts of uncertainty and
17 can't pretend to weigh evenly with the facts.
18 And given that, do you want to use that to move
19 you off the benchmark of market basket minus productivity?
20 And I have some doubts about that. I have particular doubts
21 because even if you bless the margins as accurate and bless
22 the projections as perfect, the notion that you would just

1 drop any productivity adjustment whatsoever suggests that
2 these entities have no other way to accommodate these costs
3 than to just get more money in. Which means they're out of
4 internal opportunities to reinvent, reengineer, alter the
5 way they do their business to accommodate cost pressures.
6 And I think the presentations that have happened
7 this year suggest anything but that.
8 So it's a struggle to make that go away,
9 particularly relative to the kinds of standards of evidence
10 that are presented in other parts of the Commission's
11 business. And I think it is worth thinking hard about what
12 the role of the margins, particularly projected margins,
13 play in this discussion.
14 DR. WOLTER: Just a couple things.
15 After about the third year of seeing your thesis,
16 Jack and Craig, I've come to believe in some of it. The
17 idea that in markets where there's less discipline there's
18 maybe a little relaxation of the ability to tackle costs.
19 I've been somewhat skeptical because I've been worried that
20 the other side of that coin is that there's cost shifting
21 going into the private sector that's creating tremendous
22 pressure there, and particularly in states like mine where

1 there are small businesses. That creates a very difficult
2 situation.
3 So I think there's a balance to the thesis, and
4 that is there are some legitimate cost issues. Whether
5 that's nursing or other highly paid professionals or
6 technology, some of those things are true issues. They're
7 not easily controllable, I guess I would say, some of them.
8 So we might have a little balance on that, although I
9 certainly have, as I've said, to appreciate the work you've
10 done on this.
11 Obviously the history of this, Doug, is that for a
12 while we went on the philosophy that we wanted to cover the
13 costs of an efficient provider. So that's the background in
14 the years I've been on this Commission.
15 I am appreciating, though, that we've come to a
16 point where we're trying to be more intellectually honest
17 about the fact that the real issue might be what can we
18 afford? And that we maybe are getting to a point in this
19 program where we have to make decisions about what we can
20 afford that aren't necessarily based on the existing cost
21 structure. And I think that is a reasonable, as you
22 outlined it, Glenn, issue that we need to start putting on

1 the table as we move forward. Although I certainly would
2 support the current recommendation when you look at the big
3 picture, I'll say that.
4 I also think this margin discussion again points
5 out the importance of specific tactics underneath the
6 umbrella of this. For example, much more aggressive DRG
7 reform, so that we blunt the incentive to drive volumes in
8 certain areas that really are driving up costs. I think
9 that's the more important topic almost, is to really push
10 those and other tactics.
11 I just wanted to mention on the technology
12 discussion more specifically, I'm a little worried that we
13 may need to be looking at the complexity of technology costs
14 a little bit more differently. I don't know that it's truly
15 logical to think that P4P will be a place where there's true
16 ROI for the costs of implementing clinical technology. It's
17 very expensive as an upfront cost and the ongoing operating
18 costs are significant.
19 I think the real issue there is it also does
20 involve almost a redeployment of human process. That's the
21 hardest part of it, much harder than implementing the
22 hardware and the software. And much of the gain once you do

1 that is actually not accruing to the health care system, per
2 se. It may be accruing to the insurer, the payer, or the
3 beneficiary, which is what we should be trying to do, of
4 course. But it's a more complex story than we're maybe
5 indicating in the current technology conversation.
6 And then on IME, I've come to appreciate both
7 sides of this discussion. I guess one of my worries is that
8 with what we need out of the academic medical centers in the
9 years ahead, given the significant workforce issues we're
10 going to have, given the needs that we're going to have to
11 train physicians differently, as Ron was talking about
12 earlier, we need to be very careful about underfunding that.
13 So what we're really wrestling with, it seems to
14 me, is how much of that can come out of the Medicare
15 program. I gather there have been past commissions that
16 have looked at academic medical center payment. And it does
17 seem to me this is a really important area in terms of a
18 strategic decision about how do we fund appropriate training
19 for the work force needs that we have ahead of us? Which I
20 think we're in trouble in terms of the physician
21 availability that's out there.
22 So I don't know how we put that back on the table.

1 We are dealing with a more specific issue about Medicare,
2 but there is a bigger issue about how we make sure we have a
3 strong training program in the academic medical centers.
4 And then again, I know we're going to start
5 getting to it tomorrow, but the whole outpatient system
6 really does need its own review. That's a fairly recent
7 prospective payment program. The margins are fairly
8 negative. Do we want to keep letting it sit like it is? Or
9 is there maybe something about that that needs more
10 attention?
11 And then my last question was it's not clear in
12 the recommendation, I think it's clear in the text. But the
13 implementation of the quality incentive program if this 1
14 percent came out, that would go to all hospitals? That's
15 not just limited to the academic medical centers; is that
16 correct?
17 MR. LISK: That is correct.
18 MS. BURKE: My compliments once again to the
19 staff, who I think have done a great job overall in the
20 chapter in describing a complicated set of questions.
21 Let me say at the outset that in terms of the
22 recommendations, I certainly have absolutely no issues at

1 all with the first recommendation.

2 With respect to the second, I certainly don't have
3 any issue, and in fact strongly support the pressure being
4 put on CMS to move with respect to the severity adjustment
5 and the need for that. I am concerned about the sort of
6 linkage. And I understand, I think Glenn has done a great
7 job of trying to strike a balance here, the linkage to the
8 issue of IME and I want to talk separately about the
9 reduction in the IME. But I certainly have no issue with
10 the severity and the need to do that and need to find the
11 funds to do that, nor obviously do I have a concern about
12 the recommendation with respect to the market basket. I
13 strongly agree.

14 If I could, without sort of belaboring the issues
15 that have come up before, but talk specifically about the
16 IME adjustment, there is an underlying premise throughout
17 the text. I mentioned it earlier and I'll sit down with the
18 staff and go through it.

19 There is the use of the term equity and a
20 suggestion that this is about equity, and the reason we're
21 dealing with the IME adjustment is to create a more
22 equitable distribution of funds.

1 There is the suggestion that it has gone off
2 course in terms of its original intention. The staff have
3 done a terrific job, I think, of listing the history and
4 what the original intent was when we created the adjustment,
5 and our desire to acknowledge those things that occurred in
6 teaching hospitals that could be clearly defined -- and that
7 is both with the direct medical education as well as with
8 IME.
9 And then the sort of presumption or the
10 expectation that there were other things that would occur in
11 those institutions that might result in additional costs to
12 the institutions that were less clearly defined.
13 One of the things that in the chapter the staff
14 does, in fact, was to identify what some of those social
15 related missions might well be. It is interesting, in going
16 through those, in fact were one to look at them, the earlier
17 parts of the chapter in a couple of cases in fact confirm
18 that in fact those things are occurring.
19 One example, for example, are those standby
20 services, burn, transparent and trauma. The chart earlier
21 in the chapter clearly acknowledged that in fact they are
22 present far more frequently in large teaching hospitals than

1 they are in other hospitals. There's a discussion about
2 other standby capacity that has become sadly increasing
3 important to us post-9/11 that are also readily available in
4 these large teaching hospitals.
5 The presumption or the suggestion is that the
6 extent to which we identify those as valuable social goals -
7 - and that includes the value of training physicians, as
8 Nick pointed out, the value of training really a broad array
9 of health care providers in these institutions is a social
10 goal and one that is of value to all of us not simply to the
11 Medicare population, that Medicare has made an explicit
12 commitment to doing that.
13 One might question whether or not going forward
14 that is the right mechanism. And that is certainly the
15 fundamental question, should Medicare in fact be uniquely
16 responsible for bearing this cost in a very specific way?
17 Or should it, in fact, be looked at as a broader social goal
18 that ought to be funded through an appropriations matter on
19 an annual basis? Or whether it should be done through some
20 other kind of entitlement program.
21 The staff have noted both of those things. The
22 fact of the matter is it is not. It has not been picked up

1 through the appropriations process. And I would argue, in
2 fact, going forward that the possibility of that being
3 consistently supported given the current pressures is
4 unlikely.
5 Whether or not the creation of a new entitlement
6 specifically to that activity -- and I'm setting aside for
7 the moment the issues around uncompensated care, which I
8 think is an important issue but not one I'm talking about
9 currently -- whether or not it would be likely to be
10 supported in that fashion. I think again, given the current
11 environment, it is unlikely to be funded in that fashion
12 going forward.
13 So the question for us is whether or not there is,
14 in fact, a value in us in doing it, whether it is an
15 appropriate expenditure for Medicare. And I would argue, in
16 fact, that it is. It has been in the past. I think there
17 are things that occur in those institutions. I worry a
18 little bit about the point that Nancy raises, that this is
19 inherently an anti-competitive move, that essentially we're
20 benefitting these particular kinds of institutions. There
21 are specific things that occur in those institutions
22 absolutely that do not occur in other institutions and I

1 think they are, in fact, an important and valuable product.
2 Whether it is the presence of these services, whether it is
3 the training of health care professionals.
4 So again there are clearly differences of opinion
5 among the Commission. I acknowledge that. My only concern
6 is, as we look at the text, that we not suggest that this is
7 about equity. It is about a fundamental question as to
8 whether or not this is a responsibility for Medicare to
9 bear. I would argue, in fact, that it is. And I worry
10 about reducing the adjustment, in fact, will begin to harm
11 those institutions that are doing it. In fact, there's an
12 acknowledgment that the greatest impact in the reduction of
13 the IME will be on the very large teaching facilities that,
14 in fact, do predominantly provide these services as
15 compared to some of the smaller ones that have fewer
16 residents present.
17 But again, I'll be happy to work with the staff
18 about those language issues and those sort of underlying
19 presumptions that I think perhaps somewhat overstate the
20 sort of equity issue perhaps more than they ought to be.
21 But again, I certainly don't disagree with the
22 market basket issues. I don't disagree with severity. But

1 I would strongly argue against a reduction in IME, for the
2 reasons I suggest.
3 MS. DePARLE: I was reminded when you brought it
4 up a few minutes ago, the discussion about the increasing
5 tension that you feel between continuing our long-standing
6 practice of looking at each subsector of the health care
7 industry and of Medicare payment both in a siloed fashion
8 doing our analysis and not looking at the overall Medicare
9 spending trends. We're looking at them, I guess, only in
10 the context of sort of the context for Medicare spending and
11 not really making a statement about it.
12 I think all of us, this summer at the retreat we
13 discussed this as well. I think all of us feel the
14 pressure, in my thinking about it, I do think the issue
15 about what we can afford and the bigger picture of this
16 whole program and what can beneficiaries afford needs to be
17 on the table. We should put it there and we should have
18 that discussion and perhaps with more vigor and robustness
19 over the next couple of years. And I think we are raising
20 it at every turn.
21 But I don't think -- my thinking about it is that
22 it's not our role to try to address that issue. And I think

1 that is where you, at least for now, come out as well with
2 respect to each subsector in the context of our update
3 decisions.
4 There are some folks down the street who were
5 elected to do that. There some folks up on Capitol Hill who
6 were elected to do that. There's a gathering storm about
7 this entire issue, whether it's from the trigger in the MMA
8 to the President's recent proclamation that he's going to
9 balance the budget by 2012. So these issues are on the
10 table and I don't think it's our role to solve it, although
11 we may play some part in helping to shed some light on how
12 to solve it.
13 In that regard, I support the recommendation. I
14 thought it was balanced. I think it was my colleague, Nick,
15 who said at the last meeting that given all of the data that
16 has been shared with us by the staffs, if there were ever a
17 year for a full market basket update, this seems like it
18 would be it to me.
19 And also I think, though, that we don't want to
20 lose the emphasis on the other piece of this, which is huge.
21 It's huge to me to be sitting here with a recommendation on
22 a quality incentive payment program for hospitals. I think

1 we may have gotten somewhat -- because we spend so much time
2 talking about this in this group -- numb to the fact that
3 that is big news. That will be big news if that goes
4 forward and is implemented for hospitals and Medicare.
5 So I think what we come out with is a balanced
6 approach that both rewards hospitals for doing the right
7 thing but also moves us in the right direction.
8 DR. CASTELLANOS: I have a little problem in
9 really understanding and accepting a change in IME without
10 really looking at some of its ramifications. I think there
11 is a significant workforce problem now. I hope the
12 Commission will look at that next year, perhaps when we have
13 the retreat we can think of that as a problem that needs to
14 be looked at. But I'm seeing cracks now in my community.
15 As a practicing physician I see we have a workforce problem
16 now, not just in geriatrics or primary care but in several
17 of the surgical subspecialties. And I think we, as a
18 Commission, have a responsibility to continue to provide
19 access to care for the Medicare beneficiary.
20 I also have a problem when we cut back on these
21 funds of the educational value, as we discussed previously
22 with the SGR. This again is going to impact the future

1 education of the physicians in the communities.

2 I'm not against cutting back but I would hold it
3 with a lot of trepidation.

4 MR. HACKBARTH: Let me share some comments from
5 Karen and Arnie, and let me begin with Karen since one of
6 her points picks up on what Ron just said about workforce.

7 Karen asked me to say that she, too, is very
8 concerned about the future of the physician workforce and
9 health care staff more generally. She said that we've
10 tended to focus on primary care and whether there are going
11 to be enough primary care physicians. But she believes that
12 the issue is significantly broader than primary care and
13 that there are a number of other specialties where the
14 future looks pretty bleak based on the numbers that she's
15 seen.

16 So she thinks that in the not-too-distant future
17 this is an issue that MedPAC needs to grapple with more
18 directly.

19 Having said that, Karen said that she does support
20 the recommendation to reduce IME by 1 percent concurrent
21 with severity adjustment, although her preference would be
22 to allocate the money differently, to allocate it half to a

1 fund designed to encourage changes in medical education, as
2 Arnie has often advocated, and then half just back into the
3 base payment.
4 Arnie also supports the reduction in IME but he
5 would allocate all of it to medical education, changing
6 medical education.
7 Let me now just add a comment of my own on IME.
8 Because of my own personal work experience, I am quite
9 sympathetic to the very important mission that teaching
10 hospitals fulfill within the system. I had the opportunity
11 to work closely with some really great institutions, the
12 Brigham and Children's Hospital in Boston, in particular.
13 So I've got the utmost respect for the work that they do,
14 the contribution that they make.
15 Having said that, my perennial concern in my seven
16 years on MedPAC has been that the current IME system is
17 problematic from my perspective because there's no
18 accountability for what's produced. We're putting a lot of
19 money out there. I think Nancy used the term funded non-
20 mandate or something like that. It's billions of dollars
21 for which there's no accountability. And that always has
22 concerned me, and it concerns me in a way more each year

1 given the greater sense of urgency that I feel about health
2 care costs in general and the Medicare program in
3 particular.
4 So what I would like to see is appropriate funding
5 for these important institutions coupled with more
6 accountability. I see this link to the severity adjustment
7 as a very small, admittedly meager, step in that direction
8 in the sense that one of the historical reasons for doubling
9 the IME adjustment was teaching hospitals care for our
10 sickest patients, and we've got to make sure that they are
11 not financially damaged in the process of doing that.
12 And I agree with that, but there's a better way.
13 There's a better way and that is to get on with the process
14 of adjusting specifically for the severity of the patients
15 treated. That will shift more money towards teaching
16 hospitals.
17 And given the overall issues, the disparity in
18 margins, whether you characterize it as inequity or not,
19 there is a large disparity. I don't think now is the time
20 to shift still more money to teaching hospitals. So this
21 recommendation sort of says okay, let's establish
22 appropriate payment for caring for really sick patients but

1 let's not shift still more money in our limited budget
2 towards the teaching hospitals.
3 MS. BURKE: Glenn, if I could just respond for a
4 minute, I don't disagree with a single thing that you've
5 said. I absolutely agree that we ought to be moving to a
6 system that, in fact, is sensitive to the actual acuity of
7 the patient and we ought to pay in that fashion. Separate
8 from the question of teaching hospitals, that is a
9 fundamental responsibility of the program that ought to be
10 dealt with.
11 I don't disagree with you, frankly, that the
12 industry has done a very poor job of documenting, and we
13 haven't frankly asked them to document how, in fact, these
14 funds are spent. And I don't disagree that there ought to
15 be far more accountability. Whether we could agree on those
16 things that we think they ought to be accountable for,
17 whether it is standby, whether it is the presence of certain
18 services.
19 The difficulty has been, I think. on our part from
20 failure to define what those things might be. On their part
21 failure to, in fact, define what it is that they're doing.
22 So I don't disagree that we ought to get there, we ought to

1 decide what it is that we think they ought to be spending
2 the money on if we choose to spend the money.
3 My concern is -- I think severity is the right way
4 to go. That is a piece of it. There will be teaching
5 hospitals who qualify for that, in fact, because they have a
6 higher acuity of patient. So I don't argue against that at
7 all.
8 And I don't fundamentally argue long-term about
9 getting to a situation where we agree on what it is that we
10 think ought to be paid for and that they ought to be
11 accountable for doing it. Whether it is an improvement in
12 the way they teach physicians and others, I absolutely
13 agree.
14 My concern is once the money is gone, the chances
15 of putting the money back in any near term if, in fact, we
16 would agree that there are certain kinds of things, always
17 becomes more complicated. Once it goes into the base, once
18 it goes into another delivery system, it is difficult to
19 recapture those funds.
20 And so my concern is simply not that maybe there
21 isn't a reduction that's appropriate. I wouldn't deny that.
22 And I wouldn't deny that the severity piece is one piece to

1 go to.

2 It will have the biggest impact on the largest

3 teaching hospitals who, in fact, are doing the things that

4 we at least vaguely articulated as appropriate. For

5 example, these standby services, the presence of things like

6 burn units, trauma units, and so forth.

7 My concern is they will get a piece of it back in

8 severity. They won't certainly get all of it back, which

9 makes sense because it's more widely distributed. But it's

10 the failure to have articulated ultimately what should the

11 policy be. I don't disagree that's the direction we ought

12 to go. And if we were ready to go there, I'd be on board.

13 My concern is the reduction in the absence of a clearly

14 articulated long-term strategy. But I don't disagree at all

15 with the direction you want to go.

16 DR. REISCHAUER: I agree with all of the

17 recommendations that we are considering. But I have a hard

18 time seeing how the IME recommendation has anything to do

19 with workforce issues, although that keeps coming up. Do we

20 honestly think that if we reduce by 1 percentage point the

21 IME payment hospitals are going to train fewer physicians?

22 We're still paying them more than the empirical amount. If

1 we were to go below the empirical amount, there might be
2 some adjustment. Do we think that by keeping the payment up
3 at its current level we're going to address the shortage of
4 certain specialties, gerontologists, general practitioners?
5 No, unless we become very prescriptive about what you can do
6 with this money.

7 So at this stage I think these are two issues that
8 are more or less disconnected and shouldn't enter into the
9 debate.

10 Just going forward as a warning for where we might
11 be next year when I guess we're going to consider workforce
12 issues, whenever I hear all of the discussion about
13 shortages, et cetera, et cetera, I am reminded by what Jack
14 Wennberg and Elliott Fisher have been saying which is there
15 is huge variations in the physician-to-population ratio
16 across the country. In those areas where there seem to be
17 tremendous numbers of physicians per person, there seem to
18 be a lot of usage of supply sensitive services which don't
19 seem to have too much impact on health outcomes.

20 And we want to keep that body of evidence in mind
21 at the same time we're considering what the projections look
22 like for the physician workforce going forward.

1 DR. CASTELLANOS: I'd just like to reply to the
2 workforce issue. Bob, it's not an issue that they're going
3 to cut back. We already have a shortage right now. We have
4 a shortage in general surgeons. We have a shortage in
5 vascular surgeons. And what we're not doing is increasing
6 the programs and putting more people out.
7 We have the baby boomer population coming up and
8 we're not preparing for it. By cutting back, the residency
9 programs are not going to expand to the needs that are
10 needed today, not the projected needs that are going to be
11 needed with the baby boomers.
12 DR. HOLTZ-EAKIN: I just wanted a echo something
13 that Nancy-Ann said which is, in looking at the update
14 recommendation, as I said earlier, I have a hard time
15 supporting it. The only way I can get to supporting it is
16 if, in fact, it is really the case that this concurrent
17 implementation of the quality incentive payment program is
18 news and is emphasized. Because I think absent that it's
19 hard to make the case that this is the right amount of money
20 and that that really has to be a central part of the
21 message.
22 MR. HACKBARTH: Let me just pick up on that. Here

1 again, I think I'm repeating something I said in the past
2 but I'll do it anyhow.
3 We've been recommending pay-for-performance now
4 for several years. We began with those areas of the program
5 where we thought that the opportunity was relatively easiest
6 in terms of clearly defined quality measures and the like.
7 And so our initial recommendations were to begin pay for
8 performance with Medicare Advantage, dialysis and hospitals.
9 Then, in subsequent iterations, we made similar
10 recommendations for post-acute providers and physicians.
11 What I fear is happening is that the movement has
12 slowed, maybe even to a halt, over the complexity of doing
13 pay for performance for physicians, which I think we noted
14 when we talked about physicians, that for a variety of
15 reasons it is perhaps the most complex area to do pay for
16 performance. The number of physicians, the relatively weak
17 information infrastructure, the degree of specialization and
18 the like.
19 Yet that seems to be the rate limiting step now in
20 the policy process. We can't do pay for performance for
21 anybody else until we figure out how to do it for
22 physicians. That doesn't make sense to me.

1 So I do see this as an opportunity to again
2 reiterate that we think that there are relatively easier
3 opportunities -- none of them is simple -- but there are
4 easier opportunities than physicians, including hospitals,
5 and it's now time to move on with that. And so I agree that
6 that's an important message that we ought to emphasize in
7 the text.
8 I think we are ready to vote now, so would you put
9 the recommendations up?
10 On recommendation one, which is on uncompensated
11 care data, all opposed to recommendation one? All in favor?
12 Abstentions?
13 On recommendation two, all opposed? All in favor?
14 Abstentions?
15 On recommendation three, all opposed? In favor?
16 Abstentions?
17 DR. KANE: [off microphone] I just feel like we
18 didn't get to talk about in and out and whether there should
19 be a differential for in and out, and it all got bundled
20 before. And I just don't feel we got a chance to really
21 talk about it. But maybe it's just me being stuck on the
22 fact that in and out are very different.

1 MR. HACKBARTH: So how would you like us to record
2 your vote?
3 DR. KANE: [off microphone] I hate to make trouble
4 but it's more than I --
5 MR. HACKBARTH: Making trouble is not one of the
6 options I'm giving you. Yes, no, or abstain.
7 [Laughter.]
8 DR. KANE: [off microphone] I'll support it but I
9 do feel I don't know yet what's going on. But I'll support
10 it.
11 DR. REISCHAUER: Record Nancy's enthusiasm.
12 MR. HACKBARTH: We are ready for a brief public
13 comment period, and we're running a little bit behind so I'd
14 ask that you keep your comments even shorter than usual.
15 Consider this a productivity adjustment.
16 Please identify yourself first. If somebody
17 before you has made a comment similar to yours, please just
18 say I support that comment as opposed to going on with it.
19 Any comments?
20 Okay, thank you. We will reconvene at 1:20.
21 [Whereupon, at 12:46 p.m., the meeting was
22 recessed, to reconvene at 1:20 p.m. this same day.]

1 AFTERNOON SESSION [1:30 p.m.]
2 MR. HACKBARTH: We are ready to roll. Our first
3 discussion is on dialysis.
4 MS. RAY: Good afternoon. During today's
5 presentation we are going to review key information about
6 the adequacy of Medicare's payments for dialysis services.
7 You have seen most of this information during last month's
8 meeting.
9 I will present a draft recommendation for you to
10 consider about updating the composite rate for calendar year
11 2008. This will be my final presentation on this topic
12 before the March report.
13 Before I start, I just want to remind you that we
14 are discussing the care provided to about 320,000 dialysis
15 patients in the U.S. Most of these patients are covered by
16 Medicare. Thus, how Medicare pays for outpatient dialysis
17 services is relevant to their care.
18 Reviewing information about beneficiaries' access
19 to care. There was a net increase of 79 facilities between
20 2004 and 2005. There are about a total of 4,600 facilities
21 in the United States. The number of dialysis stations is
22 keeping pace with the growth of the patient population.

1 There is little change in the mix of patients providers
2 treat. For example, the demographic and clinical
3 characteristics of patients treated by freestanding
4 facilities did not change between 2004 and 2005.
5 With respect to facilities that closed, some of
6 what we found is intuitive. Facilities that close are more
7 likely to be smaller and less profitable than those that
8 remained in business. We see, however, that African-
9 American and dual eligibles are over represented in
10 facilities that closed compared to those that opened in
11 2005. However, the overall access appears to be good for
12 these two patient groups because facilities closures are
13 infrequent.
14 The draft chapter includes a strong statement that
15 we will keep monitoring patient characteristics for the
16 different provider types.
17 Moving on to the change in the volume of services,
18 first we see that the growth in the number of dialysis
19 treatments has kept pace with the growth in the patient
20 population. However, the use of drugs increased between
21 2004 and 2005 more slowly than in previous years. For
22 example, erythropoietin, which is the dominant drug of all

1 dialysis drugs, its dose per treatment remained about the
2 same between 2004 and 2005. By contrast, it increased by 7
3 percent between 2003 and 2004. These changes in drug use
4 are related to the MMA.
5 As mandated by the MMA, CMS lowered the drug
6 payment rate for most dialysis drugs beginning in 2005. At
7 the same time, the MMA shifted some of the excess drug
8 profits to the composite rate. So as the drug payment fell,
9 CMS increased the payment for the composite rate by about
10 8.7 percent through an add-on payment.
11 Reviewing information about dialysis quality, it
12 is improving for some measures, the proportion of patients
13 receiving adequate dialysis and patients with their anemia
14 under control. Between 2000 and 2004, the share of patients
15 receiving adequate dialysis increased by about 4 percentage
16 points, from 91 percent in 2000 to 95 percent to 2004.
17 The proportion of patients with their anemia under
18 control showed even more improvement, increasing by 9
19 percentage points between 2000 and 2004, from 74 percent to
20 83 percent of all patients.
21 At the same time, there has been concern raised
22 about the steadily rising erythropoietin dose per treatment.

1 This raises the concern about whether paying for drugs on a
2 per unit basis promotes efficient behavior from providers.
3 One policy option the Commission could think of evaluating
4 in the future is bundling drugs as an interim step until CMS
5 bundles both composite rate services and dialysis drugs,
6 labs, and other commonly used services. A dialysis drug
7 bundle might be one step towards addressing the potential
8 incentive for overuse.

9 One quality measure, nutritional status, has
10 showed little change over time. One strategy that Medicare
11 might consider is collecting information about patients'
12 nutritional status on hemodialysis claims. This type of
13 information could be used in Medicare's quality improvement
14 efforts. We don't collect this information for all patients
15 like we do for patients' anemia status and dialysis
16 adequacy.

17 CMS and researchers have shown how valuable this
18 information is to monitor care, to pay for care and to try
19 to improve care.

20 Looking at providers cost for composite rate
21 services and dialysis drugs between 2004 and 2005, the cost
22 per treatment fell by 5 percent. This decline is partly

1 related to the MMA reducing the payment rate for dialysis
2 drugs. As I just discussed, the MMA has slowed the increase
3 in the volume of drugs providers have furnished.
4 Here is the Medicare margin for both composite
5 rate services and dialysis drugs. It has increased since
6 2003. We project it to be 4.1 percent in 2007. Without the
7 auto-correction, we project it to be 1 percent in 2007.
8 There's a couple of points here to consider.
9 Drugs were still profitable in 2005 under Medicare's payment
10 policy, and that was average acquisition payment. Part of
11 the drug profit moved to the composite rate in 2005 and it
12 moved into the add-on payment. Costs for composite rate
13 services and drugs decreased between 2004 and 2005.
14 Providers received an update in 2005 and 2006 to the
15 composite rate and an update to the add-on payment in 2006
16 and 2007.
17 Finally, the 2007 margin projection also
18 incorporates the law just passed by Congress that increases
19 the composite rate by 1.6 percent beginning in April of
20 2007. For the first three months of 2007 the rate stays at
21 the 2006 level.
22 You can see here that the Medicare margin varies

1 by provider type. It was larger for the largest two chains,
2 the large dialysis organizations, than for everybody else.
3 This is partly due to the differences in drugs profitability
4 between these provider groups. Even after holding patient
5 case-mix constant, we find that the large dialysis
6 organizations have costs significantly lower than other
7 freestanding provider types.
8 So let's review our indicators of payment
9 adequacy. Most are positive. Our analysis of beneficiary
10 access is generally good, although we still continue to
11 monitor access to care for specific patient groups like
12 African-Americans and dual eligibles. Providers' capacity
13 is increasing, as evidenced by the growth in dialysis
14 stations. The volume of services, dialysis treatments and
15 dialysis drugs is increasing. Dialysis drugs at a lower
16 rate than in previous years but quality did not decline for
17 two key measures, dialysis adequacy and anemia status.
18 Providers appear to have sufficient access to
19 capital, as evidenced by the growth in the number of
20 facilities and access to private capital for both large and
21 small chains. Per unit cost growth declined between 2004
22 and 2005.

1 The second part of our update process is to
2 consider cost changes in the payment year we are making a
3 recommendation for, 2008. CMS's ESRD market basket projects
4 that input prices will increase by 2.5 percent in 2008. As
5 is the case with other provider groups, we consider the
6 Commission's policy goal to create incentives for
7 efficiency.
8 The draft recommendation is to update the
9 composite rate by the market basket less the adjustment for
10 productivity growth, that's 1.3 percent. So this
11 recommendation would increase the composite rate by 1.2
12 percent. There is no provision in current law for an
13 update.
14 So this would increase Medicare spending relative
15 to the current law: $50 million to $250 million for one
16 year and less than $1 billion over five years.
17 No effect on providers' ability to furnish care to
18 beneficiaries is expected.
19 The Commission could couple the update
20 recommendation with text in the chapter about implementing
21 pay for performance for dialysis providers. We recommended
22 a quality incentive program for facilities and physicians

1 who treat dialysis patients in 2004. Quality incentives are
2 feasible for facilities and physicians because accepted
3 measures are available, systems are in place to collect
4 data, data are available to risk adjust measures, and
5 providers can improve upon measures.
6
7 As a future topic, Commissioners could consider
8 evaluating alternative measures including dialysis adequacy,
9 anemia status, nutritional status, the use of home dialysis,
10 the use of recommended types of vascular access,
11 hospitalization rate, and mortality rate.
12 Underneath the recommendation, we can also include
13 text about distributional concerns concerning the current
14 payment method. We already have raised the first two items
15 in our June 2005 report, where we recommended that the
16 Congress combine the composite rate and the add-on payment
17 and eliminate differences in paying for composite rate
18 services between hospital and freestanding facilities.
19 We could also raise a concern about the MMA
20 requirement that CMS update the add-on payment based on the
21 growth in drug expenditures. Updating based on such an
22 approach is not consistent with the Commission's approach

1 for developing payment policy. And updating the add-on
2 payment would not be necessary if Medicare would bundle both
3 composite rate services and drugs together, which is, of
4 course, another Commission recommendation.
5 I look forward to your discussion.
6 MR. HACKBARTH: Questions? Comments?
7 DR. KANE: Why did Congress not have any update in
8 current law? Was that just random or was there some intent?
9
10 DR. MILLER: We can say it, we don't know.
11 MS. RAY: We don't know.
12 MR. HACKBARTH: This is an issue that Nancy-Ann
13 and I have often talk about. Nancy Kane asked about why
14 dialysis is different from other providers, where there is
15 an update included in current law.
16 MS. DePARLE: Mark, do you know? I don't know. I
17 remember being shocked when I found this out in 1997 or so.
18 I didn't know it and I don't know why.
19 MR. HACKBARTH: So understanding the origins is
20 beyond our ability. The question has come up in recent
21 years whether that ought to be changed and whether dialysis
22 ought to be given sort of a baseline update written into

1 current law. And that issue Nancy-Ann and I have discussed.
2 We've discussed at some Commission meetings, as I recall as
3 well.
4 My own view, for what it's worth, is that if
5 anything, what I'd went like to do is move all of the other
6 providers to the position that dialysis facilities are. In
7 fact, our basic approach to updates is each year you ought
8 to take a look at the adequacy of rates and not have built
9 into the baseline a hospital market basket or any other
10 particular number. You ought to start from zero. And they
11 ought to be treated equitably, but they ought to be treated
12 equitably in that way as opposed to moving dialysis into
13 what is, to me, a more problematic approach.
14 The good news, I suppose, from the perspective of
15 dialysis providers, has been that MedPAC has been pretty
16 consistent in recommending updates in the rates and we've
17 been one of their few allies in some years of advocating
18 update in rates when other people have been inclined to
19 freeze them.
20 So that's an inadequate answer to your question.
21 Others?
22 DR. CASTELLANOS: Just a comment on one of the

1 indicators for nutritional status. It's my understanding
2 that if you're in chronic renal failure but not on dialysis
3 they'll pay for a nutritional consult. But once you go on
4 dialysis, CMS doesn't pay for it. Maybe a more appropriate
5 thing would be to suggest that CMS also pay for nutritional
6 consults on patients on dialysis.
7 MS. RAY: You are correct, in the nutritional
8 counseling, that Medicare covers it before you're on
9 dialysis.
10 Part of the composite rate bundle, my
11 understanding, is the requirement for a dietitian and
12 dietary counseling of patients within the facility. Now
13 whether or not there should be even more could be a future
14 topic for the Commission.
15 MS. DePARLE: That was a point that I was going to
16 make because I think I said this last month too, or maybe
17 I'm just repeating from a prior month. But I think we have
18 made this point about the nutritional inadequacy and that
19 it's not getting better a number of times. I would like to
20 see us make a stronger recommendation on it. Maybe it's the
21 one that Ron suggests.
22 It just doesn't seem like it's getting better. I

1 think one of the reasons is the reimbursement.

2 MS. BURKE: I agree, but it would seem to me that
3 -- for someone who's in dialysis and the extent to which
4 we're paying a composite rate, a well-run facility who is
5 looking at the long-term needs of the patient ought to
6 incorporate that into essentially the basic services. So if
7 they're not doing it, rather than create an external payment
8 outside of that it would seem to me we ought to find a way
9 to put pressure on by saying you're not going to get an
10 update or something if you don't begin to address these
11 nutritional issues.

12 I'd keep it as part of it, because you don't want
13 to begin to break out payments again. The difference is if
14 you're in dialysis you're in an organized system of
15 delivery. If you're not, essentially if you're in renal
16 failure but not yet dialyzed, arguably you need that
17 additional sort of opportunity to purchase those services.
18 But I would strongly encourage us to find a way within the
19 composite rate to encourage facilities to do this.

20 MR. HACKBARTH: What I hear you saying, Sheila, is
21 that given that for years now we've been advocating more
22 bundling, not less, to recommend a separate additional

1 payment may not be strategically the right thing.

2 MS. BURKE: Particularly if we're assuming that a

3 well run facility ought to be providing a fairly --

4 DR. REISCHAUER: We've made a recommendation about

5 pay for performance here, and obviously that would be

6 component of performance. So in a way, if the

7 recommendation is followed, it's taken care of.

8 MS. DePARLE: I agree but I think we have to be

9 clear about what the composite rate covers when it comes to

10 nutritional supplements, et cetera.

11 MS. BURKE: It's dietary consultation and...

12 MS. RAY: It covers a dietitian and dietary

13 counseling. My understanding is it does not cover the oral

14 supplements, the oral drinks.

15 MS. DePARLE: So I'm not necessarily saying do a

16 separate add-on. That doesn't seem like the way to go. But

17 I do think it should be part of the composite rate.

18 MR. HACKBARTH: Others?

19 Okay. I guess we are ready to do our vote on

20 draft recommendation one.

21 All those opposed? In favor? Abstain?

22 Thank you.

1 MS. DePARLE: I feel like I've made this point
2 four years in a row. On the nutritional piece, we keep
3 complaining about it every year. But I do think -- we don't
4 have a recommendation yet again, and it just seems a little
5 like a broken record. If we think there's something that
6 can should be done, it seems to me we should be making a
7 recommendation.
8 I voted for the recommendation on the update
9 because I agree with it, but I'm a little uncomfortable in
10 continuing to make these same observations every year and
11 not say more.
12 Perhaps, Bob, you think it's just covered in our
13 pay for performance recommendations, but I don't think it
14 is.
15 DR. REISCHAUER: [off microphone] I'm saying
16 that's a mechanism to make sure it happens. If the
17 composite doesn't include appropriate resources for this
18 particular aspect, it should be beefed up so that's the
19 case.
20 MR. HACKBARTH: So what I hear is Nancy saying
21 that built into the initial composite rate was counseling on
22 diet but not included was payment for therapy for

1 nutritional issues. And you are advocating, as I understand
2 it Nancy-Ann, that we make some payment adjustment in the
3 facility rate to cover the added cost of therapy and not
4 just counseling?
5 MS. DePARLE: Yes. I would say that the composite
6 rate should be adjusted. This may be some of several ways
7 in which we think it should be adjusted. We've certainly
8 talked about others. But the composite rate should be
9 adjusted to cover those costs because we've raised this --
10 I've been on the Commission now four years I guess. This is
11 my fifth cycle. And we've raised it every year and yet we
12 don't ever make a recommendation about it and nothing seems
13 to happen.
14 MR. HACKBARTH: I apologize for that. I would be
15 reluctant just, without knowing what those costs are, to
16 vote on a recommendation right now but I will make the
17 commitment that we will have a specific recommendation next
18 year. We'll look at it and discuss it as a Commission and
19 decide what to do.
20 Any other questions or comments about dialysis?
21 MS. BURKE: Just following up on Nancy-Ann's point
22 for just a second. I wonder if there's something that ought

1 to be said -- I mean the text talks about the absence of the
2 nutritional supplement piece. It also references the anti-
3 kickback statute issues which will clearly quickly come into
4 play.
5 I wonder if there's anything that we ought to add
6 to the text in that section that talks about the Commission
7 remains concerned and would like to begin to collect the
8 information necessary to establish this for purposes of
9 establishing a pay for performance and incorporating this
10 into the rate.
11 Because one of the issues will be gathering the
12 information that allow us to figure out what is the
13 adjustment that needs to be made, how you link it so you
14 don't end up with everybody suddenly getting nutritional
15 supplements. But that it's linked to some quality
16 indicators that can be tracked, and that we put on and
17 clearly send the message we want the data collected, we want
18 to be able to do this.
19 That may be another further step to strengthen
20 this.
21 MR. HACKBARTH: I wouldn't have a problem with
22 that sort of discussion of the issue in the text.

1 Before we leave dialysis, I haven't really focused
2 on the language in that draft chapter but I'd like to make
3 sure that the language about bundling is strong and placed
4 at a very visible place in the chapter. I really do think
5 it's time to move ahead with a broader bundle for dialysis,
6 both for financial incentive reasons and for clinical
7 reasons. So I just want to underline that.
8 Thank you very much, Nancy
9 Next is the physician update analysis.
10 Cristina, I just forgot to mention that Karen
11 Borman did give me a comment here. She wanted to say that
12 she supports the recommendation of market basket minus
13 productivity for the update and that we urge Congress and
14 CMS to move ahead with bundling.
15 She also encourages us to investigate the issue of
16 other dialysis methods and why they haven't been more widely
17 used, home dialysis. So that's an interest of hers.
18 DR. MILLER: Actually, at lunch we were talking
19 about whether to go ahead and present the slide that you
20 have on how the payment system works and I said wait for it
21 come up on question. It came up on question during lunch,
22 so actually why don't you go ahead and work it right in.

1 MS. BOCCUTI: So I'll be flipping back and forth
2 in slides, so bear with me. I'll warn you when I'm doing
3 that.
4 But even before we get to what Mark just brought
5 up with the new law that just passed, I just want to answer
6 some questions from our good discussion last month that came
7 up. The first one I have here, Nancy-Ann, you asked about
8 comparing the CAHPS-MA, the health plan CAHPS, with our
9 beneficiary survey. It is, of course, more challenging than
10 it might appear. I talked with Carlos Zarabozo, and he's
11 looked into that and looked into the whole CAHPS-MA survey
12 quite in-depth.
13 He was telling me how it's challenging to compare
14 the two because the questions are different. We ask, in our
15 beneficiary survey, about finding a new specialist or a new
16 primary provider. But in the CAHPS survey they ask about
17 seeing one. It's enough of a difference, I think, in
18 substance to not be able to compare the two questions very
19 well.
20 But with that said, I will mention there is, as
21 you know, increased enrollment in MA. And as I mentioned,
22 there is no way in our survey to distinguish between

1 Medicare fee-for-service beneficiaries and those in MA, just
2 due to the restraints of getting a survey in time. You have
3 to ask a lot of questions.
4 To some degree, if MA enrollment is increasing,
5 then there are going to be more MA beneficiaries in the
6 survey. And when a beneficiary goes into an MA newly, they
7 have a higher likelihood of needing to encounter the
8 circumstance where they have to find a new physician due to
9 the plan having some sort of preferred provider constraint
10 or something like that.
11 So there is a possibility that an increase in MA
12 enrollment may be affecting what we picked up, which was at
13 least at that time of the survey somewhat of a dip in access
14 to specialists. That came from a good discussion with
15 Carlos. You could probably talk with him a little bit more
16 if you wanted to get into that.
17 Bob, you asked about comparing the CAHPS fee-for-
18 service, so that's a different survey but a lot of the same
19 questions, to our volume. So you said on the questions
20 about finding a specialist or getting an appointment how
21 does that compare to the number of services the
22 beneficiaries are actually getting?

1 It's not a straightforward one-to-one. The maps
2 don't look exactly the same. And GAO has looked at that
3 kind of question pretty carefully with maps than I drew
4 from.
5 In the areas where there is low use, like Montana
6 and Wyoming, Colorado, Minnesota, Iowa, they do tend to have
7 lower rates of reporting problems, getting an appointment,
8 seeing a specialist, et cetera. But it's not consistent.
9 You can't draw that line or that relationship across all of
10 the country. In fact, a lot of the areas that have low use
11 are pretty middle of the road in terms of reporting access
12 problems.
13 There was even areas with high use, like Florida
14 and Alabama, that don't have access problems. The
15 beneficiaries aren't reporting that. But in California, I
16 noticed that there is some high use areas that also have
17 high access concerns. And that's where you think oh, people
18 are using the services a lot and they can't get the
19 appointments. I think that's what we were sort of thinking
20 was happening but it's a lot more mixed.
21 Bill, you and Sheila and Karen were asking a bit
22 about the mammography, but you asked specifically about the

1 percent decline. Because if you recall, there were some
2 declines in quality measures for mammography.
3 I put this in the chapter but I'll just say it
4 just went down between 1 and 3 percentage points. I think I
5 said about one, so it depends on the measure.
6 But you also asked about whether those measures
7 were high to begin with, in which case the decline is just
8 more likely because if you're so high where do you have to
9 go? They are not that high. I think they were between 61
10 and 77 percent, depending on the measure. So I think two
11 out of the three don't even meet our two-thirds threshold on
12 what we would expect because these are measures that they
13 should really be doing. Consensus is built that these are
14 the things that are pretty much necessary care.
15 Ron, you mentioned about making sure that we
16 include not just in our workforce -- we had a small
17 discussion which was mostly about what we hoped to be able
18 to do, not just mentioning that the baby boomers are the
19 patients but they're also the physicians. So we made sure
20 that that was in there. And so there's a retirement issue
21 that might come up as well.
22 And then Jay, you asked about examining by region

1 the physician survey that we did. Unfortunately, while I do
2 have information about where the physicians are practicing,
3 the survey sample was not drawn to be regionally
4 representative. It's drawn to be nationally representative.
5 So we really can't draw conclusions based on specific areas
6 because the population doesn't support that.
7 And finally, Mitra, you asked about comparing --
8 we had a list on the physicians reporting that they were
9 very concerned about specific aspects. For example, the one
10 I think that came up was about reimbursement levels. You
11 had said -- because for some questions we looked at the type
12 of physician, proceduralists, non-proceduralists, and
13 surgeons, and how does that vary when you're looking at
14 reimbursement?
15 When you break that down, surgeons were the most
16 likely to say that they were extremely concerned,
17 proceduralists -- and those are like cardiologists,
18 ophthalmologists, and radiation oncologists, those were the
19 next most likely to say they were very concerned. Non-
20 proceduralists, like primary care providers, they were the
21 least likely to say that they were extremely concerned.
22 And note that these are not just Medicare. The

1 same rank order happens with private, non-HMO reimbursement
2 levels.
3 So It was all this side of the room, interesting.
4 So if there's any follow-up to that, I can
5 probably -- okay.
6 Now I'm going to continue on with the
7 presentation. The first thing I'm going to do is talk about
8 the recent law that just passed, the Tax Relief and Health
9 Care Act of 2006. Then I'm going to review indicators of
10 payment adequacy for physician services that I presented
11 previously. I'm going to go over the latest estimates of
12 cost changes expected in 2008. And then present the draft
13 recommendation for your review and discussion.
14 I'm going to discuss four provisions in the Tax
15 Relief and Health Care Act that relate specifically to
16 physician payment. The first provision has to do with the
17 conversion factor for 2007. Specifically, the law allows
18 the 5 percent cut imposed by the SGR to go into effect but
19 then offsets it with a 5 percent bonus outside of the SGR
20 formula. So this results in a 2007 conversion factor that
21 is the same that it was in 2006.
22 Note that this provision relates only to the

1 conversion factor, so payments for some services will
2 increase or decrease because of RVU changes that also go
3 into effect.

4 The second provision extends the floor to the work
5 GPCI through 2007. This floor was originally imposed by the
6 MMA and was set to expire at the end of 2006. It increases
7 the work GPCIs in low-cost areas, so it primarily affects
8 rural physicians, raising their work index to a floor of
9 1.0.

10 A third provision in the Act establishes the
11 opportunity for physicians to gain a 1.5 percent bonus on
12 all covered services they furnish between July 1st and
13 December 31st, 2007. To obtain this bonus, physicians must
14 report quality measures for 80 percent of the services for
15 which CMS will have established measures with some
16 adjustments based on the share of services the physician
17 provided that actually have measures. CMS will calculate
18 the bonuses from physician claims, sum them up, and pay
19 eligible professionals in one lump sum in 2008.

20 The fourth provision in the law establishes a fund
21 of $1.35 billion to be directed towards 2008 physician
22 payment. The allocation mechanism is at the Secretary's

1 discretion but it must be directed towards physician payment
2 or quality and it should be fully allocated in 2008, to the
3 extent possible.
4 I'm going to now go forward and show you a picture
5 of what I just said to illustrate how these all fit
6 together. So go back to the original, when I talked about
7 the conversion factor. When you look at the slide, these
8 red lines show the conversion factor before the act. So you
9 can see in 2006 about $38. In 2007, and you can see it
10 jumps down 5 percent, rounded, of course.
11 Then when you go to the next piece of legislation
12 that I mentioned, which is what I'll call the 2007
13 conversion factor bonus, that's where the SGR still goes
14 into effect technically, but on top of that there is a 5
15 percent bonus. That's the yellow dotted line. So it
16 effectively leaves the conversion factor for 2007 to be
17 equal or equating to what it was in 2006. So you can see
18 that bump up.
19 Then on top of that you see the blue 1.5 percent
20 increase. I put that on the 2007 because it refers to the
21 2007 services that they provided, and that's the quality
22 reporting bonus that they will get if they report the

1 measures adequately. They will get the money in 2008, but
2 it refers to the 2007 services.
3 What's not on here was the work GPCI information
4 but it complicates things to put that on here, so you'll
5 remember that.
6 So then if you're looking at 2008, you may be
7 hearing in media reports that there's a 10 percent decline
8 in 2008. Realize that it's a 10 percent decline if you're
9 taking it from what the conversion factor will be
10 effectively in 2007 or is, but it's a 5 percent because it's
11 simply adhering to the conversion factor that the SGR had
12 originally intended. So it's a 5 percent decline from the
13 year before if the conversion factor had stayed the same.
14 Am I explaining that okay? So that's that
15 demonstration of where that 10 percent that you may be
16 hearing comes from.
17 This gray dotted line is that fund, that $1.35
18 billion fund, that is not as yet allocated in the sense of
19 its determined where it's going to be and how it's going to
20 be allocated. But it's there in 2008, so I put it in the
21 slide. But it's not going to be part of the scoring of an
22 update unless the Secretary determines that it will be part

1 of that.

2 And then this has it all together.

3 MR. HACKBARTH: What might be helpful is to

4 explain why this approach of allowing the SGR to technically

5 take effect and then having a separate payment to offset it,

6 why that approach was used.

7 MS. BOCCUTI: Let me go back to the final tally of

8 all that and that might come into play here. This is the

9 spending and financing of it.

10 So one of the reasons the SGR is still in effect,

11 I'm not going to really postulate to the reasons, but the

12 effect of keeping the SGR cut essentially in place is that

13 you are finally pulling out of that cumulative hole.

14 Whereas, if you delayed the SGR from being implemented, then

15 you increase the cumulative hole. So here you're finally

16 eating away at the hole but you're pulling in new money.

17 You're pulling in new money from the SMI Part B Trust Fund

18 to pay for that bonus. So instead of being able to score it

19 like it's going to be repaid within 10 years, that's no

20 longer the case with this provision.

21 You can see on the slide it costs out. This is

22 from CBO scores -- the different provisions.

1 DR. MILLER: Just a slightly different way of
2 saying that is if you do this you can give an update, for
3 example in 2007, but it doesn't extend the length of time
4 that negative updates are assumed into the baseline. You
5 said that, but that's just a different way to think about
6 it.
7 MS. BURKE: Cristina, just so I understand the
8 reference to the term new money, this is money coming out of
9 the existing SMI Trust Fund, so it is simply a further draw
10 down of the Trust Fund which will translate into what
11 percentage of the program is now going to be funded out of
12 the Trust Fund? It's a plus to the Trust Fund draw down.
13 Not new money, it's simply out of --
14 MS. BOCCUTI: Right, the money that is in the
15 trust fund so it draws that trust fund down.
16 To say what share it is of the Trust fund, I would
17 first like to Rachel.
18 DR. REISCHAUER: But the Trust Fund consists of
19 money transferred from general revenues and premiums
20 contributed by beneficiaries, so this is an example of
21 Doug's Congress will have to face the pain; right?
22 MS. DePARLE: Here they did, in a way. They took

1 $5 billion or whatever the number was.

2 MS. BURKE: The reason I want to understand it is

3 what impact does it have on the premium?

4 MS. BOCCUTI: It will increase the premium, but

5 not in 2007, not until 2008, but they have determined --

6 MS. BURKE: It will be calculated on the basis of

7 the 2007 cost, so it will translate into the 2007 rate

8 increase.

9 MS. BOCCUTI: Into the 2008 rate.

10 MS. BURKE: Into the 2008 rather, it will be

11 calculated for the premium increase.

12 MS. BOCCUTI: Right. They determined that in 2007

13 it's been set already.

14 MR. HACKBARTH: So you said at the outset this

15 doesn't contribute to the hole actually in budget

16 accounting. Because you allow the 5 percent cut to occur,

17 you're actually climbing out of the hole. But that assumes

18 that then next year that you go to the conversion factor,

19 which is 10 percent below the current prevailing rates. If

20 you don't do that, then you jump back down into the bottom

21 of the hole again; right?

22 MS. BOCCUTI: Yes.

1 MR. HACKBARTH: Okay, having sorted that out,
2 let's move on to the rest of the presentation.
3 DR. MILLER: Actually, just one clarification.
4 DR. HOLTZ-EAKIN: Must the Secretary spend all
5 $3.5 billion in 2008?
6 MS. BOCCUTI: The Secretary is directed to spend,
7 to the extent possible, all the money in 2008. But the
8 extent possible, or feasible is the word that they said.
9 DR. REISCHAUER: It's an election year.
10 MS. BOCCUTI: So CBO scored it so they spent about
11 90 percent of it in 2008 and there is other language to say
12 that they have to do an actuarial projection to make sure
13 that they're not going to spend more than that.
14 MS. BURKE: But that's also funded by Part B?
15 MS. BOCCUTI: Correct, it's funded by Part B,
16 which is 25 percent beneficiary premiums and 75 percent
17 general revenue.
18 DR. MILLER: The only reason you were using
19 language new money is in a sense it's not SGR money. It's
20 different money from the Part B Trust Fund, is sort of what
21 we're trying to stumble around and say here.
22 MR. HACKBARTH: I think we've dwelled on this long

1 enough.

2 MS. BOCCUTI: It's important. It's new

3 information and they were doing this while we were meeting

4 last time.

5 MR. HACKBARTH: And actually, I thought you did a

6 very good job of explaining it.

7 MS. BOCCUTI: Thank you

8 Now I'm going to review what we talked about last

9 month, so a lot of this information won't be new.

10 We started with the physician survey MedPAC

11 sponsored. As you may recall from our last meeting, our

12 survey found that the majority of physicians, or 96 percent

13 of them, accept at least some new Medicare fee-for-service

14 patients and 80 percent accept either all or most.

15 Acceptance of new Medicare fee-for-service

16 patients compares very favorably to Medicaid and HMO

17 patients but it's a little lower than for private non-HMO

18 patients.

19 For comparison, I want to mention that these

20 numbers are very similar to two other national surveys,

21 namely the NAMCS and the HSC physician surveys, both of

22 which however only go through 2005.

1 Regarding referral difficulty, physicians more
2 frequently reported a little more difficulty referring
3 Medicare fee-for-service patients than private non-HMO
4 patients, 7 and 3 percent respectively. But referring HMO
5 or Medicaid patients appeared more difficult than Medicare
6 fee-for-service.
7 On our survey many physicians reported recent
8 changes to their practice to increase revenue or streamline
9 costs. Specifically, they've increased the number of
10 patients they see, expanded in-office testing and imaging,
11 and changed the mix of personnel that they have in their
12 practice.
13 Our survey also asks physicians about the factors
14 that affect their individual compensation. Most, about 80
15 percent, reported that their own productivity, which is
16 typically measured by their service volume and even RVUs,
17 was a very important determinant of compensation. Other
18 factors, including patient satisfaction, quality measures,
19 and resource use, were considerably less likely to be as
20 important to their compensation.
21 These findings are generally consistent with those
22 reported by HSC last week in an issue brief, but HSC's

1 survey was conducted in 2004 and 2005, so it's little bit
2 older.
3 Turning to the beneficiary surveys, taken from
4 several of the studies, one of which is ours, most
5 beneficiaries report small or no problems scheduling
6 appointments and finding physicians. Finding new
7 specialists continues to be easier than primary care
8 physicians, but we're monitoring a recent rise in reported
9 problems accessing specialists. Transitioning
10 beneficiaries, such as those who have recently moved to an
11 area or switched to Medicare fee-for-service, are more
12 likely to experience problems finding a new physician,
13 especially in some markets. And Medicare beneficiaries
14 report similar access to physicians as do privately insured
15 individuals age 50 to 64.
16 Quickly, I'll review the other indicators that
17 you've seen before, and all of these come from claims
18 analyses. We found that the number of physicians billing
19 Medicare has kept pace with Medicare enrollment. This held
20 true even when we separated physicians by the size of their
21 Medicare caseload. Also, participation and assignment rates
22 remain high.

1 We also found that the difference between Medicare
2 and private fees, averaged across all types of services and
3 areas, has steadied over the last several years. Previous
4 research by HSC has found that in areas where Medicare fees
5 are closer to private fees beneficiary access is not
6 measurably better than in areas where the fee differential
7 is greater. This suggests that other factors, such as local
8 health system developments, may influence beneficiary access
9 as much or more than Medicare payment levels.
10 We saw continued growth in the use of physician
11 services per beneficiary. Across all services per capita
12 volume grew about 5.5 percent between 2004 and 2005. As in
13 previous years, imaging grew the most, it grew about 8.7
14 percent, but the category of non-major procedures was close
15 behind. E&M and major procedures did not grow as quickly.
16 We looked at quality care measures for ambulatory
17 care, focusing on two general measures: ones that captured
18 the use of clinically necessary services and ones that
19 captured rates of potentially avoidable hospitalizations.
20 We found that on most of these indicators rates were either
21 stable or improved from 2003.
22 In sum, our adequacy analysis from available data

1 suggests that beneficiaries are able to access physician
2 services.
3 Now for the second part of our update framework,
4 changes in costs for 2008. The latest forecast for input
5 price inflation is an increase of 3 percent. These
6 forecasts are revised quarterly so this number was revised
7 downward by three-tenths of a percentage point since I show
8 them to you last month. The other factor that we considered
9 in our input cost analysis is productivity growth. Our
10 analysis of trends in multifactor productivity suggests a
11 goal of 1.3 percent.
12 The SGR allows for price changes by incorporating
13 the MEI into the formula, as you know. But for the update,
14 CMS uses historic rather than projected MEIs. So the MEI
15 that they use in their update for 2007 was 2.0.
16 So here is the draft recommendation for you to
17 review. The Congress should update payments for physician
18 services by the projected change in input prices less
19 expected productivity for 2008.
20 Spending implications, they would increase
21 Medicare spending by greater than $2 billion in one year and
22 greater than $10 billion in five years. These numbers

1 reflect a comparison to current law, which continues to call
2 for a cut in 2008 which would lead to cumulative impacts if
3 that cut were averted.
4 In terms of beneficiary and provider implications,
5 this recommendation would increase beneficiary cost sharing
6 and would help maintain current supply of and access to
7 physicians.
8 I have a couple of more slides here. These are
9 additional comments to include in the chapter following the
10 recommendation.
11 The first point is that rapid volume increases for
12 some services may signal that Medicare's payment for those
13 services is too high relative to the cost of furnishing
14 them, if physicians or their staff are able to perform them
15 considerably more quickly than they did when these services
16 were first introduced. Consequently, physicians can
17 increase their volume of these procedures with little change
18 in the number of hours they work, making them more
19 profitable and creating financial incentives for physicians
20 to furnish them over services that may be less profitable.
21 On the slide I mention work RVUs but other parts
22 of the RVUs, like the practice expense, could also be a

1 factor. Staff are examining this issue as well. So in
2 general, if you dig into the RVUs, you'll see several
3 reasons why services have differential profit levels that
4 could be affecting their provision.
5 So beneficiary access to less profitable services
6 and the professionals who furnish them may be threatened if
7 providers avoid furnishing them relative to more profitable
8 services.
9 So in the future, the Secretary could play a lead
10 role in identifying and correcting such misvalued services
11 by conducting analyses that calculate changes in the
12 productivity of individual services. Such analyses could
13 begin by examining specialties that show rapid volume
14 increases per physician over a given time period. Volume
15 calculations would need to take into account changes in the
16 number of physicians furnishing the service to Medicare
17 beneficiaries and the hours those physicians worked.
18 Despite the additional funds provided for
19 physician services in 2008 through the recent legislation we
20 just discussed, the Commission is concerned -- and I'm going
21 on to the second bullet -- that future consecutive annual
22 cuts would threaten beneficiary access to physician

1 services, particularly primary care services.

2 Finally, we reference the SGR report in

3 reiterating that ideally Medicare's physician payment system

4 would include incentives for physicians to provide better

5 quality of care, coordinate care across settings and medical

6 conditions, and use resources judiciously.

7 Thank you.

8 MR. HACKBARTH: Comments?

9 DR. HOLTZ-EAKIN: Cristina, I have a question.

10 When you said the bottom line on the spending implications,

11 if you go back to that last graph you showed.

12 You have the gray area. Is your spending

13 implication from the top of a gray area, $2 billion on top

14 of that? Or is it from the red bar for 2008.

15 MS. BOCCUTI: Spending implication of the

16 recommendation?

17 DR. HOLTZ-EAKIN: Yes, for 2008.

18 MS. BOCCUTI: We're doing for 2008. It compares

19 it to the red line.

20 DR. HOLTZ-EAKIN: But we also know they're going

21 to get another $1.3 billion.

22 MS. BOCCUTI: Right, we don't know how, at all,

1 that will be allocated.

2 DR. HOLTZ-EAKIN: So my question is does the

3 Commission think that matters?

4 MR. HACKBARTH: Matters in terms of the update

5 recommendation.

6 DR. CROSSON: I really liked the question and

7 answer thing as we started out. So I thought maybe I would

8 kick off this side of the table with another series.

9 If you could go to slide eight for a second, and

10 go back to the physician survey again. Those issues that

11 physicians considered very determinations of compensation.

12 In the text, because I just looked back over it, you talk

13 about that difference between the productivity and the other

14 three elements as a function of payment methodology in the

15 sense that physicians who were prepaid tended to identify

16 the three at the bottom more frequently.

17 Is there also enough data to look at that from a

18 structural point of view? In other words, is there a

19 relationship between those three and the structural form of

20 practice that the physicians are in, or not?

21 MS. BOCCUTI: Structural meaning like the size of

22 their groups?

1 DR. CROSSON: The size of their groups.

2 MS. BOCCUTI: We do have some of that information
3 on group size but a lot didn't answer that question. So
4 whether their level of capitation in their revenues is what
5 I discussed in the chapter. But I'll look back and see --
6 we asked some more questions about their group, but I'm less
7 confident that we can make a distinguishing remark.

8 DR. CROSSON: Would capitation also include being
9 paid by salary in the way you're using that term?

10 MS. BOCCUTI: No, it's about the revenue of the
11 office. The individual compensation is a different kind of
12 question.

13 DR. CROSSON: Of the office?

14 MS. BOCCUTI: The revenue coming into the office.

15 DR. CASTELLANOS: Just some observations. Just on
16 this slide, I think this supports what Nick was saying this
17 morning on the top part. You'll see that 50 percent of the
18 doctors in this survey brought things into their office to
19 increase their revenue.

20 And this is what's happening in the real world.
21 I'm a practicing physician. I'm a small businessman. When
22 I lose money on something, I have to look for other avenues

1 of income, not different from any other business.

2 You're saying this, and this is really what's

3 happening in the real world. I'm surprised it's just 50

4 percent.

5 Can we go to the slide just before that, slide

6 seven? I made this comment last time. What really bothers

7 me on this whole slide is something that we don't deal with.

8 It's called Medicaid. As you can see that, I have a hard

9 time -- we're the only group of urologists in my area, in

10 the five county area, that accepts that program. We do it

11 really for a social basis. We certainly don't do it

12 economically. But this is what's happening in the real

13 world.

14 Physicians are not dealing with patients always

15 from an altruistic viewpoint. Sometimes you have to look at

16 it from an economical viewpoint. This is just a reality of

17 life and I just wanted to mention that.

18 I guess the real issue that I wanted to bring up

19 and hopefully we can also discuss this at the retreat, is I

20 don't understand productivity as it applies to a physician.

21 I really don't understand that and I would like that not to

22 be brought up now but perhaps we can discuss that in detail

1 at one of our sessions next year.

2 DR. WOLTER: I was going to make the same

3 observation. There certainly would be some evidence in the

4 survey of some of the issues that we talked about this

5 morning. One could argue that these kind of innovations, if

6 you want to use the word, into the office practice would

7 occur anyway, although I suspect that this sense of looming

8 cuts certainly is a driver of motivation to some degree.

9 And it wouldn't show up in the survey, of course,

10 but I would add that really the rapid expansion of

11 hospital/physician joint ventures is another part of what's

12 going on here that we really haven't talked about very much.

13 I wanted to mention also, just to reiterate

14 something from this morning, there may be some need to think

15 about investing more in some aspects of physician

16 reimbursement. I don't know where that fits into our

17 conversation, not in the overall update I'm sure. But if

18 you were to look at the need to have better chronic disease

19 management or some of the medical home ideas, are we going

20 to have enough internists to help manage care in a more

21 coordinated way in the future, these are some issues that

22 are worthy of discussion although they aren't necessarily

1 part of this update discussion.

2 I'd like to just bring up again, because I'm so

3 very, very worried about it, I think that the mixing up of

4 measures for every physician specialty with the update is

5 taking us in a dangerous direction. I think you summarized

6 it very well this morning, Glenn, we're kind of at a rate-

7 limiting point in where pay-for-performance can go because

8 we're struggling with how to apply it to physicians because

9 it is so much more difficult with so many of them, so many

10 different specialties, lack of infrastructure.

11 In my view, even the IOM report if I'm

12 remembering, Bob, that you were just part of, recommended

13 being voluntary for a while with physicians because of some

14 of these issues. And yet we're now kind of headed in a

15 different track, which I am afraid could derail pay for

16 performance if it goes badly.

17 So if we could start thinking about some

18 recommendations that would create some focus in the early

19 years on pay for performance and making sure there's synergy

20 between some of the physician reporting and hospital

21 reporting, which would mean it might be more limited to

22 which physicians we start with, but it could really create a

1 lot of value. I think it could have a higher chance of
2 success and it could help us deal with some of the low
3 hanging fruit in these early years.
4 But we're kind of in, I would say, a dangerous
5 time in the development of pay for performance because the
6 mindset is we need to have a measure for every doctor in
7 order for us to do payment. And that's probably going to
8 get us in really big trouble.
9 MR. DURENBERGER: My question has already been
10 brought up by Ron and it deals with productivity. I bring
11 this up periodically because we seem to talk about it as
12 efficiency and things like that.
13 But when I think I first expressed it was in the
14 early days of prospective payment system, and I'm quite sure
15 what is ophthalmic surgery, when the technology began to
16 reduce the time and a lot of other factors, prices came
17 down. And I never knew exactly who figured out how the
18 prices came down to what.
19 So one of my questions is do we already have built
20 into the system -- and I'm trying to get at least three
21 questions from this side for next time, as opposed to only
22 two over there.

1 But do we already have built into the CMS system a
2 way in which to accomplish some of the things that are on
3 page 25 of the paper, I think alluded to it?
4 But the second one, as related to that, came to me
5 reading a little interview in the New York Times last week
6 of Clay Christensen, who is the Tipping Point guy. And he's
7 talking about productivity, and he uses several examples,
8 including Permanente and so forth. But in a more specific
9 example is like MinuteClinic, which originated in Minnesota
10 and eventually got sold for $270 billion to somebody, simply
11 because they identified eight procedures that used to be
12 done in some primary care physicians' office at X number of
13 dollars, which could be done for $38 each if you had the Cub
14 Food stores or Safeway or whatever your local grocery store,
15 cum pharmacy, happens to be.
16 It suggested to me that people like Christensen
17 and others will be raising on our screen generally, and you
18 can see it in communities in which many of us operate, the
19 opportunities for taking a lot of the things that are being
20 done, whether it's on the technology side, the technology
21 intensive side like I referred to earlier and we referred to
22 here, or it's on the primary care side, and say if it's

1 access, if it's affordability and so forth that you're
2 looking for, how long do we have to wait for the physician
3 community itself to create a more productive way of
4 delivering services? Or do we have to continue to create
5 the MinuteClinics or the so-called disruptive technologies
6 in order to get it done?

7 So I want to just add that dimension to the
8 analysis of productivity because it's such an important part
9 of how much of our money should we be spending via Part B on
10 physician spending.

11 MS. BOCCUTI: In response to your first question
12 about the process for seeing what is being done more quickly
13 now than it used to be --

14 MR. DURENBERGER: Can't it wait until next time?

15 MS. BOCCUTI: Okay, Dave, you asked about...

16 Recall the RUC process. Now that's every five
17 years. What we discussed to include in the chapter this
18 year around the recommendation is for the Secretary to
19 perhaps take more of a lead on identifying these services
20 that can be done quicker now or less expensively because of
21 equipment and supply issues. If the Secretary could take a
22 lead role in identifying and perhaps potentially

1 automatically correcting these efficiency gains that are
2 learned over time, then maybe we could move forward more
3 quickly.
4 But the process that's currently in place, and
5 that's just for the work, is the RUC Committee. And there's
6 other PE examinations, but they're slower.
7 So I think you're exactly bringing up what we're
8 bringing up in the chapter, too.
9 And then the MinuteClinic, yes, I see the
10 connection that you're making. I think also, with the
11 MinuteClinic, I read that article, too. And I note that it
12 was bounded by state policy issues about whether nurses
13 could write prescriptions or not. But also those were
14 specifically ones that don't need follow-up, so it's not as
15 applicable to Medicare patients. These were strep throat
16 and those kind of things. Pediatrics, I think, where a high
17 component of the MinuteClinic. But your point is well taken
18 and perhaps you all want to comment on that.
19 MS. BURKE: Cristina, could I just do a follow-up
20 question to Dave's question?
21 Remind me. We had a very lengthy discussion as I
22 recall, and I've now forgotten the time frame, around the

1 RUC process and a whole discussion around what occurred,
2 what got on the table, how it on the table.
3 The reference in the chapter is relatively brief,
4 just that the Secretary ought to be more active in
5 identifying things.
6 I wonder if there's any value in reflecting back
7 on that conversation. There were concerns about what was
8 brought up, the frequency with which those items that were
9 identified were ones where there was an uptick not an
10 adjustment, that the predominant -- as I recall, I don't
11 remember the number, but the large majority of issues that
12 were raised were all about how we had to increase rather
13 than decrease the modifiers to these particular diagnoses or
14 these particular categories of activities.
15 And I wonder if there's any value in adding to
16 that section of the chapter a little more substance to our
17 concern about the need to evaluate and become much more
18 aggressive in evaluating what it is that goes on the table,
19 what gets evaluated, who sets the agenda and, again
20 reflecting back on that earlier conversation, I just don't
21 recall -- I think it was earlier this year or last year,
22 rather.

1 MS. BOCCUTI: I think I cross-reference it in the
2 chapter but I can easily add a more full discussion, drawing
3 directly from what we punished before.
4 MS. BURKE: Great.
5 MR. HACKBARTH: I was going to pick up on that
6 point on Karen Borman's behalf. Karen had several comments
7 that she wanted me to offer and one of them does pertain to
8 this issue.
9 Point number one is that Karen is concerned about
10 the overall RBRVS system. In fact, the way she put it was
11 that she would like to sign on with some of Bill Scanlon's
12 previous comments about RBRVS requiring some investment, and
13 maybe some fundamental rethinking. Karen's way of putting
14 it was that conceptually we have this system that is
15 designed to base our unit payments on the inputs that go
16 into producing the service, whether it's physician work or
17 practice expense or professional liability and that is
18 legitimate as far as it goes.
19 But she said from her perspective there are other
20 factors that also ought to be included in setting a proper
21 price for services. One would be the value of the service,
22 and the second would be to assure adequate supply of the

1 service. In a competitive marketplace it's not necessarily
2 just looking at the input costs but ultimately generating
3 sufficient supply in order to meet legitimate needs for
4 valued services.
5 So she's got some deep reservations about the
6 basic conceptual structure that all we ought to be doing is
7 looking at input costs in setting physician fees.
8 She also said that she would like to associate
9 herself with Nick's comments about pay for performance for
10 physicians. She shares Nick's concern that we're just sort
11 of running off in all directions with an unfocused approach
12 that is not likely to be productive and could be very
13 expensive for physicians and CMS to do and the combination
14 of those two things just create on a lot of disillusionment
15 with pay for performance and set it back, as opposed to
16 advance it.
17 A third comment that she had was she wanted to
18 remind people that for at least some services the current
19 payment levels, she said, are at or below 1989 levels for
20 those particular services. And maybe that was by design in
21 some cases, that was part of the rethinking done with RBRVS,
22 that the old charge structure led to inappropriately high

1 payments for some services. But she said she thinks that
2 people sometimes lose sight of the fact of how dramatic the
3 payment changes have been in unit prices and that some of
4 these are very low compared to where they used to be.
5 So those are Karen's comments. Let me just sort
6 of add a little bit to one of those.
7 I wanted to touch on this productivity issue for a
8 second, that Cristina talked about, and the idea that the
9 unit prices ought to be adjusted based on an assessment of
10 improved productivity which may not be equal across all
11 physician services and may be greater in some than in
12 others.
13 There's a lot about that concept that needs to be
14 thought through, worked out, to make it an operational idea.
15 I like the idea of including some reference to it, for this
16 reason.
17 One of the SGR options that we were asked to look
18 at was to have a formulaic system that adjusted rates by
19 type of service. So the rapidly growing stuff would be
20 squeezed more than the slow-growing stuff. I understand the
21 motivation for that, one of them being a concern about
22 primary care being squeezed along with, say imaging.

1 I think that there are a number of different ways
2 that you might get at that issue. One is a big formulaic
3 system, SGR-like system. But another is an ongoing review
4 of the relative values of the sort that Cristina described.
5 So my goal in putting that in this chapter is to
6 basically create a placeholder and say if that is your
7 policy concern SGR isn't the only available mechanism to get
8 there. There may be other tools that we can develop for the
9 annual update process and the updating of the RVUs that also
10 address that problem.
11 DR. KANE: I just had a question about the $1.35
12 billion that Congress has set aside for 2008-2008, somewhere
13 in there. Will we have a chance to talk about how we'd like
14 to spend that? Or is that going to -- how is that process
15 going to work out? Because that could be an opportunity to
16 pay for care coordination or get started on some of the pay
17 for performance. Are we going to have a chance to talk
18 about that?
19 MR. HACKBARTH: That goes back to Doug's question
20 earlier. One way to look at it is well, this is another
21 $1.35 billion to be spent in 2008. Maybe that ought to
22 affect the update recommendation for 2008. It supplements

1 the pool of dollars available.

2 Another way to think about it is the way that you

3 described, that maybe it ought to be thought of separately

4 from the update but we ought to think about how it ought to

5 be distributed. Those questions are on the table.

6 DR. REISCHAUER: Remember, we're putting 1.5

7 percentage points out there to reward quality in 2007 that

8 disappears. And we've created an appetite. So already

9 there is, in a sense, a use for this resource if you think

10 that initiative has had a positive impact.

11 DR. HOLTZ-EAKIN: But there's no guarantee that's

12 where it's going to go.

13 DR. REISCHAUER: I know there isn't. I'm not

14 saying that we shouldn't speak about it. But we shouldn't

15 speak about it as if there are no legitimate claims if we

16 think the 1.5 percent is a legitimate claim in 2007.

17 DR. SCANLON: I have a question. Is our update

18 applying to a conversion factor for 2008 that is 10 percent

19 less than the conversion factor in 2006?

20 MR. HACKBARTH: I was afraid you would ask that.

21 Logically, that would be the prevailing conversion

22 factor which, to me, might put this in a whole different

1 light. If, in fact, rates were cut by 10 percent, then MEI
2 minus productivity might no longer be the right number.
3 Which is why I was afraid you would ask that.
4 Personally, I doubt that's going to happen, but
5 technically that would be the base from which you're
6 working.
7 MS. BURKE: In that context, Glenn, perhaps -- I
8 mean, one could argue it probably won't happen. But whether
9 or not we ought to put in some language, some caveat, that
10 suggest we make this recommendation on the assumption that -
11 - or something that suggests that if, in fact, we're that
12 much farther in the hole it's a whole different
13 conversation, arguably.
14 MR. HACKBARTH: I suppose we could do that in the
15 context of the discussion that Cristina referred to, our
16 historic concern has been that dramatic cuts in physician
17 payment could ultimately affect access to care and it might
18 fall disproportionately on some types of physicians. So we
19 could align it with that point and say that the basis for
20 this discussion assumes that there is not going to be a 10
21 percent cut in 2008, and if there were...
22 DR. HOLTZ-EAKIN: Can I suggest that at least to

1 me it makes sense to have a different formulation, which is
2 this recommendation is based on the notion that we have
3 adequate access to care, quality of care, that the metrics
4 that went into this recommendation were not dollar jump off
5 points or anything that has to do with a dollar value for
6 the conversion. It has to do with the quality of the
7 beneficiaries' treatment in the program. And that that has
8 to be assured -- not any dollar figure -- in order for the
9 recommendation to be executed as written three
10 I don't want to write something that says if you
11 do 10 percent then we can't make this recommendation. If
12 you tell me that access is as we envisioned when we made the
13 recommendation, quality is as we envisioned when we made the
14 recommendation, then yes, go ahead, no matter what the
15 particular numbers are. But those are two very different
16 things.
17 MR. HACKBARTH: I understand the distinction
18 you're making, but then it means that we need to speculate
19 on whether, in fact, access would be the same after a 10
20 percent cut as it is today. I wouldn't want to speculate on
21 that.
22 So what we can say is that our existing --

1 DR. HOLTZ-EAKIN: I don't think so. I think we're
2 just saying these are the conditions under which we made the
3 recommendations; right?
4 MR. HACKBARTH: And access is adequate at a
5 conversion factor of 38, but not 10 percent lower.
6 DR. HOLTZ-EAKIN: We don't know that.
7 MS. BURKE: That's what we're doing it on, today.
8 MR. HACKBARTH: Just follow your own logic.
9 DR. HOLTZ-EAKIN: We don't know what it would be
10 at 10 percent lower. We didn't go to check. That's my
11 point.
12 MR. HACKBARTH: There's literally no way of
13 knowing.
14 DR. HOLTZ-EAKIN: Right, but we don't know what
15 they're going to do, either. So I don't understand why
16 we're going to speculate on access and not speculate on what
17 they'll do. Just give the conditions for the
18 recommendation.
19 MS. BURKE: I think those are the conditions, as
20 we know them today. They could change, in which case we'd
21 want to revisit it. I agree with you, you don't want to
22 presume it would not stay the same or stay the same, but

1 we're making it on the basis of certain understandings
2 today.
3 DR. HOLTZ-EAKIN: So can I ask a different
4 question, which is is our recommendation inclusive or
5 exclusive of the $1.35 billion? If the money is there, the
6 money will be spent.
7 DR. MILLER: Just to be clear from a technical
8 point of view, all of this was going on when we were talking
9 about it.
10 DR. HOLTZ-EAKIN: I understand.
11 DR. MILLER: So the answer to your question,
12 technically and directly, is that it was exclusive. It
13 assumes that the second step in her minus five chart is
14 going into place. And to the exchange that you're having
15 now, we're always in this very situation that you describe,
16 which we are describing the environment as it exists on the
17 day that we put the surveys out to ask about access and did
18 the data analysis, et cetera, et cetera. And so that's the
19 situation that we're in.
20 So I think the question that you've put on the
21 table is one of two things, and there may be a middle ground
22 for everybody to gravitate to. I'm not 100 percent sure.

1 But if we assumed it was really the minus five and
2 it's actually not quite minus five, there's another $1.3
3 billion there that we didn't taken into account, you are in
4 part asking should we have a different recommendation than
5 the one that we've currently put on the table, market basket
6 minus productivity.
7 Or alternatively we could say the recommendation
8 is based on the baseline path and the information that we
9 currently have, which is how it was constructed. And we now
10 are aware of this new pot of money. And this is where some
11 people seem to be headed.
12 And if you have feelings about how that money
13 should be, it shouldn't necessarily be across the board to
14 every physician -- and I suspect there's probably a lot of
15 people who feel that way -- then maybe we should say
16 something in the text about what we think at least
17 directionally ought to happen to those dollars.
18 Is that too far out of line? That's what I sort
19 of felt like people were beginning to --
20 MS. BURKE: I would argue -- I think I understand
21 where Doug might be headed. Or where Doug is not headed.
22 We don't know how the $1.3 billion will be spent.

1 I think to make a recommendation on an adjustment assuming
2 how that would be spent would not be wise. I think to make
3 a comment on how we might hope they would think about
4 spending the money I think would be consistent with at least
5 some of what I'm hearing, which is that you might do for
6 some kind of quality related -- if you're going to spend it,
7 here's ways to do it.
8 But I think to make a recommendation on an update
9 based on all of a sudden there's a new $1.3 billion, I think
10 could quickly turn on us if, in fact, the $1.3 billion all
11 goes to something that is unrelated to payment updates. We
12 will have, I think, avoided the responsibility we have to
13 make a recommendation specifically relating to the update.
14 But we could certainly say if you're going to
15 spend $1.3 billion, here's things you ought to think about
16 spending it for, quality or reporting or whatever it happens
17 to be.
18 DR. KANE: When will we have a chance to talk
19 about the $1.3 billion, if not now? That's sort of what I
20 originally thought I was asking. Is this the time to talk
21 about it, or is another opportunity to get a shot at it
22 where we actually get a chance to think about it and then

1 make a recommendation? I just couldn't tell where in the
2 cycle we got a chance to say something else.
3 DR. SCANLON: I'll start by apologizing for
4 raising the minus 10 percent.
5 But let me say I think we're not in the business
6 here of writing the mathematical formula for increasing
7 payment rates. What this recommendation does is expresses a
8 sentiment. And the sentiment is that we really think that
9 physician prices in 2008 should be roughly kept in line in
10 real terms by taking into account inflation. And that
11 because I think that maybe prices are overvalued or because
12 there are productivity gains that are possible, we'd like to
13 make a deduction from that.
14 If the Congress takes this recommendation as it's
15 written, there is a lot of latitude in terms of what it
16 actually does. It can consider the $1.3 billion and think
17 about changing -- they have to write the mathematical
18 formula. They can change that mathematical formula so that
19 the combination of the $1.3 billion and what they do in 2007
20 gets them to this point.
21 I'm fully supportive of this, but it's a
22 sentiment. It's not a formula, in my mind. Because we

1 can't sort all of this out. There's chaos in terms of these
2 conversion rates as they move over time. And we would be
3 speculating, we would be creating all kinds of contingencies
4 like we mean this if...
5 And I think that's not a good use of our time.
6 DR. HOLTZ-EAKIN: Bill, would this be consistent
7 with that sentiment? I'm just trying to figure this out.
8 The Congress should update payments for physician services
9 inclusive of the physician fund by the projected change in
10 input prices less expected productivity. Go figure out how
11 to do it.
12 I said inclusive of the physician fund. Who cares
13 where they take it, if that's the sentiment, that there's
14 going to be money from somewhere, somehow defined, here we
15 go.
16 DR. SCANLON: I'm thinking that what we're really
17 aiming it is the 2007 level versus the 2008 level. I think
18 we're not saying that the 2008 level should be inflation
19 plus $1.3 billion above inflation. That's what Doug is
20 making explicit.
21 MR. HACKBARTH: I think there's two distinct
22 issues that Doug has raised. One is the 10 percent cut.

1 And then the second is how do we include the $1.35 billion
2 in the update. The first one is easier, to me, than the
3 second one.
4 We deal with the first one simply by including
5 clear language that says that all of the access data, et
6 cetera, is based on a certain level of spending. And so
7 we're basing on our recommendations on what is known not
8 what is so unknown. And we're not -- be very explicit,
9 we're not speculating about what access would look like if
10 there were, in fact, to be a 10 percent cut. We're talking
11 about the updates off the prevailing level of actual
12 spending, the actual conversion factors.
13 I think we can work out that issue relatively
14 simply.
15 I suspect that there may be a division of opinion
16 about the second issue, whether to say that our update
17 recommendation nets out the $1.35 billion or maybe in
18 additional. What I hear Sheila saying is we don't know how
19 that money is going to be allocated. Therefore, to say
20 we're just going to net it out.
21 DR. HOLTZ-EAKIN: Just to be clear, I thought we
22 established, it will be spent.

1 MS. BURKE: No, the language, as I understand it,
2 says to the extent practical or feasible. That to me, in
3 Congress word, means there's enormous flexibility. What is
4 and what is not determined to be feasible is in the eye of
5 the beholder.
6 I don't think we know for a fact. The presumption
7 is yes, but we don't know that for a fact, that all that
8 money will be spent in 2007 or 2008. I don't think. I
9 don't know that. Maybe we do, but that isn't how I thought
10 I heard you describe it.
11 MS. BOCCUTI: I guess I would say I'm not as much
12 in question that it will be spent in 2008. That isn't as
13 much a question for me in my discussions with folks at CBO.
14 It's whether or not it's going to be used as an update fund
15 that's more in question. There's a quality component that
16 could be part of it. It could be used for many different
17 ways. And to assume that it's going to be attached to the
18 conversion factor again, I think is what is a little bit
19 more in question.
20 MR. HACKBARTH: Just to pursue that a little bit
21 further, if it's as an update, then it goes to all
22 physicians, it effects the conversion factor. It could be

1 that by 2008 the Secretary has seen the wisdom of Nick's
2 recommendation, which is rather than trying to make this
3 available to all physicians for reporting data, that we want
4 to use it in a very targeted way, in which case it might
5 have a very different distributive impact, the $1.35 billion
6 and put your update decision in a different light.
7 I guess I'm with Sheila, that just saying well,
8 our update recommendation is net of the $1.35 billion, seems
9 a little bit simplistic to me, not that I have a great
10 solution. These are good questions and not easy to answer.
11 DR. REISCHAUER: But with respect to hospitals,
12 we're saying here's an update but take a percentage off it
13 and put it into this quality pool and we don't know how it's
14 going to get distributed. And in a sense, we're taking
15 something away from all hospitals and then redistributing it
16 to others.
17 And this is no different from that. We don't know
18 that it's for good purposes, that it's going to be --
19 MS. BURKE: Bob, at least as I understood the
20 hospital piece, we explicitly stated the expectation that
21 they would create a severity adjustment. Admittedly, we
22 don't know how the severity adjustment will be structured

1 but it's very explicit.

2 DR. REISCHAUER: That was for the IME money.

3 MS. BURKE: Right, the 1 percent.

4 DR. REISCHAUER: But we were also saying in the
5 update we were going to take a percentage point out of that
6 for the quality thing.

7 MS. BURKE: For the quality indicators. In this
8 case, is there any direction on how this money is to be
9 spent, this $1.3 billion? What are the terms?

10 MS. BOCCUTI: It has to go towards physician
11 payment but that could include quality initiatives or the
12 update. It has to be in some way related to physicians or
13 the physician payment system. But that's about as much
14 direction that there is. And that it be used in 2008 to the
15 extent feasible.

16 MR. HACKBARTH: Nick has been waiting patiently so
17 let's do him. Then I want to try to sum up where I think we
18 are and agree on a next step.

19 DR. WOLTER: On the $1.3 billion, I can see the
20 logic of whether that should be part of the update or not.
21 But in a way, we're back into this tension between global
22 economic allocation and what are the appropriate strategies

1 that would be the best use of the money. That's what I see
2 the tension as right here.
3 I would say, Bob, there are extremely big
4 differences in how this is going to unfold in the physician
5 world from the hospital world, because 1 or 2 percent to a
6 hospital is a very large number, in terms of the percentage
7 of their ultimate end of the day operating margin. 1.5
8 percent to a physician, based on their percentage of
9 Medicare business, may not cover the costs of hiring the RN
10 to do the chart abstraction. It may not cover anywhere near
11 the cost of trying to get going with IT to make it easier to
12 do the numbers.
13 I think we're into an interesting experiment here
14 as to whether 1.5 percent to a small physician group is
15 going to create any incentive whatsoever. Which is kind of
16 back to the point that we're really at an interesting
17 crossroads with pay for performance in the physician world.
18 My concern about rolling it into the update is
19 that it almost, by the very nature of doing that, is going
20 to have the effect of making it impossible to really get to
21 the discussion at least of our focus strategies may be of
22 more value than more diffuse strategies. I really worry

1 about that.

2 I would also like to see us get into the text that
3 there are some who are concerned that broad measures for
4 every specialty as part of payment may not be as effective
5 in the physician world as starting with more focused
6 strategies in high volume high cost areas where there's
7 synergy with some of the hospital measures.

8 I don't see anybody saying that right now in this
9 town and it should at least be on the table for
10 conversation.

11 Maybe this isn't our decision. Maybe it's CMS and
12 the AQA and the HQA group and the IOM. I don't know where
13 it's going to ultimately end up where some of these
14 decisions get refereed by the appropriate experts. But
15 there is a body of knowledge around clinical process
16 improvement and how to do it and how hard it is to do, but
17 right now we're on this rush to add measures to everybody to
18 solve certain payment problems and it's not being informed
19 by appropriate clinical process improvement skills sets.

20 That's why I really worry about how this might
21 unfold.

22 DR. CROSSON: Just a quick point on your first

1 point. Not this, but the 10 percent.

2 In this situation this year, to make it clear what
3 Bill said the intent was of what we're doing, would it makes
4 sense to add some language to the recommendation, for
5 example to say Congress should update payments for physician
6 services in relationship to actual 2007 payment rates by the
7 projected change in input prices?

8 DR. REISCHAUER: That's what we're doing. We're
9 not making a change off of the projected baseline for 2008.
10 We're saying how should things change from 2007 to 2008.
11 The cost of it will be the difference between that
12 recommendation and the baseline as it exists with the 10
13 percent, so it will be a humongous amount of money.

14 MR. HACKBARTH: So Jay is suggesting that we alter
15 the language in the recommendation itself to make that
16 point. Does anybody have any objection to that?

17 So we can redraft it to reflect that.

18 On the issue of the $1.35 billion, I think Bob and
19 others are right that consistent with our past logic about
20 the funding of pay for performance, if this $1.35 billion is
21 a potential pay for performance pot, it ought to come out of
22 the update and be deducted from it.

1 Yet I hear some real reservations from Sheila and
2 Nick about that approach. I, for one, would like to think a
3 little bit more through that issue and talk to some of the
4 rest of you about that. I don't want to do it more now
5 because I think like we're spinning our wheels a little bit
6 and we're already behind. We're going to be really far
7 behind.
8 So let us come back tomorrow morning with the
9 recommendation language revised, as Jay suggested, and then
10 a proposal on how to proceed with the $1.35 billion, if
11 that's okay.
12 DR. REISCHAUER: I shared Nick's concerns and
13 reservations. The $1.35 billion has been, in a sense,
14 authorized and appropriated. It's there. What it's going
15 to be used for has not yet been determined. So we can't
16 imagine that it doesn't exist. It exists more than anything
17 else.
18 MR. HACKBARTH: But I think Nick has a point that,
19 given that it is there, there is a certain imperative that
20 says well let's try to make it available to everybody but
21 saying we'll pay it out based on some reporting requirement
22 for everything that will still be another step down an

1 unfocused pay for performance path.

2 I am Mr. Pay For Performance. I am a believer in

3 it. But I must confess that I, too, am concerned about the

4 physician piece in particular and whether there's strategic

5 thinking around the approach of how to get this done

6 effectively. I don't want to just throw another stick on

7 that fire that leads further down a mistaken path.

8 MS. BURKE: Glenn, in anticipation of tomorrow's

9 discussion, it would certainly be helpful to me to

10 understand if there was any context at the time that this

11 was proposed and agreed to, if there's any legislative

12 history or language that suggests that this was in lieu or

13 in addition to what was anticipated in terms of update, if

14 there is an language or any discussion. I don't know what

15 occurred at the time.

16 But to the extent we can find out whether there

17 was any conversation or anything in the language surrounding

18 the debate or the provision, that would certainly be

19 helpful. Whether it was their expectations that this would

20 be used in a particular way or in lieu of what was otherwise

21 going to be anticipated in terms of an update. That would

22 at least help me think about it.

1 MR. HACKBARTH: I'd like to move ahead now and
2 we'll come back tomorrow morning with some specific
3 proposals there.
4 Next up is skilled nursing facilities.
5 Before you start Kathryn, just a schedule update.
6 What we're going to do, tomorrow we're schedule to start at
7 9:00. We're going to move that up to 8:30 to accommodate
8 this discussion.
9 Now we're ready to move on.
10 MS. LINEHAN: This presentation will summarize
11 what you heard last month to inform your update
12 recommendations for skilled nursing facilities for 2008.
13 Just for variety, unlike Cristina, I've embedded
14 the answers to your questions into my presentation for you
15 to find.
16 DR. REISCHAUER: Will you identify which of us
17 you're answering?
18 MS. LINEHAN: No. I'm just going to point.
19 [Laughter.]
20 MS. LINEHAN: To review briefly, our indicators of
21 SNF payment adequacy are generally positive but quality has
22 declined. Overall, the supply of providers remains stable

1 in 2006. The most recent data show a net decrease of 0.1
2 percent in 2006.
3 Beneficiaries generally have ready access to SNF
4 care. The OIG found in 2004 -- that's the latest year they
5 did this study -- that Medicare benes appear to have little
6 or no delay in accessing SNF services, especially if they
7 need rehabilitation therapies. Beneficiaries with certain
8 conditions, though, may experience delays that mean they
9 stay longer in the hospital. The IG reported that Medicare
10 patients were harder to place if they need IV antibiotics or
11 expensive drugs, vent care, or have behavior problems. This
12 is consistent with earlier findings by the IG and the GAO
13 about services that have been identified as being underpaid
14 by the SNF payment system.
15 Volume, as measured by total days and total
16 admissions, increased between 2004 and 2005. I updated the
17 volume numbers in your paper to be consistent with the time
18 series we've used in previous years. Specifically, we see
19 days increased 6 percent and admissions were up 5 percent.
20 Spending was up 8 percent in 2005.
21 Volume growth was not even across RUGs. Case-mix
22 continues to shift toward a greater share of higher

1 intensity rehab RUG days and a lower share of lower
2 intensity not-rehab RUG days.
3 Our two measures of SNF quality show that between
4 2000 and 2004 quality has been going down. Average facility
5 rates of discharge to the community declined and average
6 facility rates of potentially avoidable re-hospitalizations
7 increased. These are risk-adjusted measures that are
8 measured within 100 days of admission to the SNF.
9 There was a question last time about whether a
10 change in policy whereby the program pays to hold a bed for
11 a patient who is rehospitalized. I think the thinking was
12 that a change in this policy could change a facility's
13 incentives to rehospitalize.
14 I looked into this and found that Medicare doesn't
15 have a bed hold payment policy. It's a Medicaid policy and
16 it varies by state. Since we're looking at patients under a
17 Medicare stay, a change in a state's bed hold policy is not
18 likely a major driver in the national rate of change in
19 quality for Medicare patients.
20 But if there is an additional question on this,
21 I'm happy to take it and try to track down the answer.
22 Finally, providers in the nursing home sector have

1 access to capital. Medicaid is the predominant payer of
2 nursing facility care but because Medicare is generally a
3 better payer analysts told us that Medicare's share and
4 payments enhance a nursing home provider's access to
5 capital.
6 For-profit chains report new acquisitions and
7 construction financed by debt. The National Investment
8 Center reports good loan volume and performance in this
9 sector. And analysts we interviewed report several factors
10 that make this sector appealing to investors, including a
11 stable reimbursement environment, better than expected
12 payment under RUG refinements, improving state fiscal
13 situations removing the threat of Medicaid cuts, and SNFs
14 being positioned to be the low-cost post-acute care provider
15 for Medicare beneficiaries.
16 Now turning to margins, in fiscal year 2005 the
17 aggregate Medicare margin for freestanding SNFs, which are
18 about 92 percent of all SNFs, was 13 percent. We continue
19 to see some variation across facilities and differences by
20 facility type. Margins for rural facilities continue to be
21 higher than those for urban facilities and they are higher
22 in for-profit than nonprofit facilities, which we have seen

1 since the beginning of the PPS.

2 Based on 2005 cost report data we estimate that
3 the 2007 aggregate Medicare margin for freestanding SNFs is
4 11 percent. This estimated margin is a function of payment
5 changes that increased payments, including a full market
6 basket update in 2006 and 2007, and changes due to RUG
7 refinements, and changes that reduced payments including the
8 elimination of temporary payment add-ons and a change to bad
9 debt reimbursement.

10 This brings us to the update recommendation we
11 discussed in December, which is to eliminate the SNF update
12 for fiscal year 2008. Current law provides for a full
13 market basket update and the most recent estimate is 3.1
14 percent in 2008. Providers should be able to accommodate
15 cost increases next year without an increase in the base
16 rate.

17 The spending implications are a reduction in
18 Medicare spending relative to current law from between $250
19 million to $750 million for fiscal year 2008 and $1 billion
20 to $5 billion over five years.

21 This should have no effect on providers' ability
22 to furnish care to Medicare beneficiaries.

1 Finally, to come back to an issue that came up
2 last month and has come up many times in our payment
3 adequacy discussions for skilled nursing facilities,
4 hospital-based SNFs have negative aggregate margins. They
5 were minus 85 percent in 2005. The reason for hospital-
6 based SNFs' higher costs are unclear and likely multiple and
7 vary by provider.
8 One of these reasons could be allocation of
9 overhead from the facility to the SNF. Hospital-based SNFs
10 may also have higher cost structures which could be a
11 function of different practice patterns. They may also
12 treat different patients than freestanding nursing homes.
13 For example, we know that they have more patients in
14 extensive services if it's a non-rehab RUG group that
15 freestanding SNFs. But again, this varies by facility.
16 Underlying all of these potential explanations
17 about higher costs is whether the higher costs of hospital-
18 based SNFs result in better quality in the facility.
19 Another important question for the program is the
20 comparative cost and quality of an episode, by which I mean
21 inpatient and post-acute care. That includes a hospital-
22 based versus a freestanding SNF stay. Is the hospital-based

1 SNF stay a substitute for acute care or a substitute for
2 freestanding SNF care?
3 Evidence suggests that hospitals decisions about
4 SNF operations are not solely driven by the profitability of
5 the SNF, but on how their SNF fits into the broader context
6 of the hospital's primary function as acute care providers.
7 In other words, they look across the episode to decide
8 whether and how a SNF fits into their operation.
9 On site visits with hospital-based SNFs, we
10 learned that those that have remained opened described
11 operating different models with respect to selecting their
12 SNF patient population. Hospital-based SNFs allowed
13 hospitals to short their inpatient length of stay by
14 transferring patients more quickly to their hospital-based
15 SNFs compared with transfers to freestanding SNFs. Some
16 hospital-based SNFs reported taking patients that they
17 cannot place with freestanding facilities. The hospital-
18 based SNF allows the hospital to receive an additional
19 payment for the episode, since the hospital is paid per stay
20 for the inpatient care.
21 Consistent with the kind of broader look at the
22 episode of care, our analysis that Craig Lisk did of direct

1 costs of hospital-based SNF care found that while hospitals
2 have a negative fully allocated margin over the entire
3 inpatient and post-acute episode, the direct cost margin for
4 the inpatient and SNF stay together is about zero.
5 While hospitals would like to make a profit on
6 each stay, if they can cover the direct costs for these
7 complex cases, they have an incentive to care for these
8 patients. These data suggest that hospitals with SNFs are
9 covering the direct costs for the episode.
10 The SNF payment system does need to be improved to
11 more accurately pay for medically complex patients, such as
12 those using IV drug regimens and respiratory therapy.
13 Studies have found these patients to be less financially
14 desirable than rehab patients, which hospitals and SNFs told
15 us are their most profitable cases. But medically complex
16 patients are treated in all types of SNFs, so the payment
17 system should be improved to better account for these
18 patients' costs regardless of the type of facility that
19 treats them.
20 Creating different base rates for hospital-based
21 and freestanding SNFs moves payment policy in the direction
22 of payment based on facility type. This is counter to the

1 Commission's broad goal of a payment system that bases
2 payment on patient needs and characteristics regardless of
3 the setting.
4 CMS is beginning the work to examine assessment
5 and payment across post-acute settings. Other payment
6 policy changes, such as improving the accuracy of the case-
7 mix system or paying for quality, are consistent with the
8 Commissions goals to pay for necessary care delivered
9 efficiently regardless of the setting without creating
10 payment differences based on facility label.
11 This concludes my presentation and I'll take any
12 questions you have.
13 MS. BURKE: This is terrific, Kathryn. There were
14 a couple of questions that I had in terms of the quality
15 indicators in this continuing issue and trying to understand
16 the differences between the hospital-based facilities and
17 the freestanding.
18 In the discussions, I was just looking back to see
19 if I could find it and I didn't but I may just have missed
20 it.
21 In the discussions around rehospitalization and
22 the extent to which we can look at the avoidance of

1 rehospitalization as one of the indicators, and track the
2 patients, the difference between hospital-based and
3 freestanding, is there a difference in the frequency of
4 rehospitalization between the two? I assume there is a
5 difference in terms of staffing. I thought that's what I
6 understood you to stay in the text and you just comment on
7 different models. I assume one of them is the use of RNs
8 versus non-RNs and the presence and whether or not that has
9 a direct impact all of the other issues that patients
10 confront in terms of lengths of stay, rehospitalization.
11 Are there qualitative differences in what's
12 occurring between the two settings? And are we able to
13 track that?
14 MS. LINEHAN: We're continuing the work that we
15 started with the University of Colorado where they developed
16 these measures and looked at the national rates. One of the
17 things we're looking at is differences by facility type in
18 not only the level but the rates of change over time.
19 We haven't presented any of that work yet.
20 They're still working on some of the differences in the
21 facility rates.
22 MS. BURKE: I think you're right, our goal is not

1 to differentiate payment based on the where, but rather on
2 the kind of service. So you don't want to just uniformly
3 say hospital-based units ought to get a different update.
4 But if, in fact, we're able to determine whether
5 there is a qualitative difference between the two, the
6 shorter lengths of stay are, in and of themselves, not a bad
7 thing. There are questions in terms of the management of
8 very acutely ill post-hospitalization patients, whether
9 they're ventilator dependent, whether or not they're on IV
10 antibiotics. And there is difficulty in placing them in
11 freestanding facilities, although they are spread clearly
12 across a variety of facilities.
13 But I think it would be very important for us to
14 understand the extent to which those things translate into
15 quality issues, whether there is, in fact, a difference
16 between these different kinds of facilities. Because the
17 extent to which they continue to have hugely negative
18 margins, and whether we are discouraging the presence of
19 those kinds of facilities, or whether the hospital is just -
20 - we presume they can just suck it up over a period of time
21 and keep them going regardless.
22 But I think we need to understand whether there

1 are real qualitative differences in staffing and all the
2 indicators between the kinds of patients have are being and
3 how.

4 MS. LINEHAN: We're going to have results but we
5 don't have them yet. We're going to have them in the
6 spring. We are looking at staffing. We know there is a
7 difference in staffing, just if you look at the OSCAR data.
8 But how does that relate to differences in quality and
9 costs, and try to sort out at the facility level what the
10 relationship is between staffing, quality, cost and other
11 facility characteristics.

12 MS. BURKE: And severity, some kind of adjustment
13 to track the patient may be the way to solve that problem as
14 compared to entirely separate rates. But I think that will
15 be important to know.

16 DR. KANE: Another clarification issue.

17 I thought when we talked about the hospital
18 updates that the hospital-based SNF was folded in and was
19 part of the reason we -- now I'm confused because when we
20 looked at the hospital-based, the margin included the SNF
21 and the HHO. But we're saying this doesn't affect the SNF
22 at all. So this is for hospital-based and freestanding,

1 this recommendation?

2 DR. MILLER: The update would be the impact of the

3 margin as reflected in the hospital setting because for a

4 whole variety of reasons, including the problem with cost

5 allocation. But the update that we ultimately make here

6 will have an affect on both freestanding and hospital-based.

7 MR. HACKBARTH: A reason for that, as Sheila

8 indicated, is going down that path of having different

9 payment rates based simply on a provider type is a

10 problematic path. In fact, in a lot of ways that's where

11 we're trying to get away from, our issues around long-term

12 care hospitals.

13 The question is can those same patients be treated

14 in the facility with a different name over the door and

15 achieve quality care at a much lower cost? And so we don't

16 want to just be paying more because it has a certain

17 provider type.

18 DR. KANE: I'm all for one payment regardless of

19 site, the same thing. I guess the issue is whether there's

20 some sort of synergy that only the hospital can obtain.

21 Which is what I thought you were saying there might be.

22 In which case, would we be adjusting payment or

1 not? Because if that same type of patient was treated in a
2 freestanding, they would not be able to achieve the same
3 type of synergy as if they were in a hospital-based SNF.
4 MS. BURKE: I don't think it's a synergy issue.
5 DR. KANE: It is in if the hospital gets the
6 benefit of getting the patient out faster, then there is a
7 little bit of a synergy if --
8 MR. HACKBARTH: If they can't do the same thing
9 with a freestanding SNF.
10 DR. KANE: That's what I meant.
11 MR. HACKBARTH: To me the significance of what
12 Kathryn presented was she gave a series of potentially
13 rational reasonable explanations why hospitals might persist
14 in this business despite the reported negative margins of
15 minus 89 percent. One is, as Ralph has said in the past,
16 some of these patients are just very difficult to place in
17 freestanding SNFs, in some cases maybe because of flaws that
18 we've often noted in the case-mix adjustment for
19 freestanding SNFs. So that's one rational reason.
20 Another is that hospitals look at them as a joint
21 activity. And when you combine both the SNF payment and the
22 inpatient payment, that it's a reasonable financial thing to

1 do.

2 DR. KANE: It works better than if you didn't have
3 it because you'd be stuck with the patient on a DRG --

4 MR. HACKBARTH: They may feel marginally more
5 comfortable moving the patient out of the acute hospital
6 into the SNF if a SNF is on-site with their staff. And they
7 might be a little more reluctant to a free-standing
8 facility.

9 DR. WOLTER: I would like to underscore Sheila's
10 comments. I think we're doing good work in this area now.
11 Certainly in our facility the patients going to our
12 hospital-based SNF are more on the cusp between acute care
13 and post-acute care than those that go out into the
14 freestanding SNFs.

15 When we did the LTCH visits a couple of years ago,
16 we heard loud and clear in a couple of the communities that
17 there really weren't any freestanding SNFs that could take
18 some of the patients they were taking care of.

19 So I think there's some differences here. I think
20 the points made in the chapter, that these are often
21 patients where there's a high probability that a relatively
22 short length of stay will get them home, differentiates them

1 a bit from those who go out to the freestanding SNFs.

2 So I think the work you're talking about

3 continuing on will be very useful because if there is value

4 in the hospital-based SNFs -- and a third of them have

5 exited, if I'm remembering the numbers we've looked at

6 previously -- zero percent updates over a number of years

7 could have a valuable resource be affected.

8 We didn't look at it the way you described it but

9 I think it's very similar. Every time we've analyzed the

10 financial impact of eliminating our hospital-based SNF, it's

11 kind of a wash, I would say. Even though we're losing money

12 over there, there are some benefits on the inpatient side

13 and there's clearly been clinical benefits to the patient.

14 So it seems to me we're starting to get our arms

15 around this and that's good to see.

16 MR. HACKBARTH: Other questions or comments?

17 Why don't you put up the recommendation.

18 All opposed to the recommendation? All in favor?

19 Abstentions?

20 Okay, thank you. Next up is home health.

21 MR. CHRISTMAN: Good afternoon. Next I'm going to

22 take you through the home health benefit and review some of

1 the things I shared with you at the last meeting.

2 MR. HACKBARTH: Even, before you start, it just

3 occurred to me that I forgot to mention on Karen Borman's

4 behalf that she supported the recommendation of no update

5 for SNFs.

6 MR. CHRISTMAN: Up here on the screen you'll see a

7 lot of the information I presented at the December meeting

8 for home health.

9 We found that access to care is generally pretty

10 good, 99 percent of beneficiaries live in an area served by

11 home health. The volume of services for home health

12 continues to grow. The number of episodes increased by 9

13 percent and the number of users increased by 6 percent.

14 Total home health spending will reach about $11 billion in

15 2005.

16 In terms of quality measures, you remember I

17 showed you six of them. The first four were functional

18 measures and those were generally increasing over time. The

19 exception to that were the two adverse event measures where

20 we had seen level or no change in the number of

21 rehospitalizations or ER visits in the last four years.

22 Finally, you might remember I mentioned that the

1 supply of agencies continues to increase. We expect an
2 increase of about 6.3 percent in 2006, an increase of over
3 500 agencies.
4 As I commented last time, the variation in growth
5 among the states is insignificant. This next slide kind of
6 walks through some of that.
7 Before I go through it, I want to lay out a couple
8 of caveats to the data I used to put this table together.
9 These numbers are based on the net change in the number of
10 providers in a state over the four-year period. That is it
11 accounts for the churn that can occur as new providers enter
12 and other providers exit.
13 Also, since home health is not facility-based, the
14 site of care isn't at least at a facility, the change in the
15 number of providers in an area does not necessarily measure
16 the change in the capacity to deliver care. Agencies can
17 adjust their service areas as local conditions change.
18 Some of the change we see may be due to
19 consolidation such as mergers. Again, this would reduce the
20 number of individual providers but again, it doesn't
21 necessarily affect the capacity in the local area.
22 With this point in mine, let's go through the

1 table. The first row shows that 18 states experienced an
2 decreased relative to where they were in 2002 by 2006. The
3 average change for that category was about five agencies.
4 However, in these category and in each of these
5 categories, among those 18 states, there was a broad
6 variation in the size and the number of providers. So the
7 absolute change can be misleading.
8 Just as an example, Montana had 50 providers in
9 2002 and it fell to 37 by 2006 or lost about a quarter of
10 them. For other states who were much larger the average
11 change was still pretty small but the decrease as a
12 percentage was much smaller, frequently in the low single
13 digits.
14 The next row down is just the no change. There's
15 not much to say about that. Those are states that didn't
16 change over the four-year period.
17 The line below that shows that 25 states
18 experienced moderate growth of between one to 31 agencies.
19 The average state in that category grew by about nine
20 agencies.
21 The final row shows where most of the growth has
22 occurred. It shows that six states increased by 90 agencies

1 or more and by an average of more than 270 agencies.

2 MR. BERTKO: Evan, just out of curiosity, do the
3 53 total mean you have the two territories there?

4 MR. CHRISTMAN: We have Puerto Rico and the Virgin
5 islands in this.

6 DR. REISCHAUER: I thought it was Northern and
7 Southern California.

8 MR. CHRISTMAN: The last category, the six states
9 are Florida, Texas, California, Illinois, Michigan and Ohio.
10 I would note that four of those states, Florida, Texas,
11 California and Illinois, were targeted for additional
12 enforcement activities as a part of Operation Restore Trust
13 in the home health area.

14 We recognize that these numbers show a tremendous
15 growth in certain areas of the country and we've discussed
16 this with CMS. The numbers that we show here match their
17 expectations.

18 At the last meeting there was a question about the
19 relationship of Medicaid and the growth we're observing,
20 specifically whether the trend in Medicaid towards moving
21 people out of institutions and into the community was
22 affecting some of this growth. We did some further research

1 and spoke with the industry on this issue and we really
2 couldn't find any clear linkage between Medicaid and the
3 growth.
4 Again, as you're probably all well aware, the
5 Medicaid programs vary tremendously across the country, as
6 do market conditions. For these reasons, it's difficult for
7 us to assess how the shift to community-based services has
8 affected growth.
9 This next table we saw at the last meeting. It
10 shows what the home health agencies' margins were in 2005.
11 I'll just go through quickly. Overall, we found that their
12 margins were 16.7 percent. It's worth noting that there is
13 some variation, that the agency at the 25th percentile of
14 the margin distribution had margins of 2.3 percent. The
15 agency at the 75th had a margin of 27.2 percent.
16 Looking below at geography the story is very
17 similar to what we found in previous years. The agencies
18 that serve beneficiaries in both rural and urban areas had
19 the highest margins. They're referred to as mixed. You'll
20 see them there, they're 17.7 percent. And then the rurals
21 had the lowest margins. Still their margins were 13.7
22 percent.

1 Under type of control, you'll see again that the
2 for-profits continue to have the highest margins of about
3 18.2 percent and the government agencies continue to have
4 the lowest margins, still over 10 percent.
5 In terms of costs per episode, our findings were
6 similar with what we found in previous years. Home health
7 agencies continue to have a lot of success controlling
8 costs. Our findings show that their costs per episode only
9 grew by 0.7 in 2005. This is below the market basket
10 inflation for that year, which was 3.1 percent. Again, this
11 is a trend we've seen in past years where the actual cost
12 growth we observe is less than 1 percent and the market
13 basket increase is generally between 3 and 3.5 percent a
14 year.
15 This shows that agencies continue to effectively
16 control their costs and keep their annual inflation well
17 below that you'll find in the market basket.
18 Really quickly, I'm going to walk through the
19 payment changes for 2006 and 2007. Home health agencies
20 were held at the 2005 levels for 2006. That is they didn't
21 get a market basket update. The one exception is for
22 beneficiaries in rural areas there was a 5 percent add-on

1 that was only in effect for 2006. It was not extended in
2 the most recent bill.
3 There's also a new pay for reporting requirement
4 that goes into effect in 2007. For this year home health
5 agencies will receive the full market basket of 3.3 percent.
6 Based on this information, we estimated the margin
7 for freestanding agencies will be 16.8 percent in 2007.
8 That takes us to our recommendation. Our
9 recommendation is the Congress should eliminate the update
10 to payments for home health care services for calendar year
11 2008.
12 Home health agencies will receive a full market
13 basket of 2.9 percent in 2008 under current law. They
14 continued trend of low cost growth and high margins indicate
15 that agencies should be able to observe any cost increases
16 within existing payments and that the market basket increase
17 is not necessary.
18 This would decrease spending relative to current
19 law by $250 million to $750 million in 2008 and between $1
20 million and $5 billion over five years.
21 We believe this would have no effect on providers'
22 ability to furnish care to Medicare beneficiaries.

1 That completes my presentation.

2 MR. HACKBARTH: Comments?

3 DR. REISCHAUER: About every couple of years I
4 bring up this point, Evan, and it's not solely with respect
5 to home health. It's several of the other provider groups,
6 too.

7 We're stuck on providing unbelievable detail on
8 institutions which are a rather meaningless concept,
9 especially here but I think it's also true in hospitals,
10 where we don't talk about bed-weighted hospitals or anything
11 like that. We're counting a little gut and a huge guy as if
12 they were the same.

13 And here we aren't even sure when an agency means.
14 We go through the number of agencies and we take comfort in
15 the fact that they are growing like bandits in most of the
16 country.

17 And really what you care about is percent of
18 Medicare beneficiaries who have access to this type of care
19 -- and you said it was 99 percent -- and tracking that.

20 And then the change in episodes per 1,000
21 beneficiaries and whether one agency provides that or 500
22 doesn't really make that much difference for the kinds of

1 things that we're concerned about. Maybe you want to get
2 into the change in the growth of episodes by the level of
3 episodes per 1,000 beneficiaries that are available to see
4 if these things are growing fastest in the areas where there
5 is the most being provided or the least being provided.
6 But I think in the future we should -- you know,
7 the only place we really do this is in dialysis centers
8 where we talk about the number of stations and the
9 difference between the chain-related ones and non-chain-
10 related ones.
11 But I don't know what kind of comfort I should get
12 from all of the numbers that we provide, or discomfort, for
13 that matter. I think we can simplify a lot of this and have
14 it more meaningful.
15 This is a criticism of how we've been doing this
16 for 10 years really and a suggestion for the future.
17 MR. HACKBARTH: I agree with your point, Bob, that
18 home health is particularly difficult and that the concept
19 of an agency is elastic, shall we say, and it ranges from
20 Carol Raphael's VNA in New York to the mom and pop home
21 health agency run out of the gas station. The agency
22 numbers, I think, are particularly problematic.

1 But just to be clear -- and I know you know this -
2 - the margins for this and all of the sectors are patient
3 weighted. They're not facility weighted or agency weighted.
4 The reflect the volume of patients.
5 DR. MILLER: So given that, if I could just get
6 you to say a little bit more. I think in last month's
7 presentation we did go through things like growth in the
8 number of episodes and that type of thing, if I recall.
9 MR. CHRISTMAN: We did do that.
10 DR. MILLER: And then we went through the access
11 information to the extent that we have it. Maybe if you
12 could just kind of hit again what's the innovation you're
13 looking for.
14 DR. REISCHAUER: I think that's great. But then
15 the document we're going to publish for the public has none
16 of it in it. Is that not this or not?
17 MR. CHRISTMAN: That's in there. There should be
18 a table in there that shows the episode volume and the user
19 volume, for example, that we've seen over the last five
20 years.
21 DR. REISCHAUER: You're talking about states and
22 things like that. That's what I'm talking about.

1 DR. MILLER: The state analysis, if that's what
2 you're referring to, that was an innovation because of the
3 question asked the last time. And that will be -- we can
4 put that in the report. It maybe hasn't made its way into
5 it as of yet.
6 MR. CHRISTMAN: Not in the way you saw it here.
7 DR. MILLER: That can certainly get in there.
8 DR. REISCHAUER: We have a client that is
9 geographically based, shall I say, and is going to focus on
10 the fact that five states have declines or eight states or
11 whatever it is, and get all hot under the collar about that.
12
13 DR. MILLER: I see, and you want to make it more
14 clear in the future.
15 DR. REISCHAUER: I don't know if there is a
16 problem but I suspect there isn't a problem in that respect,
17 and that there's been growth in episodes per 10,000
18 beneficiaries, that's been robust even in those areas.
19 DR. MILLER: That's I was looking for. Thanks.
20 DR. REISCHAUER: Do I care that there's been
21 umpteen million new agencies set up in Florida or
22 California? I would expect so. I don't expect it to happen

1 in North Dakota. It has to be relative to the potential
2 demand.
3 DR. SCANLON: I was going to agree with you, Bob,
4 except for that last comment. I maybe care about California
5 and Florida.
6 I think when we go back to the Operation Restore
7 Trust era, even though the concept of an agency in terms of
8 a supply indicator is weak, the gross differences across
9 states, we did see problems between the areas where there
10 was huge numbers of agencies. Texas had 2,000 at its
11 heyday.
12 And we saw that in areas where there were controls
13 over the supply of agencies, like Vermont where it didn't
14 change because there's one per county and you had rules like
15 that. There were huge differences in terms of the provision
16 of services that in the states where there was this large
17 proliferation of agencies, we saw tremendous growth in
18 visits per beneficiaries. And in other places we saw none
19 in the same time period under the same payment system.
20 So I think it is useful to bring more of the state
21 work into our publication, as well as to group the states in
22 terms of where is the growth happening? And are we starting

1 to see some of the same problems?

2 We have a fairly poorly designed episode here in

3 terms of what is required and the margins and the

4 distribution of margins reflect that. And so knowing more

5 about what we're getting and how we should be intervening in

6 terms of greater oversight is very important.

7 DR. REISCHAUER: But you really should agree with

8 me because I'm saying we should do episodes per 1,000

9 beneficiaries, not number of agencies.

10 DR. SCANLON: We were disagreeing on whether I

11 want to look at California or Florida.

12 DR. REISCHAUER: I want to look at them but using

13 the right metric.

14 DR. KANE: I'm just concerned when the episode

15 growth is only 0.7 of a percent that there isn't something

16 fatally flawed about the episode definition.

17 MR. HACKBARTH: The cost per episode?

18 DR. KANE: The cost growth is only 0.7 of a

19 percent. What's changing it? I'm guessing it's that

20 there's fewer units of service being provided per episode.

21 And I'm also guessing perhaps there's classification issues

22 that are really not right on target and that there is

1 capability to get the less sick people into the higher cost
2 episode, the higher paying episode. And that's what this
3 signals to me is that there's something fundamentally with
4 the episode system.
5 I remember last year, in my fog of the first year,
6 we did something about cost and case-mix not explaining
7 something about episodes. But it seems we need to do
8 something a little more. Because 0.7 of a percent, even
9 with minimum-wage workers there's something wrong with --
10 fuel costs? Something's got to go up.
11 MR. HACKBARTH: We have several times over the
12 last several years expressed concern about the case-mix
13 system and whether, in fact, it appropriately adjusts for
14 the expected costs of different types of patients. That's
15 been one set of issues that we've raised repeatedly.
16 A broader concern, that Bill has often mentioned,
17 is that in home health, probably more than any other sector,
18 the definition of what it is we are buying is obscure. That
19 could be affecting the cost growth.
20 Some of the things that account for low cost
21 growth are relatively straightforward. In some parts of the
22 country there were a lot of visits per episode and those

1 numbers have been coming down. The average has been coming
2 down. Although that decline has slowed in recent years.
3 But for a while that provided sort of one ready explanation
4 of why costs per episode growth would be low.
5 DR. KANE: If this were physician RVUs, we would
6 say we should be recalibrating these or reweighting these.
7 In other words, is there something that needs to be
8 reweighted now that visits per episode have come down?
9 MR. HACKBARTH: Another potential factor is
10 substitution of lower wage staff for higher wages staff with
11 uncertain implications for quality. We've tried to look at
12 available measures of quality for home health but they are
13 relatively few in number, although the ones we have suggest
14 stability or even slight improvement on average.
15 This is a very difficult area to get a grip on.
16 And when I look at those high average margins, as opposed to
17 looking at them and saying oh everything is okay in home
18 health, I think the spin is a little bit different. I think
19 the spin is money is not the immediate pressing problem.
20 But there may be a host of other problems in the home health
21 payment system around how the dollars are allocated.
22 Evan, can you tell us where the work stands on

1 refining the case-mix system for home health? Is any
2 progress being made on that?
3 MR. CHRISTMAN: CMS has an effort underway to
4 develop a refinement rule and our understanding is they're
5 supposed to come out with a rule soon. But when that is
6 this year it's not clear, but they do have an effort
7 underway to look at refinement issues.
8 DR. MILLER: Just to say something more broadly,
9 this same issue has been kind of enjoined on the SNF side at
10 different points in time. So we've been working in the
11 background, in the midst of everything else, and we're
12 hoping to bring online -- I think this spring, which is in
13 just a couple of months, March to be exact -- a discussion
14 of what those ideas are.
15 And then we were sort of looking ahead to CMS to
16 maybe kick that process off for home health and then maybe
17 use that as a springboard to start that destruction.
18 If, like SNF, that doesn't quite happen, then
19 we'll move ahead and start to develop our own sets of ideas
20 and bring those in front of you.
21 But in terms of the priorities, we've kind of been
22 drilling down on SNF. That come up literally starting in

1 March and then we'll see what happens with home health and
2 start drilling there.
3 DR. SCANLON: I'm not sure if I heard this but
4 they're two different refinements. There's one, the issue
5 of refining the patient classifications. And then there's,
6 secondly, refining the episode definitions or the episode
7 structure. And we, I think two years ago, had a discussion
8 about that briefly, but I think we need to revisit that.
9 DR. MILLER: We would look at all of it. We
10 wouldn't just say we'll stick with the 60 days and get to
11 the patient classifications. I think we would open the
12 whole thing up.
13 MS. BEHROOZI: Actually, Nancy foreshadowed a
14 little bit of what I was interested in, and you did also,
15 Glenn.
16 I think home health is unique in relying
17 significantly on the labor of low wage workers to provide
18 the service that Medicare is paying for. I mean, there are
19 obviously significant other components to it, in terms of
20 therapy and registered nurse services and things like that.
21 But in all the different areas, this is the one that really
22 a chunk of the payment goes to pay for the services provided

1 by low-wage workers.

2 It's been a number of years, hopefully it's over
3 now, that the federal minimum wages hasn't gone up. I
4 wonder whether you see differences in margins between the
5 states where minimum wages are higher and puts a little bit
6 upward pressure on the wages of low wage workers?

7 But our experience in providing health care or
8 trying to provide health care for these low-wage workers, is
9 that the employers are part of that 20 percent that actually
10 didn't show up in the chart, I guess they're below that 25th
11 percentile, who have negative margins. So the distribution
12 of margins is pretty broad. It's almost a 30 point spread.
13 And you say it's been consistent over a few years.

14 So I guess some of those employers that have been
15 experiencing the consistently low margins who, if our
16 recommendation is accepted, won't be getting an update
17 again, will go back to their workers and say sorry, I can't
18 give you any more money. Because that's the only place
19 where they can achieve the efficiencies -- not the only
20 place. But given that it's such a big chunk of the cost,
21 that's a place where they're going to have to look to make
22 those efficiencies. So they won't "be able" to raise the

1 workers wages or benefit levels.
2 And those that have the same high margins that
3 they have had for several years, I guess that's where they
4 look, that's one of the only places -- not the only place,
5 but that's one of the major places they look to protect
6 their margins because there isn't any other pressure
7 requiring them to pass any more of that money that Medicare
8 pays onto the workers who provide that direct service.
9 So I feel kind of caught in a quandary here,
10 looking at the aggregate margins. It certainly doesn't look
11 like you need to put any more money into this sector,
12 they're doing fine. But thinking that I understand, at
13 least from our local corner of the world, a little bit about
14 how those vary widely distributed margins have stayed the
15 same over the years on the backs of these low-wage workers,
16 I don't feel good about saying no, we shouldn't increase the
17 rates because that's what the agencies will say to their
18 workers.
19 I'll save for tomorrow, I guess, when we talk
20 about home health quality pay for performance measures,
21 talking about some of the ways in which we might look at
22 some factors other than outcomes measures but structural or

1 process measures about worker training or incentives
2 designed to enhance worker retention which I think is an
3 area that we need to look at in terms of its relationship to
4 quality.
5 MR. HACKBARTH: Evan, could you put up the table
6 that has the margin information on the distribution?
7 I understand what you're saying. What this says
8 to me, though, is that even at the 25th percentile we've got
9 an average margin of 2.3 percent. Let's stipulate that with
10 the people that you're talking to there are some issues
11 about the ability to hire workers.
12 What this says to me, though, is that if you add
13 more money to the system it's not going to be spent on
14 higher wages for low-wage workers.
15 MS. BEHROOZI: I understand that, Glenn. As I
16 said, I don't advocate putting more money into the system
17 because they're protecting their margins. I think that's
18 really the message. Though there are 20 percent of them --
19 as I said it doesn't show up on the chart, it's in the paper
20 -- there are 20 percent of them that are at negative
21 margins. So they have a little better case when they plead
22 poverty, perhaps.

1 But no, I completely agree with you, it's clear
2 that there has been no shift. They've been taking advantage
3 of the fact that there has been no upward pressure on the
4 lowest wages and keeping the margins that healthy looking.
5 I agree.
6 DR. REISCHAUER: Evan, do you have any idea what
7 impact the rise in the minimum wage might have on the cost
8 of this sector?
9 MR. CHRISTMAN: Obviously, for those workers
10 affected by it, it would raise their wages. We didn't do
11 anything like that in our modeling.
12 Our experience has been, though, that across the
13 years, whatever changes have occurred across the last five
14 years, these providers have been successful at keeping their
15 cost growth very low. So if they're faced with an increase
16 in wages, the track record suggests that they will have an
17 ability to adjust to it.
18 DR. REISCHAUER: But as Nancy pointed out, we
19 don't know if this ability is the revelation of productivity
20 or stinting on care that we can't pick up because our
21 quality of care measures are too crude.
22 MS. BEHROOZI: It's more than five years since the

1 federal minimum wage went up.

2 MR. HACKBARTH: Other questions or comments on

3 home health?

4 Would you put up the recommendation?

5 Okay, all opposed to the recommendation? All in

6 favor? Abstentions?

7 Okay, thank you. Evan.

8 Next is inpatient rehab facility hospitals.

9 DR. KAPLAN: Inpatient rehabilitation facilities,

10 or IRFs, make up the third post-acute care sector we'll

11 access for payment adequacy today. I'll review the evidence

12 on the factors I presented last month and these will

13 hopefully inform your discussion of the recommendation.

14 The number of IRFs increased slightly after the

15 PPS started in 2004 at 1 percent per year, but between 2004

16 and 2005 stayed the same. Rural IRFs, however, have grown

17 rapidly at almost 7 percent between 2004 and 2005. This

18 growth is consistent with a 21 percent payment adjustment

19 for rural IRFs under the PPS and critical access hospitals'

20 ability to have IRF units starting in October 2004.

21 Between 2002 and 2004 the volume of cases and

22 Medicare spending increased rapidly while average length of

1 stay decreased. Spending increased 16 percent per year
2 during this period.
3 In 2005 the story changed. There was a drop in
4 the number of cases and a shift in the type of patient who
5 was admitted to the IRF due to the modification and
6 enforcement of the 75 percent rule.
7 Between 2004 and 2005 the volume of cases dropped
8 10 percent and spending dropped 3 percent. The drop in
9 volume resulted in more complex patients continuing being
10 admitted to IRFs while less complex patients went to
11 alternative settings.
12 We have no direct measures of access and the
13 decrease in IRF cases is difficult to interpret. The number
14 of beneficiaries who used IRFs, in indirect measure of
15 access, increased 3 percent between 2002 and 2005. In some
16 markets IRFs closed and in other markets that previously had
17 none, IRFs opened.
18 To assess quality we examined the difference in
19 functioning at admission and discharge and found that all
20 patients using IRFs and those discharged home improved
21 functioning slightly from 2004 to 2006.
22 More than 80 percent of IRFs are hospital-based

1 and access capital through their parent institutions who
2 have good access. In addition, private equity firms are
3 investing in freestanding IRFs. These facts suggest IRFs
4 have access to capital.

5 Now we look at the comparison of payments and
6 costs. As you can see from the chart on the screen, under
7 TEFRA -- which is pre-PPS -- the change in costs per case
8 were slightly greater than the change in payments per case.
9 Under PPS, payments per case increased rapidly. Costs
10 started to accelerate in 2004. In 2005 the 75 percent went
11 into effect and costs per case accelerated rapidly,
12 increasing by 10 percent as volume of cases decreased and
13 CMI increased.

14 this is what we know up to 2005. Of course, this
15 is the last cost report information we have. But we do
16 think IRFs are trying to control costs.

17 Last month commissioners questioned what IRFs are
18 doing to control their costs as volume drops. We went back
19 to the industry, as you suggested, and they told us they are
20 closing beds and reducing staff. The industry also raised
21 concerns about enforcement of the 75 percent rule. The
22 industry reported that some FIs are being very aggressive in

1 denying claims. We've been unable to confirm this
2 information with CMS.
3 In 2005, the aggregate Medicare margin for IRFs
4 was 25 percent. IRFs at the 25th percentile had a margin of
5 negative 4 percent. IRFs at the 75th percentile had 22
6 percent. As you can see, there is a similar pattern between
7 hospital-based versus freestanding IRFs and nonprofit versus
8 for-profit IRFs. Hospital-based IRFs are predominately
9 nonprofit, as hospitals are, while freestanding IRFs are
10 predominantly for-profit.
11 Government IRFs have a 5 percent margin in 2005,
12 although these IRFs have few Medicare cases and don't
13 operate under the same constraints as other facilities.
14 We estimated a margin of 13 percent in 2005 and a
15 margin of 2.7 percent in 2007. The 75 percent rule has the
16 biggest effect on the projected margins. To model the 2007
17 margin, we had to make several assumptions. In part, we
18 based these assumptions on what IRFs experienced in the
19 first year of the phase-in of the 75 percent rule.
20 20 percent of the IRF cases disappear between 2005
21 and 2007. We tried to be reasonable in making assumptions
22 about costs. We assumed that IRFs are able to get rid of 90

1 percent of the direct costs or patient care costs for the
2 patients they no longer admit. We assumed that indirect
3 costs don't change. These assumptions together bring us to
4 the 2.7 percent. If we vary those assumptions, the margin
5 would be between 0.5 percent and 5.5 percent.
6 To recap the payment adequacy factors: supply,
7 quality, and access to capital are positive. Volume is down
8 and access is difficult to interpret. We project a
9 significant drop in margins. The range in margins depends
10 on what one assumes about costs.
11 On the one hand, IRFs have enjoyed strong positive
12 margins for several years. On the other hand, there has not
13 been the rapid growth we've seen in other post-acute
14 sectors. We've observed the effect of the 75 percent rule
15 on the number of cases and the types of cases admitted to
16 IRFs.
17 In December we discussed a zero update for IRFs.
18 The alternative I'm presenting is a 1 percent update.
19 The draft recommendation is on the screen. The
20 Congress should update payment rates for inpatient
21 rehabilitation facility services by 1 percent for fiscal
22 year 2008.

1 The update in law is market basket.

2 Implications of the recommendation are that it
3 decreases federal program spending relative to current law
4 by between $50 million and $250 million in one year and less
5 than $1 billion over five years.

6 For beneficiaries and providers, we expect no
7 effect on providers' ability to provide care to Medicare
8 beneficiaries.

9 That concludes my presentation.

10 MR. HACKBARTH: Questions or comments? No one?

11 MS. DePARLE: Where did you come up with 1
12 percent? It's not market basket minus productivity.

13 MR. HACKBARTH: From moi. It would be wrong to
14 suggest some way of calculating 1 percent.

15 The factors that seems significant to me, and
16 Sally touched on all of them, that this is an industry that
17 has had high margins for a number of years in the past. We
18 are in the process of seeing a significant change and
19 reduction in those margins, largely attributable to the 75
20 percent rule. So I think a case can be made for something
21 higher than the zero update that we've recommended in the
22 past.

1 But in view of where they've been in the recent
2 past, with I think double-digit margins each of the last
3 three or four or five years, I don't think that market
4 basket minus productivity -- which is sort of our starting
5 point, our benchmark, would be appropriate.
6 Hence, something between market basket minus
7 productivity and zero, and that's around 1 percent. That
8 was my logic.
9 DR. MILLER: This is, I think, just a minor
10 clarification but Sally, it's more like two or three years
11 they've had those higher margins?
12 DR. KAPLAN: You're right. They went into the PPS
13 in 2002 and so 2003, 2004 and then 2005 is above 10 percent.
14 The first year was not, but ramping up.
15 MR. HACKBARTH: The projected market basket is
16 what?
17 DR. KAPLAN: 3.1 percent, like all the other post-
18 acute.
19 MR. HACKBARTH: So 3.1 percent minus 1.3 percent,
20 which is the productivity adjustment, would be 1.8. this is
21 sort of between the zero and that.
22 It's science.

1 MS. DePARLE: No, it's a policy judgment, and that
2 would be my point.
3 MR. HACKBARTH: Other questions, comments?
4 DR. KANE: You do get concerned about how well the
5 case has been adjusted, given the profit margins. But do we
6 have a sense that once the 75 percent rule is in place that
7 the payments and costs are pretty much calibrated to each
8 other?
9 Unlike home health, where it looks like things are
10 pretty far out of whack, do we have a sense that once the 75
11 percent rule is in place that this big spread in your third
12 slide here will really go away? You know there's a huge
13 ramp up in costs over the period.
14 DR. KAPLAN: Let me speak to that. The IRF PPS is
15 a good prospective payment system, and so far the payments
16 have been -- for the individual case-mix groups -- have been
17 very closely calibrated to the costs. It was recently
18 revised. In fact, I believe for fiscal year 2006. And the
19 weights are recalibrated every year which is in contrast to
20 what you see with the SNFs and home health.
21 As far as to whether the difference in the margins
22 will go away, I'm unable to predict that.

1 DR. MILLER: Another part of that answer might
2 have been is we're still -- and this in part this is
3 reflected in our estimated margins -- we're still trying to
4 watch how the industry is going to respond to these changes.
5 I think that also drives some of the policy judgment here,
6 is that you have this impact occurring from these rules.
7 Things are happening. Admissions are dropping. Exactly how
8 they're going to calibrate out the admissions and respond
9 with their cost structure to a different presumably type of
10 patient, because the 75 percent rule went after a type of
11 patient, is I think also a little bit in flux right at the
12 moment, which might make it hard to answer that question.
13 DR. REISCHAUER: Just a question. 81 percent of
14 these institutions are hospital-based and presumably all the
15 problems that we have with SNFs and hospital-based SNFs
16 apply as well? Or not?
17 DR. KAPLAN: Craig did a pretty careful analysis
18 last year on the comparison of hospital-based versus
19 freestanding. He should speak to that. Is that going to
20 answer question?
21 DR. REISCHAUER: I don't know. I'm all ears.
22 DR. KAPLAN: Are you asking about cost allocation?

1 MR. LISK: If you go to the TEFRA period before we
2 went to the PPS, we actually saw margins about the same for
3 freestanding and hospital-based IRFs.
4 The other thing that's of interest here is for the
5 freestanding IRFs, IRF business in Medicare is their primary
6 line of business. On the freestanding SNFs, Medicare is not
7 their primary line of business. So there could be cost
8 allocations issues on the Medicare side in the freestanding
9 SNFs that produce some of the disparities. But what we saw
10 were very similar margins.
11 We've seen more disparity once the PPS went into
12 effect in margins with the hospital-based margins being a
13 little bit lower than the freestanding margins.
14 But the interest is in the TEFRA period we saw the
15 margins for both freestanding and hospital-based about very
16 similar to one another.
17 DR. MILLER: This question came up a year or a
18 year-and-a-half ago or however long ago it was and we went
19 through fairly extensive analysis and talked it through a
20 lot of hospital people like Nick and Ralph and some others
21 and sort of had this conversation and came to a consensus
22 that we thought we could move ahead with these.

1 MR. HACKBARTH: Others? Okay let's proceed to a
2 vote.
3 All opposed to the recommendation? All in favor?
4 Abstain?
5 Okay, thank you.
6 DR. KAPLAN: It's us again. Last but not least
7 are long-term care hospitals.
8 The last post-acute care payment adequacy
9 assessment is for long-term care hospitals.
10 As with IRFs, I'm going to review the evidence we
11 presented last month and then after give you the draft
12 recommendation and its implications, I'll tell you a little
13 bit about the RTI study of the feasibility of CMS's adopting
14 our recommendations to establish criteria to define long-
15 term care hospitals. This study is hot off the press. It
16 was published on December 26th and is in your tab A of your
17 folder.
18 Under the PPS, supply of long-term care hospitals
19 grew 10 percent per year. The same number of long-term care
20 hospitals entered the Medicare program in 2005 as in 2004.
21 Hospitals within hospitals entered at a faster pace than
22 freestanding long-term care hospitals. Many of the new

1 long-term care hospitals have located in markets that
2 already have long-term care hospitals, which raises
3 questions about their role, especially because the patients
4 who need this type of care are relatively rare.
5 Under the PPS, the number of long-term care
6 hospitals also increased 10 percent. Spending increased
7 almost triple that rate at 29 percent per year.
8 Although we have no direct measures of access and
9 can't tell which beneficiaries actually need this type of
10 care, the number of beneficiaries who used long-term care
11 hospitals increased 10 percent per year under PPS.
12 As far as quality is concerned, we examined four
13 different types of risk-adjusted quality measures and found
14 mixed results. On the positive side, the rate of death in
15 the long-term care hospitals and the rate of death within 30
16 days of discharge and one patient safety indicator improved
17 from 2004 to 2005. On the negative side, readmissions to
18 the acute care hospital and three out of four patient safety
19 indicators worsened between 2004 and 2005.
20 Long-term care hospitals have adequate access to
21 capital. Private equity firms have invested over $3 billion
22 in this industry between 2004 and 2006.

1 This chart shows how changes in payments per case
2 have compared to changes in costs per case. Under TEFRA
3 changes in costs were slightly higher than changes in
4 payment per case for most years before the PPS began.
5 Payments have increasingly under PPS. And as
6 payments went up, so have costs. The increase in payments
7 has been driven by observed case-mix. However, almost two-
8 thirds of the case-mix increase has been coding improvement.
9 The 2005 Medicare margins are on the screen. In
10 2005 all types of long-term care hospitals except
11 government-owned facilities had positive margins.
12 Government long-term care hospitals are few in number. They
13 have few Medicare patients and they operate under
14 constraints than other long-term care hospitals.
15 For purposes of projecting the 2007 margins with
16 2008 policy, we modeled the changes on the screen. As you
17 can see, there were a number of policies to include in the
18 model. The changes for 2007 are the reason for the drop in
19 margins from 2005 to 2007. Effectively, CMS froze payments
20 for 2007. In addition, they changed payments for short stay
21 outliers and that reduced payments as well.
22 The range of zero to 2 percent in 2007 results

1 from uncertainty about how hospitals within hospitals will
2 behave in response to the 25 percent rule.
3 Just to remind you about the 25 percent rule,
4 growth in hospitals within hospitals resulted in CMS
5 establishing a new policy to ensure that hospitals within
6 hospitals don't act like hospital-based units. The 25
7 percent rule reduces payments when hospitals within
8 hospitals admit more than 25 percent of patients from their
9 host hospitals. There are some exceptions to the rule and
10 these have a 50 percent threshold.
11 As we mentioned last month, CMS may not have the
12 tools to enforce this policy at this time, especially since
13 there is no systematic way to identify hospitals within
14 hospitals or their host hospitals. There are also a lot of
15 possible ways to respond to the rule. For example,
16 hospitals within hospitals can take a larger share of
17 outliers from the host hospital, who are not subject to the
18 rule. They could make arrangements to take a greater share
19 of patients from hospitals other than the host hospital,
20 including trading patients. Hospitals within hospitals can
21 become freestanding long-term care hospitals or there can be
22 other arrangements that can make hospitals within hospitals

1 willing to take a financial hit on patients over 25 percent.
2 I want to recap the evidence. All but one factor
3 we use to assess payment adequacy are positive and suggest
4 generous payments. From 2002 to 2004 we have seen high
5 margins across the whole industry. Margins are projected to
6 fall because of CMS's aggressive action.
7 Commissioners might want to consider that even
8 with those changes rapid growth in Medicare spending
9 continues. We found spending for long-term care hospitals
10 was $4.5 billion for 2005. CMS projects that Medicare
11 spending for long-term care hospitals will be $5.3 billion
12 in 2007.
13 Commissioners also might want to note that the
14 reaction of hospitals within hospitals to the 25 percent
15 rule is uncertain. Hospitals within hospitals make up the
16 majority of the long-term care hospital industry. There are
17 no criteria to define these facilities and patients yet. It
18 is possible that keeping the pressure on with the zero
19 update will be more likely to bring the industry to the
20 table about criteria.
21 The recommendation is on the screen. The
22 Secretary should eliminate the update to payment rates for

1 long-term care hospital services for rate year 2008.

2 Implications of this recommendation are that it

3 decreases federal program spending relative to current law

4 by between $50 million and $250 million in one year and less

5 than $1 billion over five years.

6 For beneficiaries and providers, we expect no

7 effect on providers' ability to provide care to Medicare

8 beneficiaries.

9 Before you discuss the draft recommendation, I'd

10 like to give you some information on the RTI study. As I

11 said, we've included it in tab A of your mailing materials

12 and a summary of the study is included in a text box in the

13 draft chapter.

14 CMS contract with RTI to study the feasibility of

15 adopting MedPAC's recommendations to better define long-term

16 care hospitals by facility and patient criteria. The RTI

17 study has a number of major findings. Many are similar to

18 the findings from our study of long-term care hospitals,

19 although the timing is different. Our study was before the

20 PPS began. RTI's study was after the PPS began.

21 The results of the study led RTI to recommend ways

22 to better define long-term care hospitals that are similar

1 to our recommendations. MedPAC and RTI differ in how they
2 suggest defining medically complex patients. We suggested
3 that long-term care hospitals have a high percentage of
4 patients who demonstrate a high level of severity, for
5 example 85 percent. RTI's recommendation goes further and
6 recommends that CMS develop a list of criteria to measure
7 medical severity for long-term care hospital admissions. To
8 develop this list, CMS would establish a technical expert
9 panel who would develop a set of criteria and recommend how
10 to measure them.

11 We believe that all of these recommendations are
12 similar to the Commission's recommendation for admission
13 criteria that includes patient-specific clinical
14 characteristics and need for specific treatments and it
15 encompasses our suggestion for a standard patient assessment
16 instrument.

17 RTI also recommends measures that would make long-
18 term care hospitals more similar to acute care hospitals and
19 that CMS take administrative action to better identify
20 hospitals within hospitals.

21 As I said earlier, the RTI report just came out
22 December 26th. There's no way to tell whether CMS is going

1 to implement any or all of the recommendations in the
2 proposed rule that is due out this month.
3 That completes my presentation.
4 MR. HACKBARTH: Questions or comments?
5 DR. WOLTER: Having been part of the site visits,
6 it's really nice to see how the follow-up work is going.
7 And it seems like this is very, very solid work so I
8 congratulate you on that.
9 I did see one comment I thought was a little bit
10 harsh in the text, and that is on page 15 under the
11 rationale, the Commission concluded that a very limited
12 number of patients are appropriately treated in these
13 facilities.
14 I say that because when we did our site visits,
15 especially the best facilities, it became very clear to me
16 that there is a subset of chronically, critically ill
17 patients who in the right setting probably are getting
18 better care than they would in most acute care hospitals or
19 in any other long-term care setting.
20 So I think the appropriate wording is elsewhere in
21 the text, which is it's unclear what criteria we should use
22 to make sure the right patients are going into these

1 facilities and hopefully our recommendations and the RTI
2 recommendations are going to get us on the right path.
3 At least that's the context I remember, Sally, but
4 you might want to comment.
5 DR. MILLER: The only thing I'll comment is -- and
6 I agree, we'll change the sentence. You're right, we didn't
7 necessarily conclude that there was a limited patient
8 population.
9 But I think what we were reaching for when we
10 wrote that is that we found that when you narrowed it and
11 focused it on the most severely ill patients is when this
12 benefit looked like it was a cost-effective choice for
13 Medicare. We'll just make sure that that point gets clear.
14 Your point is taken, though, that the criteria
15 needs to be established to determine exactly who is coming
16 in these doors.
17 MS. DePARLE: I agree with Nick and I have a
18 couple of other questions.
19 First, Sally, on the margins, on slide five, you
20 talked about the estimated margin for 2007 and that there
21 was a swing of zero to 2 percent. I'm not sure I followed
22 how you got there. I got the impression it depends heavily

1 on how the hospital within hospital 25 percent rule is
2 enforced. So can you give me a little more detail around
3 zero to 2 percent?
4 DR. KAPLAN: The range is dependent on how
5 hospitals within hospitals respond to the rule. If they
6 make no changes in their behavior whatsoever, then we would
7 expect it's basically 0.1 percent. If they completely
8 change their behavior or they find ways to get around the
9 rule, then it would be 1.9 percent, which we basically
10 rounded up to 2 percent.
11 And as we said, there's a lot of uncertainty about
12 this rule and also CMS's ability to enforce it since they
13 can't identify hospitals within hospitals systematically.
14 MS. DePARLE: That would be step number one,
15 wouldn't it?
16 Secondly, there is a debate, I gather, about
17 whether there is truly -- a lot of what we're saying in the
18 chapter and in our recommendations seems to be hinged on our
19 belief that based on the OSCAR data or the data that we're
20 looking at there's been a growth in the supply of either
21 LTCHs or LTCH beds. I guess we're looking at beds.
22 You also, Mark, gave us the letters from the

1 industry that seemed to argue that isn't the case, that in
2 fact it's been flat, or they would even argue I think
3 perhaps negative.
4 Why is there such a difference in the
5 interpretation of the data or the data that we're using
6 here?
7 DR. KAPLAN: I can't explain why there is such --
8 OSCAR is not necessarily perfect data.
9 MS. DePARLE: I'm shocked.
10 DR. KAPLAN: GAO has spent many hours writing
11 about how bad OSCAR is.
12 The difficulty with hospitals within hospitals is
13 that OSCAR isn't necessarily an accurate -- it's the best
14 data we have. Let me start by saying that. But it isn't
15 necessarily an accurate representation of long-term care
16 hospitals because a long-term care hospital located in a
17 city can open up satellites in other hospitals and other
18 floors of the hospitals but use the first long-term care
19 hospital's provider number. And so you would not count
20 those other long-term care hospitals that have opened up in
21 these other hospitals.
22 So it isn't necessarily a very good way of

1 tracking supply. I think this is kind of what Bob was
2 getting to in that maybe looking at the rise in cases is a
3 better representation, or the increase in spending.
4 And CMS, I think, is pretty conservative in the
5 actuaries' estimates of spending for this sector because
6 they often don't take into consideration the growth in
7 facilities. And they are basically saying it's going up to
8 $5.8 billion.
9 MS. DePARLE: So you would argue that the
10 recommendation is based more on growth in spending than on
11 the growth in supply?
12 DR. KAPLAN: I think it's all the factors. All of
13 the factors are positive. The only one that is not
14 completely positive is quality, which is mixed. And I'm not
15 sure that you could say that that's related to them not
16 having enough money in the pot.
17 So I would really base it on all of the factors
18 and that you have supply, as far as we can tell, going up 10
19 percent. You have users going up 10 percent. You have
20 cases going up 10 percent. You have spending going up 29
21 percent per year. And then you have the quality measures
22 and you see that private equity firms think these are a good

1 deal.

2 MS. DePARLE: But you also have the margin

3 analysis that appears to show a pretty decline.

4 DR. KAPLAN: Right. That's the only one that's

5 not overwhelmingly positive.

6 MS. DePARLE: I guess, finally, the RTI study, and

7 thank you for providing us with the entire 200 pages or

8 whatever it was.

9 DR. KAPLAN: That was holiday reading.

10 MS. DePARLE: Yes, it was.

11 I agree with you that it's similar, in many ways,

12 to our analysis. I guess what was disappointing, and maybe

13 you just look at it as it confirmed what we found. But our

14 work was done two years ago and I would like to think that

15 it would have advanced the effort here a little bit more

16 than it did.

17 So I guess I'm curious. If you were just

18 guessing, how long would it take to take that study? And

19 now let's have some criteria. This is what we've been

20 arguing for several years, is that I think from our site

21 visits -- I remember, Nick, your comment that as a

22 clinician, talking to pulmonologists and others in some of

1 these communities, that you perhaps went in somewhat
2 skeptically but became convinced that in certain
3 communities, as a clinician, this is where you would want to
4 get the care for the right kind of patient.
5 So the problem is we don't know what the right
6 kind of patient as and we don't have criteria on that.
7 What's it going to take to get there? The RTI
8 report doesn't exactly give them to us, but could you take
9 that or could CMS take that and within a year have
10 something?
11 DR. KAPLAN: I think it's possible. First of all,
12 they've had this report a lot longer than we have because
13 the final report, as you noticed on the cover page, is dated
14 October 2006. So that's the final report and generally
15 there is at least one draft before you get to final. So
16 they've had this report longer.
17 My understanding pretty much through the grapevine
18 is that they're already starting on organizing a TEP which
19 theoretically -- to me, most of the things that RTI
20 recommended could be handled through conditions of
21 participation. Telling who is medically severe or medically
22 complex, and who actually belongs in the long-term care

1 hospital, is the really tough nut to crack.

2 So I think that that's already starting and

3 probably within the next month or so that they will be

4 convening a TEP. And it's going to be a TEP of clinicians,

5 is what my understanding is. And not just clinicians from

6 long-term care hospitals, but clinicians from other post-

7 acute settings so that you give the opportunity for

8 clinicians who work in SNFs to say well, we can treat those

9 type of patients. We don't need long-term hospitals for

10 that, hypothetically.

11 MS. DePARLE: This seems to be one where clearly

12 you really do run the risk of making the perfect the enemy

13 of the good. We have nothing now and we're just moving on

14 in the dark. And it seems to me we're way past the point

15 where we should have gotten started on this.

16 I guess I would just conclude, Glenn, I sort of

17 previewed this earlier and in my comments about the

18 inpatient rehab facilities. My struggle here is consistency

19 of what we're doing. I guess I'm troubled if we're making a

20 recommendation for a zero update here, where the margins are

21 declining, we project them to decline dramatically, yes,

22 other factors appear positive. But that was true with

1 inpatient rehab, as well. These are policy judgments.

2 I suppose this one is defensible. I just find it

3 inconsistent with our other analysis and I'm troubled by

4 saying yes, I can definitely say that this should be zero

5 and the other one should be 1 percent. It's hard to say

6 that, especially when I think we are relying on some data

7 that I'm not clear are accurate.

8 It wouldn't be the first time, as my friend Dr.

9 Scanlon will quickly point out, but it does trouble me.

10 MR. HACKBARTH: Other questions, comments?

11 DR. MILLER: Not on your last point but on some of

12 your other points, I think that the process could move

13 relatively quickly to get criteria started to be put in

14 place. The actual, I think, tough nut is the patient

15 criteria, when you get down -- because I think there are

16 other standards that you could put in place and begin to

17 narrow the funnel and then start to get to the patient

18 criteria.

19 Both associations have plans that they have put on

20 the table and there's a fair degree of overlap, but not

21 entirely. And actually, I think, both associations may

22 choose to comment on this when we're done here.

1 But I think if you could get some agreement there
2 within the industry, because there are two different
3 industries, and this report puts some momentum behind it,
4 you could see certainly within a year that there are
5 additional criteria and then be driving towards the one we
6 all really want, which is the assessment of the patient and
7 the classification of the patient.
8 MS. DePARLE: There is such a thing as negotiated
9 rulemaking. That's not a pleasant process, but you can do
10 that. If there's a need to do something like this, that is
11 a way of doing it. People won't win everything.
12 But what troubles me is using the update as the
13 lever for dealing with what I think are much deeper issues
14 in not just the payment system but in Medicare's benefit
15 that it's providing.
16 DR. MILLER: I blacked out when you said
17 negotiated rulemaking, having been part of a couple of
18 those.
19 I also want to be sure that I leave with you that
20 there's not so much of a difference in what we're saying in
21 terms of growth and what the industry said. There was first
22 one letter in which they said we're actually seeing things

1 going down. And we had a conversation with them and said
2 we're looking at a different data source. And there may
3 even been an issue of which year we were looking at. I
4 can't remember.
5 And then I think a letter came yesterday that said
6 looking at the data that we were looking at it was flat.
7 And looking at the data that we're looking at, we see a
8 small growth. So the distance between what we're saying and
9 they're saying on that has narrowed considerably. Why
10 there's any difference still, in the space of four hours
11 when we got a letter and now, it is sort of hard to sort
12 out. But there's much less difference than the initial
13 letter implied, where there was kind of down and we were
14 headed up.
15 You have both of the letters, the one we got
16 yesterday we threw in there at the last minute.
17 MS. BURKE: One other issue, Sally, in both the
18 context of LTCHs and the rehab facilities.
19 Again, I was just looking back through. One of
20 the things, and we talked about this in an earlier
21 discussion. One of the things that fundamentally continues
22 to trouble me is the geographic issues that exist, in that

1 these tend to be in particular areas of the country. I
2 recall in an earlier discussion the sort of question was
3 okay, if they're that great, what happens to everybody else
4 who doesn't have one in proximity? In this particular
5 document there's a specific reference to the fact that
6 proximity is one of the greatest predictors in terms of
7 whether you're going to use this as compared to something
8 else.
9 This is this underlying policy question over the
10 long term is we're developing these sort of systems that are
11 unique in some cases to Florida. One can imagine the
12 population drives some of this. But I am troubled that we
13 continue to see this kind of unique growth in very
14 particular areas, that we are developing detailed systems,
15 to Mark's point of trying to understand more specifically
16 who appropriately goes into these things, but that they
17 continue to remain largely focused on very narrow areas of
18 the country. It's not just urban/rural. It's like three
19 states, as compared to the rest of the country.
20 I don't know that there's a thing we can do, but
21 over the long term that, to me, is a very troubling trend
22 both here as well as in the rehab facilities.

1 MR. HACKBARTH: My recollection is it's somewhat
2 more pronounced in the case of long-term care hospitals than
3 it is in the case of rehab hospitals. That certainly raises
4 questions in my mind.
5 To go back to Nancy-Ann's question, there is no
6 analytic basis for distinguishing between 1 percent for
7 inpatient rehab versus zero percent for long-term care
8 hospitals. It's just a judgment. And my thinking is this:
9 these are potentially useful for at least some patients. I
10 am worried about the pattern of growth. I am worried about
11 a significant expansion of the industry until we have
12 criteria in place. And to me, in this setting, one of the
13 few tools that we have to express that, that we think this
14 is a go slow sector, is the update recommendation.
15 I would hope that the industry and CMS and
16 everybody else involved would get on with the task of doing
17 the patient criteria so that we can use them where they are
18 promising and beneficial and efficient alternative for
19 Medicare beneficiaries.
20 But to allow them to continue to grow in the
21 absence of patient criteria is, I think, a questionable
22 judgment. And so the zero is my symbolic statement about

1 that.

2 I am also skeptical about the 25 percent rule and

3 how effective that will be. So I think maybe the margin

4 estimates are a little bit conservative in that sense. It

5 seems like there are ample opportunities to work your way

6 around the 25 percent rule. So I don't think that that's a

7 very effective constraint.

8 I compare that to the 75 percent rule for IRFs

9 where we've expressed reservations about that rule and how

10 it was done and the process by which it was done. But it is

11 at least a step in the direction of establishing criteria on

12 how we think ought to belong in this type of facility. I

13 think it has a lot more teeth than the stuff that's happened

14 to the long-term care hospitals.

15 So that all adds up to me that it might make sense

16 symbolically to make a distinction between the two. But I

17 can see how reasonable people might disagree with that.

18 DR. WOLTER: I was just going to say, on the issue

19 of the geographic concentration which clearly exists, there

20 is development of these facilities now starting in other

21 parts of the country and I think we'll see a little bit

22 change in the map the next time we look at it. How

1 significant it will be, I don't know.

2 And then I think the obvious ultimate end game
3 here, because as I said I think in our visits we did find
4 some facilities where patients were getting, I believe, some
5 superior care. But in other parts of the country those
6 patients are being cared for as outliers in the acute
7 hospital or in hospital-based SNFs. There may be some of
8 them that are being cared for in IRFs and probably less so
9 in freestanding SNFs, but maybe even there to some degree.

10 So the ultimate end game, if we have patient
11 criteria, would be to compare patients in those different
12 settings and look at where the cost/quality equation seems
13 to be most effective. And that's very, very hard to get to
14 but I think it's been our goal from the start on all of
15 this. That's probably a few years out.

16 MS. BURKE: I recall, to that point Sally, and
17 does remain true that at least analysis to date suggests
18 that long-term care hospitals, when compared to acute care
19 hospitals for the same patients, tend to be more costly not
20 necessarily because of a difference in severity? That's
21 what I recall from our earlier discussion, too.

22 Exactly to Nick's point is over the long-term the

1 question is where can people appropriately be cared for?
2 Are we paying for them appropriately, irrespective of site
3 but based on the severity of the particular case? At least
4 to date, at least as I understood it, long-term care
5 hospitals were more costly, not necessarily because of a
6 difference in acuity for the patient, between that and acute
7 care hospitals.

8 DR. KAPLAN: That's what we found pre-PPS and RTI
9 appears to be finding that. Now the multivariate analysis
10 of that has not been published yet. There is a third phase
11 of this study that will have the multivariate analyses. But
12 based on the descriptive statistics, I would say that that's
13 what they're going to find for the general patient in long-
14 term care hospitals.

15 MR. LISK: The other thing that Nick had mentioned
16 earlier though is that certain types of patients, like
17 ventilator patients, since hospitals may only get one or two
18 ventilator patients whereas a long-term care hospital may
19 have many of them, they may be more effective in caring for
20 those and successfully weaning those patients.

21 MR. HACKBARTH: So the crux of the problem, I
22 think Nick, is what you've put your finger on. The map is

1 changing. The problem is we don't know whether that's good
2 news or bad news. If they're treating the right patients,
3 expansion could be a good news. But if they're not, we're
4 just increasing costs for the Medicare program without
5 benefit to the patients.
6 So it always comes back to we need to get to the
7 task of defining who would benefit from this expensive and
8 intensive sort of care.
9 DR. MILLER: There is also one other thing that I
10 think we'll keep our eye on as we watch this. Some of the
11 growth that we've seen, and Sally make sure this is all
12 correct as usual, is within the same markets. To the extent
13 that the hospital within hospital can be circumvented by
14 having other people to move patients among, you could get
15 more growth. But it isn't necessarily growth in terms of
16 expanding the availability of it more broadly to the
17 population.
18 So when we look at growth for the next cycle, or
19 as we watch it, I'm just telling you, we're going to be
20 looking pretty hard at that.
21 MR. HACKBARTH: Anybody else who hasn't had a
22 chance to comment?

1 Shall we turn to the draft recommendation?

2 All opposed to the draft recommendation? All in

3 favor? Abstentions?

4 Okay, thank you.

5 MR. HACKBARTH: We're at the end for today. We'll

6 have a brief public comment period with the usual ground

7 rules.

8 MR. ALTMAN: I'd like to make one brief public

9 comment.

10 My name is Bill Altman and I'm here on behalf of

11 the Acute Long Term Hospital Association. I also work for

12 Kindred Health Care, where I'm the compliance officer.

13 I was the one who generated the information on

14 growth, so let me just explain what I did and be clear about

15 what we did.

16 In interactions with Mark and Sally, our initial

17 analysis using the CMS provider of service file found that

18 in 2005, as you found, there was an increase of 28 new

19 certified long-term acute care hospitals. And that's what

20 was presented to the Commission.

21 When we looked at the provider of service file

22 through October 2006, which is what we had access to, we

1 showed a net decrease of two certified LTCHs, as compared
2 with what happened the year before.
3 And then when we were advised by Sally and Mark
4 that the OSCAR was available through December 18th, 2006,
5 that's when we updated the analysis to show a net decrease
6 of one LTCH for 2006.
7 so I agree with Mark that we're not far off. I
8 also agree that OSCAR is not a perfect database but it's the
9 best that we have.
10 And I think what's important is that, as compared
11 with 2005, there was absolutely no growth in the number of
12 LTCHs, subject to all of the qualifications that have
13 already been discussed. And I think that is a direct result
14 of the cumulative CMS policies with respect to LTCHs, both
15 payment and the 25 percent rule.
16 I would also note that in 2006 nine hospitals
17 within hospitals were decertified from the Medicare program,
18 voluntarily decertified, which I think speaks to the
19 effectiveness of the 25 percent HIH rule and the difficulty
20 in complying.
21 I also point just point out, we have no difficulty
22 in using OSCAR and the provider of service file in

1 identifying hospitals within hospitals. There's been a
2 long-standing requirement in Medicare that we report to our
3 intermediaries whether we have a hospital within hospital
4 and who the host hospital is.
5 CMS recently codified that in regulation, but
6 that's a long-standing requirement. So I think that it's
7 pretty easy to identify freestanding versus hospitals within
8 hospitals and that that should not be a barrier to
9 enforcement.
10 With respect to Mark's comment, with which I
11 agree, that the industry has put forward proposals to
12 implement MedPAC's recommendations, and it's CMS that has
13 not moved on this until recently through the RTI study. I'd
14 like to emphasize one very important point that speaks to
15 geographic maldistribution, which I agree is problematic and
16 is a historical artifact where you saw a lot of the older
17 LTCHs certified in the three states, Massachusetts, Texas,
18 and Louisiana. You do see a little bit of continued growth
19 even in those states.
20 What is really important is that the legislative
21 proposal that was introduced by English and Pomeroy the end
22 of last session, and which was endorsed by ALTHA, would

1 directly address that geographic maldistribution. what we
2 did was, together with English and Pomeroy, identify the
3 conditions that are correlated with medical complexity and
4 say that LTCHs -- much like the 75 percent rule -- must have
5 the vast majority of their patients in those diagnostic
6 categories that correlate with severity of illness.
7 When you do that, the LTCHs that are
8 disproportionately hit because they cannot comply with that
9 rule are concentrated in Louisiana, Texas and Massachusetts.
10 And the reason is obvious. Where you have a concentration
11 of LTCHs there is intense competition for patients and LTCHs
12 will tend to admit with loose criteria those patients that
13 are not appropriate for an LTCH.
14 Our position, as you saw set forth in the letter,
15 is that with margins approaching zero and a variety of
16 regulatory actions that have effectively stemmed growth,
17 that further changes to the payment system, including a zero
18 market basket update, is not the way to get at the issues
19 that you have legitimately raised and analyzed with LTCHs.
20 But instead, we ought all turn our attention to
21 certification criteria. And if we do that, we will address
22 all of the policy issues that you have raised.

1 Thank you.

2 MR. HACKBARTH: All right. We will reconvene at

3 8:30 tomorrow.

4 [Whereupon, at 4:50 p.m., the meeting was

5 recessed, to reconvene at 8:30 a.m. on Wednesday, January

6 10, 2007.]

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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.

Wednesday, January 10, 1007
8:38 a.m.

COMMISSIONERS PRESENT:

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

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

2 MR. HACKBARTH: As we discussed yesterday, the
3 first order of business today is going to be to vote on the
4 physician update recommendation.

5 When we talked about it yesterday, a couple of
6 issues were raised by Doug and Bill, in particular, about
7 the impact of this year's update legislation and its rather
8 complex nature and how it affects the language of our 2008
9 recommendation.

10 Coming into the meeting yesterday, the
11 recommendation on the table was for an update of MEI minus
12 productivity. And so my goal is to produce that result but
13 explain it in a way that makes it clear in the context of
14 the legislation that just passed.

15 So I think what we need to do is this: the
16 legislation that passed at the end of last year, you will
17 recall, had a provision for a $1.35 billion fund to be used
18 for physicians in 2008. I think what we need to do with our
19 recommendation and accompanying text is make clear that we
20 think that that money, which is essentially prepaying part
21 of the physician update for 2008, ought to be included as
22 part of our recommendation. It's not additional money, it's

1 included within our recommendation. And so on that's step
2 number two. I skipped over one, which is to make it clear
3 that when we talk about MEI minus productivity for 2008
4 we're talking about basing that increase off the actual
5 conversion factors in effect in 2007.

6 You will recall that the way the legislation is
7 written it's not quite so straightforward. It provides for
8 the conversion factors to drop. We're talking about off the
9 higher level.

10 And then the third issue is that Nick has raised
11 issues about the direction of pay for performance for
12 physicians. And what I want to do is invite some discussion
13 of whether we ought to add a paragraph along the lines of
14 what Nick has been saying, that the current strategy of pay
15 for performance for physicians, which is basically paying
16 additional money to get all physician specialties to produce
17 update measures, may not be the most effective strategy and
18 at that some careful thought needs to be given to a
19 potentially more productive strategy and more focused
20 strategy.

21 I'm going to defer to Nick to elaborate on that if
22 there are questions about it.

1 But that is a bit of a shift in our policy and so
2 I don't want to add that sort of language unless there's a
3 consensus within the Commission that that would make sense
4 to do.
5 So to recap, we will have a recommendation and
6 accompanying text language that makes it clear that our
7 update recommendation is MEI minus productivity. The $1.35
8 billion is encompassed within that. Essentially, we're
9 looking at that money as dollars to be used for financing a
10 piece of the update in 2008.
11 Do people feel comfortable with that? Any
12 questions about that?
13 DR. WOLTER: My discomfort with including the $1.3
14 billion in the update is that it's going to make it highly
15 likely that a more focused approach to quality and pay for
16 performance in these very early years won't happen. I think
17 it's going to be highly likely that if it does happen then
18 other physicians not involved in the focused approach will
19 feel like they have been penalized because they are not
20 included.
21 And so the politics of that discussion would be, I
22 think, very, very difficult because of the way we would

1 include this in the update. I understand the rationale for
2 including it in the update because that's how we've done it
3 on the hospital side but I think it does set up a dynamic
4 that makes this discussion difficult, if not impossible.
5 I was thinking about this last night. If I were
6 the czar, I wouldn't create this fund. I'd give physicians
7 an update. They deserve an update. They haven't had one
8 for a while. And I would take the hospital pay for
9 performance money that we're talking about and use that as a
10 pool when we do these bundled DRGs, which I hope we'll get
11 to over the next few years. And that becomes the initial
12 focus of physician hospital pay for performance, so it's
13 funded out of existing funds and we don't get ourselves into
14 this dynamic of physicians fighting amongst one another
15 about feeling penalized or either in or out of how we start
16 in a more focused way on pay for performance.
17 Having said that, I know that's probably very
18 unlikely too, given how this all unfolds. But we're really
19 setting up some difficult dynamics now and we're creating a
20 fairly high likelihood that we're going to have some
21 failures in pay for performance and some backlash.
22 MR. HACKBARTH: Let me just make sure that Nick

1 and I are on the same page. I see including the $1.35
2 billion in the update as consistent with both our goal for
3 physician update coming into this meeting and consistent
4 with our past policy on P4P that it needs to be done in a
5 budget neutral way and we're not creating separate add-on
6 pay for performance funds for providers. For those two
7 reasons I think it's very important to include the $1.35
8 billion.

9 I am prepared to open the door to talking about a
10 more focused physician strategy of the sort that you've
11 described and we can take that up in the next cycle and
12 think carefully through what the implications of that are
13 and how it ought to be funded, et cetera. I don't want to
14 do that, create a separate fund, endorse a separate fund by
15 the seat of our pants, without thinking it through.

16 So I'm willing to go so far as a paragraph saying
17 there needs to be some strategic rethinking of physician
18 P4P, but I'd really prefer to stop there.

19 DR. WOLTER: I'd be very happy if we included a
20 paragraph that just said the option of a more focused
21 approach in the early years to physician paid for
22 performance, perhaps tied in some synergistic way to

1 hospital measures -- just even if we put that, I think it
2 would be a step ahead of where we've been.
3 But I will say this, you're absolutely right.
4 What you're recommending is consistent with our past
5 statements. Our past statements, however, have not set us
6 up for the most well thought out tactical approach to how we
7 might do pay for performance.
8 MR. HACKBARTH: And that's the conversation I'm
9 willing to have.
10 DR. WOLTER: That's the problem we've created for
11 ourselves, I think.
12 MR. HACKBARTH: I'm willing to stipulate to that
13 and that's a conversation we need to have. But let's do it
14 in a thoughtful way, as opposed to by impulse confronted
15 with this situation.
16 DR. WOLTER: I totally agree with that, too. It's
17 just now we have this dilemma of these dollars that got
18 funded that are putting us in this position of including it
19 in the update, increasing the likelihood of a more diffuse
20 approach in the early years.
21 MR. HACKBARTH: Let's get some other people in
22 here.

1 DR. HOLTZ-EAKIN: If I understand, I'm not sure
2 that has to be the case. it's not like these are earmarked
3 for P4P purposes. They can just be for the update. So I
4 guess that's one possibility for the way it could play out
5 but I don't see why it necessarily has to be that way.
6 DR. WOLTER: I don't think it has to but I'm
7 thinking of the politics, like you all do, about what might
8 happen when one group feels left in or out. That's all.
9 MR. HACKBARTH: Unfortunately, the record on
10 exactly what was the intended purpose of the $1.35 billion
11 is murky. We just don't know that.
12 As I think Bob noted yesterday, 2008 is an
13 election year. So one very simple notion of what was
14 intended was to assure there's going to be some update in a
15 presidential election year. It has nothing to do with P4P,
16 but basically pre-funding some update.
17 So what the purpose was we don't know. I think we
18 should not assume, however, that this was intended to be or
19 will be used as some sort of special P4P fund.
20 DR. KANE: I actually think I would take it as an
21 opportunity to direct it toward the infrastructure rather
22 than P4P, because -- towards anybody who starts to form an

1 accountable health organization or develops the
2 organizational structure or the information system
3 structure. I know you don't want to pay for information
4 systems themselves.
5 Just putting together an accountable health
6 organization takes money and funds. So I would think it
7 would be, since it's not earmarked and it's not necessarily
8 part of the update, and you don't really want it to go to
9 P4P right away. But what we don't have is an intermediate
10 step of who do we really want to pay? We want to pay
11 organizations that span much broader provider scope that
12 just the physician.
13 But to do that they've got to reform all of these
14 PHOs and IDS's and other forms that they might come up with
15 and it costs money. They need to hire people.
16 So I would think the $1.35 billion is an
17 opportunity to really jumpstart the infrastructure for a
18 meaningful P4P in the longer term and I would just take
19 advantage of the fact that nobody knows what to do with it
20 yet.
21 MR. HACKBARTH: I wouldn't say that. It's easy to
22 conjure up ways that we could spend more money and I don't

1 think we ought to just leap on this and say well, let's on
2 the spur of the moment come up with a new idea on how to
3 spend it.

4 DR. KANE: That's much more strategic than just
5 dumping it into the update and doing P4P before we know what
6 P4P is supposed to be.

7 MR. HACKBARTH: I'm not even sure what your idea
8 means.

9 DR. KANE: We've been talking about accountable
10 care organizations for the whole time I've been here. And I
11 think it takes money to build one. And I think these things
12 don't just materialize because you've imagined them. So
13 that's where I think it would be helpful to get them
14 started.

15 MR. HACKBARTH: I do understand the concept, but I
16 don't understand in practice what it means. And I don't
17 think that on the spur of the moment again we ought to
18 endorse some broad concept.

19 I'm happy to discuss it. I'm happy to think it
20 through, discuss pros and cons for different ways to use
21 money. But I don't think we ought to just say oh, we've
22 discovered yesterday this peculiarity and we ought to spend

1 $1.35 billion.

2 MR. BERTKO: Two comments, one to put some
3 structure under what Nancy just said and to agree with her
4 and to say I think we like to -- and again, this is not
5 meant to be spur of the moment, Glenn, but just as a
6 possibility. Connectivity as being the result here, and
7 there are real-time clearinghouses now available and
8 physicians may just need a spur to sign up for them. That's
9 one part.

10 The second one I certainly agree with what Nick
11 has expressed here in terms of focusing on the P4P parts
12 that would have the most bang. But I also know that in
13 working with Beth McGlynn in particular, she has shown us at
14 least something like 20 or 30 specialties which have
15 probably mostly process measures that could be looked at.

16 And maybe this again is just something that we
17 should look at a little bit in our next cycle and perhaps
18 offer some comments and advice on, in terms of what's out
19 there that's readily doable and then for folks like Nick and
20 Jay and our other physician colleagues here to say what's
21 the best choices among these.

22 MR. HACKBARTH: So you're saying, John, that you

1 would prefer not to have the paragraph along the lines that
2 Nick described?
3 MR. BERTKO: No, I think the paragraph is a good
4 idea and it may be up for us -- I mean in my mind there are
5 half a dozen competing quality organizations out there, all
6 with their own ideas. For us -- I think what could be one
7 of our jobs for Medicare is to say here, let's sort through
8 some of these and pick the best that we think are
9 straightforward and then hand it back to CMS to take action
10 on it.
11 DR. WOLTER: I just would add, I really agree with
12 this. I don't think the idea of focus has to be exclusive.
13 But I think within what we're doing it has a lot of merit.
14 But there are some specialty societies doing good things and
15 we just need to put that all together.
16 MR. MULLER: Cristina, could you go back to the
17 kind of step chart you had yesterday? Because I want to
18 talk not just about the $1.35 billion but the quality pool,
19 as well. The one that has the quality pool in there, as
20 well. I want to make sure I understand the base for --
21 don't you have one that has both the $1.35 billion and the
22 quality pool?

1 Glenn, in terms of where you were 10 minutes ago,
2 I'm understanding that you want the $1.35 billion fund to be
3 considered part of the pool of funds that we would be
4 recommending for 2008. The 1.5 percent is just a 2007 item.
5 So in that sense it falls off that cliff and there is not to
6 -- I just want to make sure we understood it.
7 DR. REISCHAUER: It will be a lump payment in 2008
8 to those who did the right thing in the last half of 2007.
9 MR. MULLER: Yes. So in terms of the consistency
10 of our thinking, I share some of Nick's concerns that we may
11 be consistent but we may be off in terms of this.
12 I think we should, based on our past
13 recommendations, keep going with the kind of MEI minus
14 productivity as we have and take the $1.35 billion into
15 account. And the extent to which we get into a more regular
16 cycle of doing that, especially in light of our SGR
17 conversation yesterday, I think being consistent with our
18 past recommendations and have a MEI-type recommendation each
19 year, I'm in favor of that. I've argued that the lack
20 thereof spurs other kinds of behavior that I think have more
21 effect on expenditure than, in fact, the update does because
22 I think the utilization increases are somewhat driven by the

1 lack of an update.

2 So I'm in favor of continuing to go in the

3 direction of an MEI-type recommendation.

4 My sense is that that 1.5 percent will be seen as

5 part of the base because the 5 percent, the yellow there, is

6 just basically adjusting for the SGR cut. So my sense is

7 people will see the 1.5 percent as part of a new base. That

8 doesn't mean that we have to see it as part of a new base,

9 but my sense is that they'll see this not just as a one-time

10 thing.

11 So I think having a recommendation on the MEI is

12 the right way to go and I would endorse putting the $1.35

13 billion -- I just wanted to make sure I understood how the

14 1.5 percent in the white there fit into the closing of that,

15 keeping that step at the 2007 level.

16 I think that what Nick and John have suggested, as

17 we know from our past discussions about pay for performance

18 in the physician community, all the solos, all those 57

19 percent of the people who are in solo are just not going to

20 be able to play in this game anytime soon.

21 Therefore, the fact that if we have P4P and it

22 goes to a less than a majority of the physicians, I think

1 it's a policy statement that will, as Nick said, cause some
2 real divisiveness inside the physician community.
3 Like you, I don't have an answer to that. But I
4 just don't see the solos being able to play in the quality
5 reporting very easily, for the reasons that Nick and John
6 have mentioned or Nancy. It takes a bit to just get up to
7 gear to report, and many of them do not have the capability
8 inside their office to do so. It often takes the lumpiness
9 of adding on another staff member to do it and they're not
10 going to see that as worth the expenditure for the 1.5
11 percent.
12 Not to reprise all the arguments, I think one of
13 the real challenges we have is we don't have a way to get to
14 100 percent of the physician community in P4P anytime soon.
15 I think explicitly acknowledging that is a helpful part of
16 what we can say that is consistent with what we've done in
17 the past.
18 DR. CROSSON: One approach that might, I don't
19 know whether to use the term straddle or be inclusive of the
20 comments, if we're going to include the $1.35 billion, would
21 be to refer in that back to the other report, to the SGR
22 report to Congress, and say something like were Congress --

1 because we have this whole section on a phased approach to
2 improving physician reimbursement.
3 So it might be possible to say Congress should
4 strongly consider the use of this money to, in some way,
5 advance the recommended agenda for a phased approach which
6 would actually include all of these ideas, make the point
7 that the money ought to be used in some way to improve
8 physician payment over time but not have to make a choice at
9 this particular moment about which ones of those things
10 might be the best approach.
11 MR. HACKBARTH: Although we've not, in fact,
12 recommended the phased approach.
13 DR. CROSSON: No, but if Congress were to consider
14 that pathway, something like that.
15 MS. BURKE: I'm a little confused. As I
16 understand it, Glenn, what you're proposing, following up on
17 yesterday's discussion, is in the absence of clarity as to
18 the intention with respect to this money that it simply be
19 considered a pool of money that, in fact, would be
20 incorporated into the market basket update.
21 MR. HACKBARTH: Basically a prepayment of the
22 update.

1 DR. REISCHAUER: Help pay for it.

2 MS. BURKE: Help pay for it. But as I understand
3 what you're saying, Jay, is to essentially revisit some of
4 the fundamental questions we ask in the SGR report and
5 suggest it be used for something else. I think that's at
6 direct odds with what Glenn is suggesting, I think.

7 I think what Glenn is suggesting is absent any
8 Congressional intent that was clear, which is what we asked
9 yesterday and they haven't been able to find anything, that
10 we have to assume that it was presumed to be available to
11 make sure that there was the resources available for an
12 update, as compared to using it as part of a tool to do
13 something that is more targeted; i.e., in the P4P.

14 I'm not disagreeing with you that over the long
15 term Nick's concern is that if we do P4P that we need to be
16 more targeted as we go forward. But I think what Glenn is
17 saying is absent any other clear direction, these funds are
18 presumed to be available to help finance the market basket,
19 which is for everybody.

20 MR. HACKBARTH: I agree with all of that. As I
21 said, if we want to talk about how we could use additional
22 funds, whether it be $1.35 billion or some other number, to

1 advance the phased approach or to advance the development of
2 accountable care organizations, or to advance connectivity,
3 we can do that. But let's do it in a thoughtful way.
4 And right now where we are is we came into this
5 meeting trying to make an update recommendation of MEI minus
6 productivity. And I'm just trying to reconcile that with
7 this more complex framework. I think the way to do that is
8 count the $1.35 billion as basically a prepayment of the
9 update for 2008. And then we can discuss the other ideas in
10 due course and do so in a thoughtful counsel way.
11 DR. WOLTER: I guess I just came away with the
12 impression that there was some language that this $1.35
13 billion was linked to quality. So if that's not the case, I
14 certainly would agree with your logic.
15 DR. SCANLON: I just want to reinforce where you,
16 which is this is 2008 money. And to come up with a new idea
17 in terms of how to spend it well, we're too late. In terms
18 of keeping it as part of the update, we've got a framework.
19 We can use it there and can fund this. The good ideas need
20 time to develop so that they can be implemented well.
21 MR. HACKBARTH: Any other comments?
22 What I'm taking from this discussion is that

1 people do support adding a paragraph of the sort that Nick
2 described. It would be in broad terms, we need to think
3 about the strategy for doing physician P4P.
4 MR. MULLER: But my understanding is that 1.5
5 percent is one-time quality money.
6 MS. BOCCUTI: Just for reporting.
7 MR. MULLER: But I mean that's basically where P4P
8 has been for awhile, has been on reporting.
9 MS. BOCCUTI: That's the way the law is now. It's
10 silent on what would happen in 2008 with regard to reporting
11 or performance incentives.
12 MR. MULLER: Next year I understand that once you
13 put it out there some people will think it's part of some
14 base. In that sense, while it's not formally part of our
15 recommendations, and I don't think we need to speak to it,
16 I'm sure next the Commission will have to.
17 MS. BOCCUTI: It may not seem so much part of the
18 base. I think what you're saying is you could even imagine
19 this being -- instead of the 10 percent, being 11.5 percent,
20 is what I think you're starting to go towards.
21 But because it's a one lump sum payment in 2008 it
22 might not be perceived so much as part of the base.

1 DR. REISCHAUER: And also, a fraction of
2 physicians are going to get it and we don't know what that
3 fraction is.
4 MS. BOCCUTI: We don't know that. And I think
5 that physicians are trying to get measures in, so that most
6 physicians will be eligible. But we don't know that yet.
7 DR. REISCHAUER: But I think, as Nick or somebody
8 said, for many the cost of doing this will be greater than
9 the benefit that they get from the lump sum so they may not
10 be incentivized.
11 MS. BURKE: I think it will be very important to
12 the extent we can, to find out exactly how much was spent,
13 if they did the full payout in 2008, and what they spent it
14 for.
15 The language which would suggest to the extent
16 feasible still makes me nervous because you can use that to
17 say well, it wasn't feasible to do X. So I think
18 ultimately, for the Commission going forward, understanding
19 whether there was a payout in 2008, what the nature of the
20 payout was, and how they structured the payout will be quite
21 informative.
22 MS. BOCCUTI: Payout for the $1.35 billion or the

1 1.5 percent quality?

2 MS. BURKE: No, the 1.5 percent.

3 MR. MULLER: But the 1.5 percent, that's not a

4 pool. You can get 1.5 percent for reporting.

5 MS. BOCCUTI: Right, but we don't know how much

6 that will total, because it's 1.5 percent on all the

7 services that the physician provided that meet the threshold

8 requirements.

9 MR. MULLER: So if my speculation is I say half

10 can't do it, then it's 1.5 percent for the half that can.

11 MS. BOCCUTI: Right. So we don't know the total

12 sum for that. I think that's what Sheila is answering, is

13 how much did that sum up.

14 DR. MILLER: Sheila's point had to do with the

15 $1.35 billion.

16 MS. BOCCUTI: No.

17 DR. MILLER: Then I need to clarify what you said,

18 that the to the extent feasible applies, that language, the

19 $1.35 billion feasibility language applies to the $1.35

20 billion.

21 MS. BOCCUTI: Right. That's why I asked. But the

22 $1.35 billion dollars has no restraint, other than it can

1 only -- I mean, to the nth degree it can only be 1.5 percent
2 of all services provided.
3 MS. BURKE: [off microphone] So again, I think the
4 question will be -- and thank you, that helps.
5 But understanding ultimately how they choose to do
6 it, what the decisions are, and what they spent will be
7 quite useful to understand.
8 MS. BOCCUTI: We'll try and find out from CMS how
9 it's going and what they're doing. I think everybody will
10 be interested in it and we will track that.
11 MR. HACKBARTH: Let me just have a show of hand of
12 people who have comments.
13 Before we take those, I just want to go back to
14 something Nick said a minute ago, just so there isn't
15 confusion. In reference to the $1.35 billion, Nick, you
16 said that -- and I can't reproduce the exact words, but
17 something about you thought that there was language about
18 being used for quality. I want to just make sure we're all
19 on the same page as to what it says.
20 There is language that says that it may be used by
21 the Secretary for quality -- can you quote the exact
22 language. Quality is in that phrase.

1 MS. BOCCUTI: They attached that to the name of
2 the fund, but it is not technically required to be used for
3 quality.
4 MR. HACKBARTH: Right. So it's listed as a
5 possibility but not as a requirement. Then the separate
6 question is what do we know from the legislative history,
7 the intent of it, and that's the piece that is murky.
8 So it's basically up to the Secretary how to use
9 that money.
10 MS. BOCCUTI: It's called the Physician Assistance
11 and Quality and Initiative Fund. And so I think that's
12 where we're getting the quality term for it. But it's not
13 technically directed only towards quality measures. But the
14 term is linked.
15 DR. MILLER: The legislative language says that
16 the Secretary can use it either for payments or for other
17 initiatives.
18 MS. BOCCUTI: Correct, and I'll get that
19 specifically.
20 DR. CASTELLANOS: This is on the 1.5 percent. To
21 stress Bob's point and Ralph's point, not all physicians are
22 going to be able to do that because they're not going to

1 have the technical ability to put that on the bill.

2 But more important, even physicians that want to

3 do it, unless their society has put in quality measures --

4 and that date is they need to do it by January 31st -- even

5 if you want to do, if the society hasn't done it you're not

6 going to qualify. And there's about six societies right now

7 that have not done it.

8 Which speaks to Nick's point. I don't think the

9 whole medical community is ready for P4P. And if we're

10 going to make P4P effective, we need to focus it to a

11 certain area that is ready to be done.

12 MS. BOCCUTI: I have the language.

13 The Secretary shall establish under the

14 Subsection, a Physician Quality Initiative Fund, which shall

15 be available to the Secretary for physician payment and

16 quality initiatives which may include application of an

17 adjustment to the update of the conversion factor under

18 Subsection D.

19 DR. REISCHAUER: I looks like we put it in the

20 right place.

21 MS. BOCCUTI: It says available for physician

22 payment and quality improvement initiatives, which may

1 include...

2 MR. HACKBARTH: The bottom line is the Secretary
3 has broad discretion on how to use it.

4 MR. DURENBERGER: Can I just make a comment on
5 this? I think most of us know that the Secretary has spent
6 a good part of the last year bringing the hospital quality
7 and the ambulatory quality people together. He's visited a
8 number of communities around the country encouraging
9 physician quality initiatives where they already exist.

10 I am presuming without knowing that part of this
11 language derives from the Secretary's effort to encourage
12 existing physician-based or physician-initiated quality
13 projects. I think that's part of the explanation.

14 MR. HACKBARTH: He may elect to use it that way.
15 I consider him a kindred spirit, somebody who is
16 enthusiastically a believer in quality improvement and the
17 like.

18 But the fact of the matter is it is going to be an
19 election year, the budget is going to be tight, particularly
20 if the PAYGO rules are instituted, and money is going to be
21 scarce. And the path of least resistance is to use this
22 money to fund an update.

1 But how it plays out I don't know. Time will
2 tell.
3 DR. SCANLON: I'm fully supportive of what Nick
4 has proposed, in terms of how we should be moving forward
5 with physician pay for performance, this idea of being
6 universal is really a handicap.
7 But he's also pointed out the potential
8 contradiction between that and our policy of budget
9 neutrality, because it implies that people who don't have
10 the measure that we want to reward today are, in some ways,
11 poor performers.
12 I guess there's a question of how we get that in
13 this paragraph in a clear way and consistent with our prior
14 policy.
15 Part of it may be that the issue is what's the
16 budget that we're trying to be neutral toward? Is it just
17 one that's going to be increased for inflation? Or in this
18 instance are we willing to have some pay for performance
19 built into this budget?
20 When we first talked about physician pay for
21 performance, we were talking about the experience of Britain
22 and how they had introduced, seemingly successfully, pay for

1 performance for physicians. But it was all new money. And
2 it was targeted on primary care physicians.
3 But again, it was in the context of putting in a
4 new investment. So it's very different than trying to say
5 our budget is only going to grow with inflation and we're
6 going to reallocate it.
7 MR. HACKBARTH: I think that's well put, and I
8 think that is one of the central problems here in moving
9 from a broad strategy and P4P for everybody to a more
10 focused one, is how do you finance it equitably? Do you tax
11 everybody when only a subset can potentially benefit from
12 the incentive payments? And so I think we need to think
13 that through. Maybe it requires an adjustment of what we
14 said in the past. I just want to think it through.
15 Bob reminded me yesterday that the IOM Committee
16 that he chaired on this said that -- why don't you go ahead
17 and say it, Bob.
18 DR. REISCHAUER: We struggled with this issue and
19 played around with several options. One is a temporary
20 infusion of new monies.
21 But another one is to take the procedures for
22 which one has the measures that one is going to apply and

1 nick all of them and redistribute the money according to
2 performance among them, and not touch anybody else. The
3 difficulty there is then you create an incentive for people
4 not to move forward. So you have to have some inevitability
5 that at some point they're going to be part of the game,
6 even if the measures aren't available now.
7 I think what Nick is pointing out quite usefully
8 is that it may not be worth the effort for some things, both
9 the measures aren't that meaningful, never will be that
10 meaningful, the amount of money isn't that great, and the
11 administrative costs of doing it just sort of outweigh the
12 gains you have.
13 And I think all of that is the kind of thing that
14 we should struggle with next year as we say really what are
15 the next steps in the physician area as we try and move
16 forward. Because I agree wholeheartedly with you, that by
17 trying to do one size fits all or everybody's in the game
18 immediately, there's a very good chance that you're going to
19 create so much opposition and confusion that the whole thing
20 gets thrown out.
21 MS. BURKE: Bob, I'm sorry, do I understand you to
22 say that in the course of the IOM's work that they got to

1 the place Nick was ultimately, which is -- as I understood
2 you to say it -- there may, in fact, be a point at which
3 there are certain things that are not worth --
4 DR. REISCHAUER: No, we didn't get to that. The
5 Committee actually said that in the by and by, everybody
6 should be part of this thing.
7 MS. BURKE: Because my understanding of Nick is
8 there may be a point at which any number of things may
9 suggest that there is a tail that may not be worth the
10 expense to bring the tail in.
11 DR. WOLTER: Yes, although the thing that
12 intrigues me the most is the other side of that coin, which
13 is where are the high volume, high cost areas we could
14 really create some improvement on in the early years?
15 That's the exciting part of all of this.
16 And if we lose the chance to tackle that because
17 we're dealing with all of the other stuff that would be too
18 bad.
19 DR. REISCHAUER: The other thing is that
20 initially, in the IOM view and I think in our view too, that
21 this starts as a siloed kind of exercise. But over time
22 what you're really interested in is outcomes, episodes of

1 care, where the bundle of providers is larger and can
2 encompass everybody. And how the money is allocated among
3 all of the players is something that's way too complicated
4 for mere mortals to decide at this point.
5 But this would be, in a sense, just a transitory
6 phase.
7 MR. HACKBARTH: Okay, I think it's time for us to
8 move ahead. So would you put up the recommendation?
9 And then the language explaining the base that
10 that increase is off will be in the text, as opposed to
11 trying to incorporate it in the actual boldface
12 recommendation. And then the language that we've just been
13 discussing, that Nick has suggested.
14 All opposed to this recommendation? All in favor?
15 Abstentions?
16 Okay. Thanks, Cristina.
17 We are now officially done with last year's cycle
18 and moving on to a new cycle.
19 MS. CHENG: So let's switch gears a little bit.
20 What we're now talking about is a Congressionally mandated
21 report. This is due in June so we're still in the
22 preparatory stage and I'm going to bring these issues and

1 these issues back to you a couple of more times before we
2 write this report.
3 So I just want to get one concept. I am going to
4 give you my take way right at the top, which is as we look
5 at measuring quality, we have to acknowledge that in any
6 measurement of the quality of a provider you've got a
7 certain amount of noise. And what that noise argues, I
8 think, is that the statistical significance of differences
9 that we measure may be important. That's the idea I want to
10 play with this morning. Let's see where that takes us as we
11 think about pay for performance.
12 Congress asked us in this report, due in June,
13 asked MedPAC to think about four questions. The first one
14 is how should we fund pay for performance, and we just
15 talked about that so that's pretty clear.
16 The next three then are how should we set
17 thresholds for rewards and penalties? What's an appropriate
18 size for a reward? And how should a program of rewards
19 balance rewards for improving your quality from period one
20 to period two against attaining high quality in our
21 measurement period?
22 So we've been working with contractors, they're

1 called OCS, Outcome Concept Systems. They're a national
2 private quality benchmarking firm. We've gotten two years
3 of the most recent data that we could from CMS. Actually,
4 it's a pretty good set. It brings us up into the end of
5 2500. So we're looking at pretty recent data to tackle some
6 of these questions and start our thinking on them.
7 I want to start this morning by getting pretty
8 concrete, so that we've got a good base to build on.
9 What is the home health outcome? What are we
10 talking about when we're measuring the quality of home
11 health? So measuring the home health outcome starts when a
12 nurse or a therapist measures the patient's function at the
13 start of care.
14 So for example, Mrs. Jones returns from the
15 hospital after a stroke and she's being admitted in her home
16 to a course of home care. When she is assessed at the start
17 of care, this patient is unable to get to the toilet and
18 uses a bed pan. Then over the course of her care at home,
19 the patient receives supportive and therapeutic care from a
20 variety of professionals, aides, nurses, therapists, and
21 others while the patient is homebound.
22 Then at the end of the course of their care, and

1 this might be two weeks later, two months later, when they
2 are discharged from home care, the nurse or the therapist
3 uses the same tool to then measure patient function again at
4 discharge.
5 So what we're after is what was the change in the
6 level of function during the course of home care. And in
7 this example perhaps now Mrs. Jones is able to get to and
8 from the toilet without assistance.
9 So the terms of a home care outcome measure, what
10 we're measuring here is the level of function, improvement
11 in toileting. And for this patient this would be scored a
12 yes. Any improvement from a lower level of functioning to a
13 higher level of functioning -- and on this particular ADL
14 there are five levels of functioning -- would be scored as
15 an improvement. If the patient stays at a level of
16 functioning other than the lowest level of functioning, then
17 we could score that as stabilization. So you've got another
18 measure here, improvement in toileting, yes/no;
19 stabilization in toileting, yes/no.
20 So this is how the current system works. This is
21 data that's already collected. A lot of this data is used
22 to measure quality. It's also used to run the case-mix and

1 the payment system. So this is data that's already in the
2 flow, being collected and analyzed by the home health
3 agencies and by CMS.
4 DR. REISCHAUER: Is it audited?
5 MS. CHENG: To the extent that it runs payment, it
6 is subject to payment audit. So yes, there are edits at the
7 regional home health intermediary level and the OIG and
8 others look for fraud and patterns of abuse in the payment
9 as a claim.
10 DR. MILLER: But Sharon, it's not broadly audited?
11 The percentage of records pulled and things like that?
12 Aren't there some questions about how accurate the data is?
13 I do know that there are some oversight and some
14 automatic editing that goes on, but I don't want to leave
15 the impression that this is all heavily cleaned and reviewed
16 data.
17 MS. CHENG: Right, and it's shades of gray here in
18 home health.
19 DR. REISCHAUER: It's a judgment call, it strikes
20 me, a lot of it. It's very difficult.
21 MS. CHENG: And when we, as a Commission, are
22 approaching home health, for the last four or five years

1 we've been talking about home health cost report data. And
2 I think what everybody has internalized is that the rate of
3 audit on cost report data is near zero. I don't want to
4 disabuse you of that issue.

5 But this is a different stream. The data that
6 we're talking about runs the claims for payment. So in
7 terms of automated edits, almost all of this data goes
8 through automated edits like any claim for a payment from a
9 physician from a hospital.

10 And then there is a very low but typical level of
11 then targeted review, pulling 1 or 2 percent of the claims,
12 and looking for an additional level of automated edits and
13 audits. And then a small proportion of that would be kicked
14 back for medical record review or something like that. But
15 it looks like a stream of claims for payment.

16 DR. SCANLON: When the fraud and abuse efforts
17 were more intense, we were still talking about 1 to 2
18 percent of claims ever getting anything more than the
19 automated review. And the reality about automated reviews
20 are that once you understand what's going to get kicked out,
21 you don't have to ever have anything kicked out again. You
22 can develop the knowledge that makes your claim consistent

1 with their edits. That's the concern about this.

2 MR. HACKBARTH: I don't want to get bogged down on

3 this point, but it is a critical issue in terms of the

4 reliability of the data.

5 It's also one thing to audit a claim, and

6 basically the question is was a person at a particular place

7 and time? Was a home health aide present and caring for a

8 patient? It's a little more difficult to verify improvement

9 in toileting, looking back. It's a different sort of

10 question with different evidence required.

11 Why don't you go ahead.

12 MS. CHENG: So what we just looked at then is how

13 we would go about measuring one patient on one outcome.

14 So for our work to address designing a system of

15 measurement for the quality of an agency, then what we want

16 to do is bring multiple assessments of patients and multiple

17 patients at an agency together so that we have a measurement

18 of the quality of the care for the agency.

19 What we've developed for purposes of working this

20 idea through is a measure that assesses each patient's total

21 ability to function with about 20 different indicators such

22 as the toileting example that we just looked at, walking

1 around, managing oral medications and a set of functional
2 outcomes. points are scored then for improving or
3 stabilizing the functional level of the patient and points
4 are lost for each potentially avoidable adverse event. We
5 have a set of four potentially avoidable, unplanned
6 hospitalizations and use of the ER.
7 In this model, those measures are doing a little
8 bit of double duty because not only are they telling us
9 about the patient's ability to remain safely at home but
10 they're also giving us a sense of the efficiency of resource
11 use for the program's resources because an unplanned
12 hospitalization triggers the use of other resources within
13 Medicare. So we're getting a little bit of a sense of
14 whether the care is resulting in the best use of program
15 resources.
16 We then take this information together and we get
17 an agency score. The maximum score on our scale is two.
18 Agency scores in our dataset tend to range from about
19 negative 0.2 to two.
20 So what do we do with the agency scores and how do
21 we use them in a process of pay for performance and agency
22 quality measurement? This is a fairly familiar approach and

1 it's got some real strong intuitive appeal. We could take
2 all of the agencies that we've got in our performances set
3 and we could rank them according to their quality score.
4 On the screen you've got a handful of nine
5 hypothetical agencies. They've been ranked by their quality
6 score. We can draw two fairly simple lines. The first line
7 tells us the top 20 percent of performers and they would be
8 in the reward group. And then the bottom line tells us
9 where you would draw a line for the bottom 20 percent. And
10 then you could imagine putting them into the penalty pool.
11 This is very intuitive. This is the kind of
12 information that you can access now. You can find out, for
13 example, on CMS's Hospital Compare what the percentile
14 ranking of the hospital is for a score.
15 By design, doing this kind of threshold drawing
16 ensures that you're always going to have a pretty
17 substantial group of agencies in the reward pool and a
18 substantial group of agencies in the penalty pool. You've
19 designed that into the system.
20 The disadvantage that I see in this approach is
21 that it depends on ranking agencies. The nine that we've
22 put up here have pretty nice big gaps between their scorers.

1 But in reality you would end up, in a system like this,
2 making a lot of distinctions where you might not see a whole
3 lot of difference in the scores.
4 The other disadvantage to this system is that when
5 you're participating in it, as an agency if I tell you at
6 the beginning of the performance period, this is going to be
7 my approach to scoring you, you don't know necessarily want
8 your rank would be in the nation. And you don't know where
9 that line is going to be drawn. So I can't tell you at the
10 beginning of the performance period what it's going to take
11 to earn an A or what it might take to fail the system
12 because we don't know those scores ahead of time.
13 There's another disadvantage, and I'm going to go
14 to this graphically because you can't see it here but I
15 think if I can draw you a picture it will pop out.
16 What we found when we applied this concept to real
17 data is a picture that looks something like this. In your
18 mailing materials you had a figure that was pretty sloppy
19 but it actually had 4,000 points of real data. This is just
20 a handful of agencies that are not particularly
21 representative. But the agencies whose dots there are sort
22 of the pinkish-red would be the penalty pool. They have the

1 lowest 20 percent scorers. The ones that have yellow dots
2 would be in sort of this no effect zone. And then the green
3 dots would be in our 20 percent reward.
4 But I've drawn a line there according to the size
5 of the agency because what pops out to me is that if you're
6 very small you have fewer than 100 patients that we can
7 measure for the entire year, there's a lot of variation down
8 there. That's where the lowest scores are and highest
9 scores are. And if you look then upwards towards the larger
10 agencies, almost none of those larger agencies get out of
11 that no effect box.
12 What could be the case is certainly this could be
13 measuring performance. It could be the case that large
14 agencies tend to be middle of the road and small agencies
15 tend to be very poor or very good. But what we wanted to
16 look at when we saw this pattern was whether or not what
17 we're really capturing here is noise in our ability to
18 measure the performance of small agencies.
19 What you're not seeing on this picture, I've taken
20 out agencies that have fewer than 25 patients in our sample.
21 But you would put a big mass of dots right at the bottom of
22 that and they would look even messier than the dots that

1 I've got up there for you.

2 So what we did when we saw that pattern in the
3 data was to take sort of an alternative approach and apply
4 the concept then of the statistical significance of our
5 quality measurement at the agency level. We felt that
6 agencies with very small numbers of patients -- and there
7 are many of them -- are more likely to vary from the mean
8 due to luck of the draw and not necessarily because their
9 true score varies from the mean.

10 So we calculated a confidence interval around each
11 agency's score. So larger samples, where patient level
12 outcomes were consistent, would increase our confidence that
13 the mean observed score was a true measurement, and smaller
14 samples with inconsistent patient level outcomes would
15 decrease our confidence that our observed mean was the true
16 score for the agency.

17 Now when you look at this graphically you get a
18 somewhat different picture.

19 So the concept would look like this. The
20 intervals here illustrate what we measured to be the noise
21 in our quality attainment scores. The square yellow box
22 there is the observed mean score for each of the agency --

1 again this is just a handful and now we've got hypothetical
2 agencies up here.
3 So the mean score for agency A there, way on the
4 left-hand side, would be 0.4, and the confidence interval
5 around that mean estimate varies from 0.3 to 0.5. And I've
6 arrayed my hypothetical agencies here.
7 What I'm trying to communicate as the concept is
8 that for some agencies our confidence in the mean score is
9 pretty tight. We've got a very small interval around them.
10 But for other agencies that are smaller or have inconsistent
11 scores, we might have a lot of uncertainty about the
12 trueness of that mean score and whether or not we're really
13 getting a good measure of the quality of the agency.
14 What I'd like to play with this morning then is
15 using this concept to set thresholds and to assign rewards
16 and penalties to agencies. So let's take this idea, the
17 mean score and the confidence interval. And now we're going
18 to apply the national mean patient level score.
19 So for this outcome the mean score was 0.82, and
20 I've drawn the line now across the set of agencies. So what
21 I'm trying to show, again the red would be agencies in the
22 penalty group, yellow would be in the no harm box, and the

1 green then could qualify for a reward. So the way we would
2 set the threshold would be to measure whether or not an
3 agency's score is significantly statistically different from
4 the mean.
5 So these guys, although their measured score is a
6 little bit above or a little bit below the mean, what the
7 interval around each of those dots tells us is that
8 statistically it's indistinguishable from the mean.
9 The disadvantage, I think, of this system is that
10 it's somewhat less intuitive than our first fairly
11 straightforward example. You also come up with some
12 outcomes that are going to be a little less than intuitive.
13 Let's look at this pair of J and K. The observed mean score
14 for agency J is a little lower than the score for agency K.
15 But K here, because of its confidence interval, would be
16 classified as the same as the mean and J would be classified
17 as statistically significantly higher than the mean.
18 While this is somewhat less intuitive, I think
19 that this is a concept that we can communicate. This has
20 been used in other forums. The Minnesota Community Health
21 Initiative uses the concept of an estimate and an interval
22 around the estimate to communicate in public reporting, in

1 fact, about quality measurement.

2 The AHRQ is also contemplating using intervals and
3 confidence intervals in its next national health quality
4 report to get this idea across that quality measurement has
5 some noise and we should acknowledge uncertainty where we
6 know that it exists.

7 The advantage, I think, of using this concept in
8 our quality measurement system is that we can include small
9 agencies and large agencies. We can put them on the same
10 scale and we can assess what we know about their quality and
11 we can make measurements and comparisons of both large and
12 small.

13 Also, we can set this system with the national
14 mean from the previous year, so everyone knows the mean
15 going into the system. So you know the score that you need
16 to beat to get into the reward group and you could know the
17 bar that you could fall below to run the risk of getting
18 into the penalty group. So there would be some more
19 knowledge on the part of the providers of what score they've
20 got to attain to get into these groups.

21 One disadvantage though, from the program's point
22 of view, of setting the bar beforehand is that this system,

1 unlike the other system we were looking at, doesn't ensure
2 that you're always going to have a large number of agencies
3 that fall below into that penalty group or that you're going
4 to have a substantial number of agencies that are going to
5 be high enough to get into that reward group.

6 So you're not building by design into the system a
7 certain number of agencies in the reward or in the penalty
8 group. So that was a pretty big concerned when we were
9 looking at this system, so one of the things we did was to
10 go back to our data. We measured, using this system,
11 whether or not, at least in our measurement years, we would
12 have enough bodies in these pools.

13 What we found is that when we measured our
14 agencies, and we included everybody down to the smallest
15 agency and up to the largest agency, that many agencies did
16 fall into the reward and the penalty groups. Between 14 and
17 29 percent of the agencies would fall into the penalty group
18 and between 18 and 34 percent of agencies would be eligible
19 for rewards if our test was statistically significantly
20 different from the mean.

21 Just for a little bit of a stretch, you could use
22 the same concept that we've used up to this point for

1 measuring attainment and we could apply it to our
2 measurement of improvement. Throughout the presentation
3 what we've been focused on is measurement of attainment, the
4 level of quality attained by the home health agency in our
5 measurement year. But we also want to include agencies that
6 are getting substantially better. So our approach could be
7 to test then, using the same statistical method, whether
8 year two performance is statistically significant higher
9 than year one performance.
10 What this does again is it biases the system away
11 from rewarding noisiness in unstable measures and it
12 accounts for the noise in the measurement when we're
13 comparing performance across time.
14 What you can find however, when you're testing
15 statistical significance, is that sometimes numbers that are
16 small are significant. And so you could conceive of a
17 system that uses statistical significance but also has some
18 kind of threshold, some minimum amount of absolute
19 improvement before we would say that you are different
20 enough in year two to merit a reward of some kind.
21 So one of our challenges, this was the last
22 question then on that list of questions from Congress, was

1 how do you balance improvement in attainment. This is just
2 one approach but it gives us something to think about.
3 You could bring these two concepts together and
4 you could then give a full reward to agencies that are
5 statistically significantly above the mean. You could give
6 a reward that is half that size to agencies that are
7 statistically the same as the mean but show statistical
8 significant improvement.
9 You might put then, into another group of no
10 impact, agencies that statistically are the same as the mean
11 or perhaps agencies that are below the mean but show
12 statistically significant improvement from year one to year
13 two.
14 And then finally, in your penalty box, you could
15 put those agencies that are both below the mean and not
16 showing improvement during your period of measurement.
17 So we've accounted for noise. We've looked at
18 ways to bring attainment and improvement together. We're
19 still going to have a challenge in home health, and in many
20 settings in fact, of what do we do with the small actors.
21 We've set up the system so that noise isn't measured, so
22 probably small actors are now going to be less likely to

1 receive these rewards because they're going to have to show
2 statistical significance. So how do we get them into these
3 groups? Here are two proposals that we could consider as we
4 develop this idea.

5 The first one would be to allow voluntary quality
6 associations. What you could do is maybe in a geographic
7 area or you could allow them to organize themselves. But
8 before the period of performance, a group of small providers
9 could agree that for purposes of measurement they would pool
10 their patients. They would form this voluntary association.
11 And then we would count all of their patients together and
12 the sample size would be more likely to qualify them for a
13 reward. It would also be more likely that they would get a
14 penalty. But it would allow them to participate and to have
15 excellence among small agencies rewarded.

16 Another approach that I'd like to suggest we think
17 about is pooling data across two years. Conceptually, a lot
18 of these systems run on data from one year. But we found
19 that you get a lot of bang for the buck if you're willing to
20 go for two years of data.

21 It also has the advantage of taking out some of
22 the noise in measurement. That's just caused by effects

1 that are going to happen over time. A change in ownership,
2 a bad flu epidemic. If you've got a little bit more data to
3 play with, and you take a little bit more of the variability
4 out, and you might get a better true measurement of the
5 quality of the agency over time.

6 In this system, that wouldn't necessarily delay
7 the implementation. We've got five years of data so we
8 could easily look back one year from our performance year if
9 we're going to pool data across multiple years.

10 A lot of stuff to chew on. I think we could have
11 a good discussion. Our next steps then would be to discuss
12 these ideas of thresholds, attainment, improvement and
13 measurement, and then take some of our ideas and consult
14 with outside experts on quality measurement. And also with
15 stakeholders, kind of kick the tires on this and get some
16 reactions from that group.

17 Then I'd like to apply the lessons that we've
18 learned from this example of designing the home health
19 system and apply this model to addressing the mandated
20 questions for home health. But also to the extent that we
21 can, to comment on the broader questions of design for pay
22 for performance.

1 With that, I'd like to open the discussion.
2 MR. HACKBARTH: Just one clarification, Sharon.
3 In previous discussions of this we've talked about issues
4 surrounding developing composite measures of quality. In
5 this presentation I think you've focused on a single
6 example. What's the significance of your just focusing on a
7 single measure? Have you concluded that that's the way it
8 ought to be done as opposed to with composite measures of
9 quality? Or have you just consciously set the composite
10 issue aside and we'll come back to that later?
11 MS. CHENG: Certainly for the purposes of the
12 presentation, I've put all of those questions aside. In the
13 mailing materials we walked through two alternatives that we
14 still have that are available for us to look at that are
15 slightly different composites. What we have been looking at
16 is a composite, it was just the one that is most easy to
17 manipulate. It has some nice characteristics of validity
18 and reliability. But by no means have we closed the
19 question of how to develop that measure.
20 MR. HACKBARTH: I just wanted to clarify that.
21 Questions, comments?
22 DR. SCANLON: I have a couple of comments. One, I

1 think this relates back to our discussion yesterday about
2 home health payment and the payment system.
3 I think, home health is a somewhat different case
4 and yesterday's margin distribution kind of brings this
5 forward. If I'm an agency and I'm thinking about the
6 business case to see if I can qualify for a pay for
7 performance reward, I think I have to consider what is it
8 going to cost me to achieve the outcomes that are going to
9 be rewarded? And if I'm at a 35 percent margin, maybe I'm
10 doing fine compared to any reward that I could possibly get.
11 Or I don't even need to worry about the penalty that might
12 be associated with that.
13 So it's a question of grafting a pay for
14 performance incentive on top of a system that may have some
15 fundamental flaws of its own and the combination is not
16 going to serve us well.
17 In that regard, I'll come back to Bob's question
18 about audit, I think this is a very important aspect of pay
19 for performance for these agencies, given the pattern we saw
20 yesterday terms of the growth of new agencies. It's
21 reminiscent of what was happening in the 1990s in terms of
22 high concentrations of new agencies in certain areas and not

1 a real sense that these are necessary or whether they're
2 taking advantage of the fact that we've got a high average
3 margin and also the potential for even much higher margins.
4 So if we have pay for performance, we need to be sure that
5 the system has integrity in terms of the data that we're
6 using to make rewards.
7 The last comment is about home health as a
8 heterogeneous service. It relates in part to the issue of
9 small agency but it also relates to the fact that this is
10 not just a post-acute benefit. It's also a chronic
11 condition management benefit that can go on for extended
12 periods of time.
13 And when I look at the list of measures we have
14 for home health performance, I feel like we've got a lot
15 about recovery and rehabilitation and less about chronic
16 care management. So if an agency is small and dealing more
17 with chronic care management, then I think they are
18 potentially disadvantaged by the system and I think we need
19 to consider have we done enough in terms of the measures to
20 capture that type of agency if people are specializing in
21 that?
22 We're concerned in other areas about rewarding

1 things like coordination of services. That's something
2 that's going on with home health, and I think we shouldn't
3 create a system where we undervalue it compared to the post-
4 acute kinds of services.
5 DR. CROSSON: I think what struck me about the
6 presentation was the dichotomous relationship between the
7 level of sophistication of the analysis and the graphs and
8 the relative unsophistication or subjectivity of the
9 measures that they're being applied to. So there's sort of
10 non-parametric issue here.
11 And I just wonder whether, as you look through the
12 things that could be measured, and maybe this is in line
13 with what Nick was saying about pay for performance in
14 general, would it be better to start off with a smaller set
15 of measures that are as objective as possible? And some of
16 them have some objectivity to them. Things like
17 readmission, for example, and falls and things that pretty
18 much have to be documented. And perhaps add to that some
19 evaluation by the client or the family of the client. And
20 start with something that is tight. And then later on,
21 after you get some sense of what else could be measured, go
22 beyond that.

1 But to me, trying to do a sophisticated
2 statistical analysis and apply it to a set of measures that
3 includes things that are, quite honestly, gameable, just
4 doesn't seem to work.
5 MR. HACKBARTH: Sharon, any reaction to that?
6 MS. CHENG: I think one of the opportunities that
7 we have with this report is to continue to comment on a home
8 health quality measurement set. When we had an opportunity
9 to talk about that several years ago now we suggested that
10 in addition to the outcome set that we have, patient
11 experience would be a good tool to add to it.
12 We spent a little time last year thinking about
13 ways to measure the processes around fall prevention,
14 patient education, wound care and other chronic activities.
15 And so I think we'll have the opportunity here to discuss
16 the measure set and to perhaps reiterate some of our ideas
17 about ways we'd like to see this measure set evolve.
18 DR. REISCHAUER: I found this very interesting.
19 Do we know anything about the geographic
20 distribution of agencies by quality?
21 MS. CHENG: That falls smack into our next steps.
22 We do have the real data and we've run the measures so far

1 on a national level and we've gotten the agency level
2 observations. The next step is going to be attaching
3 dollars to it, which we haven't done yet, and then looking
4 at some of these agency characteristics and how they fall on
5 our quality measure.
6 DR. REISCHAUER: Do we know anything about the
7 distribution of performance, of the curve of performance
8 from year to year? Because if it doesn't change much, and
9 my guess it doesn't, I think there's a lot to be said by
10 setting thresholds based on previous years parameters so
11 people know what they're shooting for and what will obtain a
12 reward and what will get them penalized.
13 And then, as you said, we're going to try to find
14 out about using your standard errors, the relationship
15 between quality and size of agency. Because the last thing
16 you want to do is create an incentive to perpetuate a size
17 that doesn't necessarily provide the highest quality care
18 that's possible.
19 I sort of wonder, I guess along Jay's concerns,
20 that the sophistication of the analysis here is maybe
21 outrunning the underlying ability to measure what we want to
22 measure. But that isn't what we were asked to do. You did

1 a great job.

2 MS. BEHROOZI: There's really a lot of interesting
3 stuff to think about Sharon, thank you.

4 On the chart that begins on page eight you had
5 referred to the little lines coming off the sides in your
6 paper as whiskers, so I'll just refer to them as whiskers.

7 I guess I'm concerned about the length of the
8 whiskers in some of the cases. It seems to me, again
9 picking up on what Jay said, that we really need to get to
10 measures that we're comfortable enough with to shorten those
11 whiskers because it seems like consistency itself should be
12 something that we value.

13 And you referred in your paper to the fact that
14 there are small agencies with consistent outcomes or more
15 consistent outcomes than others. Well, then why shouldn't
16 they all be, assuming that we have enough confidence in the
17 risk adjustment and validity of the measures that we use to
18 judge.

19 So I think you're right, Jay, that it really does
20 all come down to that. But as I said, I would add
21 consistency to the list of things we should be looking at.
22 Because as the beneficiary, of course, you want to know when

1 you go into an agency a little bit about how you're going to
2 come out at the other end. Not just in terms of quality but
3 that you can count on that quality.
4 And just to add and trot out my little red wagon
5 that I talked a little bit about yesterday, and have in the
6 past, I think some of the measures that might be worth
7 looking at have to do with staff issues. Dr. Kramer's work
8 in the SNF area that Kathryn referred to yesterday showed
9 some evidence that there was a correlation between training
10 of staff and outcomes. So those might be the kinds of
11 things.
12 And there are certain levels of training required
13 in certain states, I guess. Frankly, I don't know if
14 Medicare has any requirements on that score. But if there
15 are any those agencies that go beyond that, is there a
16 correlate to outcomes?
17 And perhaps staff turnover, and I know that it's
18 not so easy to get that data. But again if a lot of this is
19 self-report, it might be a thing to add to the reports. And
20 it's auditable. Those are facts that you can go back and
21 check more easily than did someone's toileting ability
22 improve at a point in time in the past.

1 So those are just some suggestions. I don't know
2 if there are other areas, but again to stay with this notion
3 of something being measurable and related to quality.
4 MR. HACKBARTH: Can I ask about that, Mitra? If
5 there is a strong correlation between staff and outcome, why
6 don't you pay for the outcome and then that will create the
7 incentive to staff "appropriately?"
8 MS. BEHROOZI: Because you can measure the
9 staffing issues. I'm trying to go to what these things are
10 that are concrete. So if the outcome is stabilization of
11 the ability to use the telephone, or whatever one of those
12 things were on the list, as you said you can't go back and
13 measure how much better the person was at using the
14 telephone. But you can go back and say oh, last year their
15 turnover rate was 45 percent and we have seen a correlation
16 between stability of staff and better outcomes or that kind
17 of thing. So it's really on the measurability.
18 MR. HACKBARTH: I see your logical chain. It gets
19 circular if the study that verified the relationship between
20 staff and outcome was based on subjective, unauditable
21 outcome measures. But you could do, I guess, a special
22 study where you established the relationship between staff

1 and objectively audited outcomes and then use staff for the
2 big program where you don't have the ability to audit.
3 MS. BEHROOZI: I think that's true. I think that
4 it would be useful to study it in more depth, to have some
5 special studies looking at those things, especially if they
6 haven't been the subject of other studies that you can refer
7 to. I don't think that you can just go off the data that we
8 have and just sort of reorganize the data that has its own
9 flaws already.
10 DR. HOLTZ-EAKIN: I think this got asked but I
11 guess one question I'm still not clear on is what exactly is
12 an agency? You did something at the end, portraying it
13 almost as a virtue, that I worried about in gaming this kind
14 of system, which is aggregating and disaggregating your
15 business in order to game the uncertainty and make sure that
16 you cross the thresholds, particularly if you set them the
17 year before and you know what you're aiming for. You take a
18 couple of counties and break them apart when it's convenient
19 to dump the losers, and pull them together.
20 To what extent is that possible? The unit of
21 observation becomes very important when you start doing
22 this.

1 DR. MILLER: There's a couple things there. I
2 think when Sharon was laying out some of those ideas at the
3 beginning, particularly the notion of people coming
4 together. I can't remember whether you said it. I know
5 internally we've talked about this. The notion would be
6 you'd have to pick your partners and what you are before it
7 goes in for the given year. But you're right, you could
8 probably reform.
9 But I mean agencies -- and I'm way out here in
10 your territory so be sure this is right. Agencies, you'd
11 have to have a provider number, you have to have gone
12 through the process of being accepted as a provider in
13 Medicare. There's certain things you'd have to go through.
14 Simply switching your agency, I think, is a little
15 bit more complicated. But you're referring to changing your
16 referral area or the area that you're covering. That's true
17 and an agency could choose to change that at any point in
18 time. And I suppose some of the question is whether they
19 choose, even on a patient by patient basis, which is an
20 issue that's come up in pay-for-performance more than once
21 and not just here.
22 But the notion of just I was agency A and now I'm

1 agency B, there's a little bit more to that than just
2 changing. And the notion would be that they would have had
3 to have made this decision before the performance was
4 measured, not in retrospect, in looking back and saying now
5 I'm going to partner with you because you did a good job.
6 I hope that was all roughly correct, Sharon.
7 MS. CHENG: Absolutely right. Certainly,
8 providers in home health are not facility base, so it would
9 probably be easier to change the president of a home health
10 agency than to change whether you are a hospital or not over
11 the course of a year or two years. And to the extent that
12 they would reorganize, I think we would probably have to
13 settle on some kind of definition of the agency, probably at
14 the level of a provider number that had been surveyed and
15 certified as that provider and call that the agency.
16 The definition of an agency is the organization
17 and the direct staff to provide at least one of the covered
18 services. So what an agency is could vary quite a bit. One
19 agency might have a small cadre of nurses. Another agency
20 could have direct hires of nurses and aides and therapists
21 and medical social workers.
22 I think one of the challenges here and one of the

1 things that we have a chance to elaborate, and is not unique
2 to home health, is the problem of what is the provider?
3 What are the associations among them? And what are the
4 challenges going to be for home health?
5 I think it speaks to the challenges in the
6 physician pay for performance, what do you do in a situation
7 where you've got a lot of small providers? And that's going
8 to be the opportunity in this report, to think about that.
9 MS. BURKE: It's really the issue that Doug
10 touched on that I was interested in, just to pursue it for
11 one additional moment, and sort of reference a part of Bob's
12 earlier comment.
13 That is, in addition to the geographic issue and
14 what we understand about this, is this issue of size. There
15 are a unique set of issues around home health. But I think
16 understanding -- because they can qualify as a provider, as
17 an agency, literally providing one thing.
18 I think it will be very helpful for us to
19 understand to what extent quality -- to the extent we feel
20 comfortable with the management -- to what extent that
21 really varies through the size issues and whether there is a
22 value in relooking at what, in fact, should we expect an

1 agency to be? What, from a minimum standpoint, should we
2 expect ought to be provided, particularly to the extent that
3 we are increasingly moving towards more collaborative and
4 coordinated methods of delivery?
5 Literally, the sort of issue that you discuss when
6 you talk about the small sample size and the strategies to
7 address that suggest that they can sort of form these groups
8 to come together so you can measure, or in some cases where
9 you're looking at agencies have two patients or three
10 patients. It becomes enormously complex to understand what
11 quality means and how you control it in those settings.
12 So I think as we gather this information, as we
13 can begin to understand what size means, what does a
14 competent organization mean, what our expectations ought to
15 be, it may help us move towards this how many things ought
16 to be put together in order to provide a range of services
17 that is appropriate and that we can count on.
18 I don't think we ought to go to the end of the
19 world to try and figure how do you measure an agency that
20 takes care of two patients. Maybe that's the wrong
21 question, that is should we allow an agency that only
22 provides care for two patients? I think this information

1 may begin to help us to understand that.

2 And I suspect it will be, in part, be geographic.

3 You will see that there are tendencies in rural areas and

4 the traditional places for obvious reasons. But I think we

5 need to get a better understanding of that. It maybe you

6 do, in this way, encourage people to begin to collaborate,

7 to begin to partner with other institutions, whether it's

8 with SNFs or with hospitals or whomever it might be or with

9 other agencies.

10 But it's a little troubling. I don't want to

11 create these systems that encourage organizations that we

12 may, at the end of the day, figure out don't make a lot of

13 sense for purposes of quality.

14 So understanding that quality as it goes across

15 size, I think, will be helpful.

16 MS. CHENG: And this is an issue that I think is

17 on the table. It's not directly implicated in the questions

18 that Congress asked us but it is something that we as a

19 Commission have thought about a little bit. And that is

20 when we look at some with a very small agencies, because I

21 was curious, too. How can you be a home care agency and I'm

22 finding five, 10, 15 patients.

1 Many of the smallest agencies -- not all but many
2 -- are Medicare and Medicaid. Now the way the system is set
3 up now we do have information on their Medicaid patients, as
4 well. They are required to conduct the OASIS on Medicare
5 and Medicaid patients. And so for the purposes of measuring
6 the quality of the agency one question we could consider or
7 not would be are we measuring then the quality of their
8 Medicare patients? Or are we measuring the quality of the
9 agency, which could include Medicare and Medicaid patients?
10 That would change our picture of the size of the agency but
11 it would also implicate a question that may or may not
12 complicate things.
13 DR. MILLER: I just wanted to say one thing as
14 long as you were bringing this point up, and it actually can
15 be connected to some other comments.
16 When we've talked about pay for performance, and
17 we've run over a lot of this ground. How robust are the
18 measures? Are we going to go about classifying people and
19 looking at those kinds of things?
20 Also what is come up in those conversations once
21 or twice is as you're moving forward, shouldn't you also be
22 setting in almost floors, that as quality moves along you

1 say by the way, this should just be a condition of
2 participation.
3 The way I interpreted your comments, which I think
4 in some ways could start -- not on its own because there are
5 other payment system issues -- but this issue of what is an
6 agency and who should be in this game and who shouldn't.
7 It does drive us down that road to looking at some
8 of this data and saying maybe the condition of participation
9 here should be...
10 And so I just wanted to be sure that you
11 understand that tool was in your arsenal.
12 MR. HACKBARTH: I think that Sheila has
13 potentially presented a really radical idea, which is that
14 being of a scale sufficient that we can reliably measure
15 quality ought to be a basic requirement for all types of
16 providers.
17 DR. REISCHAUER: But if you have private pay
18 patients, Medicaid, and Medicare, what you care about when
19 we're talking about size is the whole ball of wax. When
20 we're talking about capacities and things like that, the
21 presumption that because you have two Medicare patients
22 doesn't now tell me anything.

1 MR. HACKBARTH: If Arnie were here he would make
2 his regular appeal for sharing data, pooling data across
3 different payers so that we can more reliably accurately
4 assess quality for all parties, Medicare and private payers
5 alike.

6 DR. SCANLON: The threshold is that you have to
7 have served 10 patients period before you can become a
8 Medicare agency. They don't have to be your patient load at
9 this point in time. You just have to have served 10
10 patients. This is a vast increase in from what it used to
11 be, which was one patient.

12 So this is the concern about the geographic
13 pattern we saw yesterday in terms of growth. Why do we get
14 more than 200 agencies in selected states, and you can't
15 imagine them all starting off with a large volume that we
16 might think of as the critical mass in order to be able to
17 provide quality care.

18 MR. MULLER: I want to go back to Bill's initial
19 point about a half hour or so ago. In an industry that has
20 17 percent margins for distribution between two and 27,
21 there are such powerful incentives to work on your margin
22 that are going to overwhelm any incentives for pay for

1 performance.

2 Because in provider sectors where the margins are
3 minus two or plus two, pulling a 1 percent to 2 percent pool
4 out for pay for performance has a real dramatic incentive
5 effect. If you can get 27 by taking certain steps to
6 control your population, et cetera, that's going to be much
7 more powerful than a 1 or 2 percent pool.

8 So unless we're talking about 5 or 6 percent P4P
9 pools here, which I don't think we are, I would say that the
10 underlying incentives in this sector are to -- as evidenced
11 showed yesterday -- are to grow in certain areas and under
12 the PPS we move towards much more robust margins than we had
13 in the prior period.

14 So I would say, whenever you can do 10 or 15
15 percent through effective management of whatever, that's
16 going to overwhelm any effort towards P4P.

17 DR. REISCHAUER: Presumably this is a transitory
18 situation because the Congress will turn to us for our
19 recommendations for payment increases every year and after a
20 few years we'll be down to normal margins.

21 MR. MULLER: So if we squeeze everybody down, then
22 that's the right mix for P4P. I'm not sure that's the way

1 to go.

2 I'm just saying there's a couple of sectors which
3 we saw yesterday in the updates where we have very powerful
4 performance under PPS. And my guess is in those areas until
5 you go to a different equilibrium you're going to have very
6 low incentive except for certain agencies that have a
7 certain scale, they're going to do it anyway as part of
8 their mission to perform this kind of way and invest in
9 those kind of systems.

10 So obviously, if you have thousands of patients
11 and you have more computerized records, et cetera and so
12 forth, one can go more in that kind of direction than one
13 can if there are these smaller agencies and again where the
14 margins overwhelm any P4P incentive.

15 MR. HACKBARTH: I think it's important point and
16 one worthy of inclusion in our discussion, and it seems you
17 can go one of three paths with it. You can say well, even
18 with the large margins, go ahead with P4P. It won't make
19 things worse. I don't know if that's true, but it's
20 potentially one path.

21 A second path is to say you don't do P4P in places
22 with high margins like this.

1 Or the third is you've got to rebase the rates
2 concurrent with doing pay for performance.
3 I don't know which of those is the right answer
4 but I think those are the logical possibilities.
5 MR. MULLER: I'm not arguing for the third. I
6 think in light of some of the conversations we've had about
7 where CMS puts their effort and in the sense that their
8 staff is finite, like all staffs, and so forth, I would
9 focus in areas that we've discussed not just in the last day
10 or two but areas that we've discussed in the last year or
11 two that are more ripe for the advancement of P4P than is my
12 sense is here.
13 Again, it doesn't mean therefore I would vote to
14 recommending a P4P effort here but I wouldn't make it the
15 mainstay of where one begins. I think, as we've discussed,
16 there's room in dialysis, et cetera and so forth, with the
17 bundling and so forth composite rate where the advancement
18 of a P4P effort perhaps could have a higher priority.
19 So again, it's not our role to necessarily suggest
20 to the Secretary start in dialysis rather than in home
21 health. I'm just saying for a practical matter it's more
22 likely to have traction and buy-in in that area than it is

1 in this sector for the reasons I've suggested and Bill
2 suggested in his initial comments.
3 MR. HACKBARTH: Although I think that there may be
4 some other people who look at persistently high margins of
5 this scale and say forget P4P, it's time to think about
6 rebasing the rates.
7 DR. KANE: I just wondered if given how hard it is
8 to look at home health on a stand-alone basis, are there big
9 chunks of home health that would fall into some of the
10 episode types that we are trying to develop measures for?
11 And would that be a better way or maybe a more relevant way
12 to get at the quality of home health?
13 I'm just thinking maybe there's stroke or
14 something episode types that are very big that we think we
15 can get our hands around that we can start thinking about
16 episodic quality? Of course, it would have to be into a
17 system that would be able to take accountable responsibility
18 for it. But do we have a sense of how much home health
19 might fall into an episode that would be a meaningful
20 grouping for developing measures, like stroke or congestive
21 heart failure?
22 MS. CHENG: We've got estimates of how many

1 hospitalizations by primary diagnosis are followed by home
2 health, so we could start to look at that. And just about
3 anybody who is -- everyone, by definition, who's getting
4 home health has to have a plan of care signed off by a
5 physician.

6 So all of this presumably is captured in a
7 physician episode -- almost all of it would be captured in a
8 physician episode someplace. And I would imagine it would
9 be a lot of stroke or CHF or COPD episodes. I don't think
10 home health would be a dominant form of care, though. If
11 you looked at all Medicare beneficiaries with CHF, I'm not
12 sure that the majority of them would be getting home health.
13 But we could take a couple of slices at that.

14 DR. MILLER: We've built some data sets that
15 you've seen pass through here to look at episodes that we've
16 been doing over the last year or a year-and-a-half. We can
17 present that information by condition, by type of service,
18 how much hospitalization, how much physician, how much home
19 health. So we can get at that number and pick out a couple
20 of conditions that you might be focused on here like stroke
21 and see if we can't answer it for you.

22 We have some quality indicators -- I'm talking

1 about just dollars now. The outcome indicators are a little
2 bit tougher and not as developed at all, related to the
3 specific episodes.
4 DR. KANE: That may be what you want though, in
5 the sense of trying to figure out what's meaningful about
6 home health, is to say in these types of episodes it looks
7 like when there is -- home health has a major effect on the
8 outcome of the episode and so that's where you want to put
9 your emphasis rather than on everybody.
10 MR. HACKBARTH: Okay, thank you, Sharon.
11 Next is a presentation on bundling in the
12 inpatient prospective system.
13 MS. MUTTI: Good morning.
14 Commissioners have expressed a need for fee-for-
15 service payment reform that encourages greater efficiency.
16 Specifically, commissioners have noted that payment policy
17 should foster cooperation among physicians and between
18 hospitals and physicians to promote the right care being
19 delivered at the right time. It should hold a team of
20 providers accountable for a common outcome such as
21 longitudinal efficiency. And it should encourage providers
22 to invest in care coordination.

1 Several aspects of our current fee-for-service
2 system and current Medicare regulations are barriers to
3 these goals, as we've noted before. While hospital and
4 physicians can influence the volume mix and cost of one
5 another's services, they are not currently rewarded for
6 collaborating to appropriately constrain each other's
7 service use. Instead, more admissions and use of outpatient
8 services, increased income for hospitals, and more visits,
9 procedures, and tests increase income for physicians.
10 Under PPS, hospitals are motivated to collaborate
11 with physicians to restrain physician use of hospital
12 resources. But they are prevented by gainsharing
13 restrictions from financially rewarding physicians for
14 reducing hospital costs associated with Medicare patients.
15 In addition, fee-for-service payment does not
16 reward providers for longitudinal efficiency. That is the
17 service use over an episode of care. As a result, most
18 hospitals and hospital-based physicians have not invested in
19 the coordination of care subsequent to discharge to prevent
20 certain readmissions.
21 The combined result is that patient care is not
22 coordinated, more care rather than appropriate care is

1 rewarded, and Medicare and beneficiaries pay more than they
2 should.
3 This presentation offers two options to improve
4 the incentives implicit in Medicare's payment policy and it
5 focuses on care delivered right around the inpatient stay.
6 The options are intended to be consistent with the goals I
7 just discussed on the previous slide.
8 The first policy option is to bundle hospital and
9 physician payment for inpatient care. The second option is
10 to reduce payment for potentially avoidable readmissions.
11 They could be pursued in tandem or independently of one
12 another.
13 In the next slides, I'll discuss the motivation
14 for these options and some of the information issues. I
15 should just say right at the beginning, we have not thought
16 through every aspect of these options. Our intent here is
17 to give you enough of a sense of the idea to get your
18 reactions and thoughts on how to focus our next steps of our
19 research.
20 A number of factors motivate a policy option to
21 pay a bundled amount to hospitals and physicians for the
22 inpatient care. First is the variation in spending for

1 service use around hospital stays with no indication that
2 more spending results in higher quality across regions.
3 Elliott Fisher and his colleagues have found that the rate
4 of physician visits during hospitalization varies widely,
5 much more widely, in fact, than for outpatient office
6 visits. Rates for inpatient visits and specialist
7 consultations in high spending regions were more than twice
8 that of rates in lower spending regions. This suggests the
9 opportunity to appropriately restrain resource use.
10 Second is the experience under Medicare's
11 demonstration on coronary artery bypass graft surgeries that
12 was in the 1990s where certain hospitals received bundled
13 payment for the hospital and physician care during the
14 admission. With the bundled payment, the majority of
15 participants were able to successfully align incentives
16 among physicians and hospitals so that they reduced ICU,
17 nursing, pharmacy and lab costs as well as consulting
18 physician visits and post-acute care spending. No decrease
19 in quality was observed. In fact, mortality rates continued
20 to decline among these sites across the course of the
21 demonstration.
22 It could follow then that introducing a more

1 sweeping policy related to bundled payment could result in
2 similar types of savings. Considering that Medicare spends
3 about $7 billion annually for physician services during the
4 admission, or about 12 percent of total physician spending,
5 behavior change in this area could produce significant
6 savings.

7 How could bundling work? To help illuminate the
8 implementation issues, let me outline a possible approach.
9 The payment could be set at the average amount, similar to
10 how DRG payments were determined. Hospitals and physicians
11 would need to form an organization that would receive the
12 bundled payment and distribute it among themselves. The
13 approach, therefore, permits gainsharing. That is the
14 ability of physicians to share in the hospital savings they
15 help produce.

16 Policymakers may consider applying these this
17 policy to only a subset of conditions or discharges rather
18 than across all inpatient stays. Particularly if the subset
19 were selected on the basis of volume, spending, and the
20 ability to improve, the policy could simultaneously be
21 manageable for hospitals and physicians and also achieve
22 some quick and tangible success for Medicare and its

1 beneficiaries. The availability of quality measures should
2 also be a factor in selecting target conditions to help
3 mitigate any incentive for stinting.
4 Perhaps one of the thorniest aspects of this
5 policy option, however, concerns the ability of hospitals
6 and physicians to come together to agree on how to share the
7 payment and, in turn, whether to make the policy voluntary
8 or mandatory. The first question, can hospitals and
9 physicians constructively agree on an equitably way to share
10 the payment? We've seen, in the New Jersey proposed
11 demonstration on gainsharing a couple of years back that
12 those hospitals and physicians were able to come together.
13 In the CABG demonstration in the 1990s, those hospitals and
14 physicians were also able to come together.
15 But we also know and we hear about physicians and
16 hospitals tensely negotiating the allocation of current
17 perks and payment for certain services such as ER coverage.
18 We also know that hospitals and physicians in some markets
19 are in competition with one another as physicians open their
20 own hospitals and imaging centers, further adding to this
21 discord.
22 So we wonder asking them to revisit all these

1 payment rules may make things worse. For this reason, a
2 mandatory bundled payment may not be a realistic option for
3 all communities, at least not in the short term.
4 So voluntary approach is an alternative but it is
5 also tricky because those hospital's physicians most likely
6 to financially benefit will volunteer for the bundled the
7 payment. That's assuming that they can agree on the terms
8 and get over the discord we talked about, which in turn
9 costs Medicare. For this reason, there would need to be a
10 payment penalty for those high-cost facilities and their
11 physicians who opt not to participate. The next slide tries
12 to illustrate this dynamic graphically.
13 This slide is only an illustration. It's just
14 intended to clarify the incentives under a voluntary
15 approach.
16 You can see on the left side of the slide a
17 vertical line with ascending dollar values attached and
18 $5,000 is bolded in the middle. These are hypothetical
19 combined physician and hospital payments for inpatient care.
20 The national average payment is $5,000, and in this
21 hypothetical standard we're assuming that that's
22 standardized so that it doesn't reflect adjustments for

1 wages, teaching, DSH, and outlier payments.

2 Some hospitals and physicians provide inpatient
3 care for less than the $5,000 and some provide it for more
4 than the $5,000. The difference is primarily attributable
5 to the number of physician visits during a stay.

6 These numbers do not reflect the variation in
7 hospital costs.

8 Those hospitals and physicians providing the care
9 for less than $5,000 have a strong incentive to participate
10 because they will get a higher bundled amount than the
11 payment they current receive. To the extent these are the
12 only providers that actually volunteer for the policy, we
13 spend a lot more. As I said before, that's why you would
14 need to design a penalty, perhaps a withhold on the fee-for-
15 service payments to hospitals and physician services during
16 inpatient stay in order to make it at least budget neutral.

17 So to recap the pros and cons of the bundling
18 option of hospital and physician payments around an
19 inpatient stay, the pro again is the potential to align
20 incentives between hospitals and physicians to reduce not
21 only the hospital costs but also unnecessary physician
22 visits.

1 The cons or concerns here include the challenging
2 implementation issues for Medicare and also for hospitals
3 and physicians. On the Medicare side, exactly how would
4 budget neutrality be ensured? Exactly how would the quality
5 measures be used to prevent the stinting?
6 As I said, the second concern here is the
7 potential adverse dynamics that could result when hospitals
8 and physicians are negotiating. With each hospital
9 potentially having a different payment rate for physicians,
10 which would then could vary by specialty, we raise the
11 possibility of unintended consequences in some markets.
12 Would tension between specialties arise during the
13 negotiation that might undermine their ability to
14 collaborate on patient care? Would the policy intensify
15 current competition for those physicians who bring in a high
16 volume of high-margin services? And ultimately drive volume
17 or give some hospitals an unfair competitive advantage?
18 Those are just some of the questions that we have at the
19 moment.
20 Some protections certainly could be designed to
21 try and counterbalance those adverse possibilities, such as
22 limiting the physician bonus payments or the differential in

1 bonus payments. And then, of course, if those were adopted
2 they would also need to be monitored.
3 While bundling payment for care during the
4 admission should encourage greater efficiency during the
5 admission, it does not provide any incentive to hospitals
6 and physicians to avoid unnecessary admissions. So this
7 second policy option here is focused on adjusting payment to
8 discourage a subset of unnecessary admissions and we call
9 these potentially avoidable readmissions. As I mentioned
10 earlier, it could be implemented in tandem with the bundling
11 or on its own.
12 Studies have shown that patients are more likely
13 to be readmitted if they had complications during the stay
14 such as anesthesia complications, infection due to medical
15 care and hemorrhage. Many of these can be avoided with
16 reengineering care processes, as we actually heard from a
17 panel earlier in our session here in September. Some have
18 found that by identifying vulnerable patients and providing
19 care coordination support prior and subsequent to discharge,
20 readmissions were significantly reduced.
21 Medicare readmissions are significant. In our
22 analysis across all non-ESRD beneficiaries who survive the

1 hospitalization, we found that 2.6 percent of admissions
2 result in a readmission within three days, 5.8 percent
3 result in a readmission within seven days, and 16.7 percent
4 result in a readmission within 30 days.
5 These readmission rates appear to have slightly
6 increased from 1991 and 1997, years for which we have
7 performed a similar analysis. With inpatient Medicare
8 spending over $100 billion in 2006, Medicare spent somewhere
9 in the ballpark of $16 billion on those 30-day readmissions.
10 How could a readmission policy be implemented?
11 First, because not all readmissions are avoidable, Medicare
12 would need a rule for defining potentially avoidable
13 readmissions. Some states and payers are using clinical
14 logic that identifies these related readmissions. They pay
15 pair this logic with a specified time period, 15, 30, even
16 90 days among those we've talked to, within which those
17 potentially avoidable readmissions would be identified.
18 Others have looked at all readmissions within a
19 narrow time frame. For example, under its program measuring
20 hospital efficiency, the Leapfrog Group counts all
21 readmissions within 14 days of discharge. It specifically
22 acknowledges that -- and I'm quoting here -- "the

1 readmission window was reduced from 30 days post-discharge
2 to 14 days in part to increase the likelihood that the
3 readmission was related. Nevertheless, it is likely that
4 some readmissions as counted are not related to the earlier
5 discharge, but that will affect all reporting hospitals."
6 Another issue is how the payment penalty for
7 potentially avoidable readmissions would be structured. One
8 way might be to reduce payment for the initial admission,
9 but if a related readmission was not detected at any
10 hospital within a designated time period -- 10 or 30 days --
11 Medicare would pay the hospital the balance. If the
12 readmission did occur, the hospital would not receive the
13 balance for the initial hospitalization but would receive
14 full payment for the readmission. This approach keeps the
15 penalty on the hospital whose initial care led to the
16 readmission, which may be a different hospital than the one
17 that the readmission occurs at. There are several ways to
18 structure this. We talk about another in the paper and we
19 can go into that further in discussion.
20 The final design issue I'll mention on this is
21 whether Medicare should keep all the savings or share some
22 portion with providers as further incentive to avoid

1 readmissions and forgo that revenue associated with the
2 readmission.
3 With that, I look forward to your discussion of
4 these options and thoughts on further analysis.
5 MR. MULLER: I've been in favor of more bundling
6 in comments in the past but just thinking through some of
7 the prodigal difficulties here, if we go to slide six for
8 example, looking at the national average payment. You start
9 thinking about does that include DSH? Does that include
10 IME? Does that include critical access?
11 So for example, how one brings it in. If you go
12 back to some of the work we did on specialty hospital two
13 years ago where we showed that there were major
14 opportunities within a DRG to select patients and do very
15 well with low severity patients and to have negative margins
16 with high severity patients, in some ways how one constructs
17 this payment, as you've noted, Anne, leaves room for a lot
18 of people to come in to get in under that high average.
19 So for example, I think we said in the
20 presentation yesterday that three-quarters or so of the
21 hospitals get DSH payments, and I know of different
22 magnitude. So how we bring all those special payment

1 factors in to this calculation, I think, is a very difficult
2 thing to sort out.
3 In addition to that, some of the real savings are
4 secured by management in the outpatient setting. I don't
5 think you're suggesting here we combine inpatient and
6 outpatient rates. This is largely just around the inpatient
7 stay. But how then one brings outpatient payments and APCs
8 into this, as well.
9 So I think this is one of the ones that I find
10 intellectually very fascinating but when I start thinking
11 through how one implements this given the variety of
12 features we already have inside PPS, it is just quite
13 daunting as to figure out how one, in fact, meets those kind
14 of difficulties.
15 I was just wondering, just as an illustration, how
16 would you put DSH, IME, and critical access into this?
17 DR. MILLER: I think that is -- at the outset of
18 her presentation she said there were still issues that we
19 were thinking of working through. And you've identified it,
20 we're aware of it. You could go through a couple of
21 different ways. I don't think at this point we would be
22 able to go through an example with you.

1 MR. MULLER: I would say that 80 percent of
2 hospitals would be either critical access, DSH or IME. I'm
3 just guessing off the presentations the last few days. So
4 they don't look at what they're getting right now as a --
5 DR. MILLER: Agreed, and there's a couple of ways
6 you could think about how to deal with that, and some of
7 them you would probably not particularly agree with. And so
8 I do understand your point on the bundling. Internally we
9 went through some of this and that's why we wanted to bring
10 the idea up and see how far it got.
11 But one question I have for you is do you have any
12 reactions to the readmission policy?
13 MR. MULLER: I think there's probably more that
14 can be done there in a practical way. My quick reaction to
15 it -- and not just today but having thought about this over
16 the last couple of years -- is that it's a simpler -- on the
17 basis of administrative simplicity -- not to say it's
18 simple. But I think it's simpler than the set of issues
19 around bundling.
20 I think one could think about how to implement
21 that. In fact, some states, in their Medicaid program, have
22 done such things. And the IHA now, there is some movement

1 on never events -- not to say readmissions fall in the never
2 events -- but I think increasingly people are looking at
3 that continuum from never events to reasonably predictable
4 readmissions that shouldn't occur as arenas in which one can
5 look for payment reduction that may be fairer than just
6 payment freezes and so forth.

7 I would look at -- as obviously I'm sure you have,
8 Anne. I would look at some of the state efforts on Medicaid
9 on the readmissions side to see what kind of learnings might
10 be there.

11 MR. BERTKO: This is very intriguing and hopefully
12 has promise.

13 I want to offer a word of caution and perhaps a
14 direction for you. In the late 1990s this was put up in a
15 different form called contact capitation. I don't know if
16 you've talked to any of the people that have offered that.
17 One. Okay, good.

18 And then there are two consumer directed companies
19 that have tried that in the 2000s, in terms of pooling
20 bundles together.

21 The caution here is that contact capitation didn't
22 go anywhere as a general policy but it may have been too

1 ambitious at the time.

2 The second comment is somewhat related to this,

3 but with this slide, slide six here, it strikes me at least

4 as the payment penalty part of this might be very difficult

5 to implement and I'd offer a different way to do it, which

6 would be to think of it almost more in the center of

7 excellence type of thing where there would be a benefit

8 incentive for folks to head towards the hospital systems

9 that accepted these. You might be able to structure that in

10 a way that would do that.

11 And here's where the hybrid with the readmission

12 penalty might be coming in so that it would be not only more

13 efficient but also you'd have some quality measures

14 associated with it. $100 off the $900-plus deductible could

15 be a fairly strong incentive by itself.

16 MR. HACKBARTH: Could you go back for a second,

17 John, and just say a bit more about contact capitation and

18 specifically why it didn't go anywhere?

19 MR. BERTKO: Here's my recollection only. There

20 were a couple of companies and consultants offering it.

21 They would attempt not only say for something like CHF or

22 some heart procedures, which would be very apt for putting

1 bundles together, but they tried to have contact capitation
2 for -- I'll pick a wide number -- 2,000 different procedure
3 or treatment mechanisms.
4 And the big ones, this comes back to what Nick was
5 talking about, the focus on the big ones would be useful.
6 But as a payment structure for a company say like ours or
7 some other company dealing with 15,000 procedures, it was
8 ineffective because it was much too complex.
9 In fact, the consumer directed companies -- there
10 was one, in fact, that said here's a shopping cart. Pour
11 in, as in the Amazon metaphor. Let's see, we'll buy any
12 future CHF procedures from here, we'll buy appendectomies
13 from there, we'll buy others from this group of doctors. It
14 was unbelievably complex.
15 So I think a focus here on a somewhat small number
16 of high-cost fairly common procedures might be useful. And
17 my caution is to be careful not to say this will work for
18 all 15,000 procedure treatment dyads.
19 DR. MILLER: Just to be clear, I think our sense,
20 and I think Anne said this at the outset, but just to make
21 sure case in the public or anyone else missed it, I think
22 the idea is to focus and start with a few DRGs.

1 If I could just ask, can you say a little bit more
2 about your second idea, the centers of excellence? And why
3 it doesn't potentially run into the problem of saying to a
4 group of good actors well, I'll share savings with you and
5 then letting bad actors just continue to bill? And why that
6 would be kind of a complicated -- do you see how the
7 incentive --
8 MR. BERTKO: Yes. So this reflects upon our
9 experience with Medicare Advantage folks and lining up here
10 and saying aside from Ralph's worries that that $5,000
11 number there is a good number for the bundled payment there.
12 But that the range, with $600, $400 for the less efficient
13 ones is an appropriate amount. And you are paying $200 or
14 $300 on average more to those that are efficient.
15 When you turn some -- and I'll use actuarial
16 portion or sharing over to patients, they actually do a
17 pretty good job of selecting for themselves for those
18 focused amounts. And so you are, in effect, gainsharing
19 with patients to direct them. And I'd almost guarantee that
20 if it was bundled with quality and shown as such, that you
21 would empty out the higher cost ones.
22 And again once you focus on those where, say in a

1 large urban area you have half a dozen hospitals competing
2 for hearts with a variety of cost and other implications.
3 People will vote with their pocketbooks if you provide that.
4 Now once again, the prevalence of Medigap and
5 other supplemental coverage is yet another confounding
6 factor and I was aware of that. But many of the large
7 employers, I think, would be highly supportive.
8 So now I can play Arnie. They'd be all for this,
9 except I should say it in 10 more minutes of talk.
10 [Laughter.]
11 DR. MILLER: Can we strike that from the record.
12 [Laughter.]
13 MR. BERTKO: Sorry, Arnie.
14 DR. WOLTER: I really think that we ought to
15 implement this as immediately as possible in Philadelphia.
16 [Laughter.]
17 DR. WOLTER: First of all, I'm very supportive of
18 this. I think focusing on some top number of DRGs by volume
19 and cost and whether that's three, for practical reasons of
20 the learning curve, or five or 10, I don't know. But I
21 think that would be the way to start.
22 I would favor being a little more bold in this

1 area. If we're going to be serious about the sustainability
2 issues and all of the conversations we've had over the last
3 few years, when are we going to push seriously a tactic
4 which might create some significant savings and improved
5 quality? This would be a great place to start. And what a
6 major statement if we could do that.
7 In my view, if we could work out some of these
8 details, and this worked with the DRG period, you could
9 imagine extending it to a 60 or a 90 day bundle so that do
10 bring in some of the outpatient pieces into it.
11 I think it allows the accountable care
12 organizations to start to form. I would raise the issue
13 that they might even be the organizations that receive the
14 dollars, so that we could create an incentive for physicians
15 to want to do this and maybe start to get away from some of
16 the mistrust that exists in the physician hospital
17 environment because of these concerns about hospitals being
18 in control of everything, although many physicians might be
19 quite happy to have the hospital be the recipient of the
20 dollars.
21 It allows us to have a place where we're now
22 putting measures in place more at a system and accountable

1 unit level, which gets us away from some of the issues we've
2 talked about with measures at the individual physician
3 level. It allows groups and integrated systems, as Jay and
4 I have fostered and believed in, to play in this area. But
5 it also allows IPAs and individual physicians to play, as
6 well. So it's equitable in that sense.
7 I do believe it would be accompanied by robust
8 measures of both cost and quality. That would be a critical
9 area.
10 And you know, if it did that, we would be doing
11 something here that has more value, in a way, than the
12 burgeoning physician-owned facility situation or the
13 burgeoning physician/hospital joint venture situation where
14 we don't necessarily have as robust a set of quality and
15 cost measures as we would be requiring here.
16 Back to another comment Jay made yesterday, I kind
17 of like the idea of moving from the gainsharing term to
18 something like shared accountability because we do want to
19 be talking about quality as well as cost sharing.
20 You could see this moving beyond the DRG thing in
21 years ahead, so that we could even include outpatient care
22 down the road, chronic disease management, advanced medical

1 home ideas.

2 These units would benefit managed-care companies
3 because they would know have accountable units to deal with,
4 as opposed to panels of individual physicians.

5 John, ideally the private sector would want to
6 play so that there was some uniformity in terms of how
7 organizations dealt with this. There are strong links here
8 to the hospital and physician pay for performance areas that
9 we've been discussing in the last couple of days. And in
10 fact, perhaps this is an area where that hospital 2 or 3
11 percent could sort of be linked in. And so I think that's a
12 real positive.

13 There are strong links here to the conversation we
14 had yesterday about alternatives to the SGR and that this is
15 a strong movement into more value-based purchasing. It's
16 also a strong signal about our longer-term belief that there
17 needs to be a change in how health care is organized if
18 we're really going to tackle the cost and quality issues
19 that we face.

20 It's also, I think, a strong signal that we need
21 to be more focused on the patient because right now so much
22 of the conversation is about how to pay physicians for

1 performance in this silo, hospitals in performance for that
2 silo. But really, if we want to follow the IOM principles
3 of being patient-centered, we have to find ways to follow
4 the patient across sites and over time. And this could be a
5 starting place where we could learn how to do that.
6 I'm a little leery of the center of excellence
7 term, I think, John, because my understanding in the past on
8 gainsharing is that was used in a competitive way that
9 allowed some in and some out and it led to lawsuits. And it
10 was one of the reasons this thing didn't go anywhere else.
11 So I would favor allowing anyone who wants to do
12 this to play. Actually, I would favor having it be optional
13 in year one and mandatory by year three or something like
14 that. And how you would design the penalties, I don't know.
15 But perhaps if you don't do this you're not
16 eligible for the 2 percent quality incentive in the hospital
17 world, or something like that, Ralph, so we don't have to
18 worry about all of this DSH and IME stuff. I don't think
19 the critical access hospitals are in this to start with
20 anyway. This is the PPS thing, I think, to start with.
21 I can't read my last point, so I'll stop there.
22 MS. DePARLE: I couldn't agree with Nick more. I

1 think this is really exciting and really would move us in
2 the right direction.
3 I think it builds on what we learned from centers
4 of excellence. I think you're right, Nick, that one of the
5 reasons why that foundered was because some institutions
6 resented the notion that a particular institution or set of
7 institutions would get Medicare's seal of approval. So
8 perhaps it was politically premature.
9 I think this would allow us to build on the good
10 things that we learned from that demonstration for patients
11 and for the Medicare system and yet take it forward in a way
12 that perhaps gives it a little more chance of political
13 sustainability. So I like that.
14 I wouldn't want us, and I don't think you were
15 saying this, I wouldn't want us to get away from the notion
16 that at some point, though, that we might say that some are
17 in and some aren't, or some pass muster and some don't.
18 At some point I think, and maybe we'll be in some
19 happy situation where that wouldn't be the case, where
20 everyone is in Minnesota and is above average. But in the
21 system we're now dealing with, I think we do have that. And
22 at some point I think we have to be clear-eyed and willing

1 to say there are some differences here. But I'm willing to
2 start right here.
3 I'm interested, Anne, in following up a little bit
4 on the readmissions piece of this, as well, because I think
5 that's potentially very exciting for patients.
6 I didn't see numbers in here. Do you have any
7 estimates on what kind of savings Medicare could get from
8 avoiding readmissions? To say nothing of savings for
9 patients and just the impact on them.
10 MS. MUTTI: We just did the back of the envelope
11 estimate where we were thinking if there's about $100
12 billion on inpatient PPS spending and we were seeing
13 readmission rates of 16 percent. That's total readmissions.
14 That's not just potentially avoidable, so this would be like
15 the maximum, within 30 days, that 16 percent of the $100
16 billion.
17 I don't know exactly what percent of those are
18 potentially avoidable readmissions. That would be what we
19 would need to find out.
20 MS. DePARLE: It's still a rather large number.
21 MR. BERTKO: If I can just add to that, some of
22 our private fee-for-service would indicate that not only

1 readmissions, but there's an ER admit category, too. It
2 could be reasonably in the 2 to 3 percent neighborhood.
3 MS. DEPARLE: That's avoidable admissions. I
4 think you and I have talked. Initial admissions. Or are
5 these readmissions?
6 MR. BERTKO: No, it's mostly in the readmission,
7 extra ER, category in terms of what we're fighting. I think
8 that comes up as a reasonable estimate of that 16 percent
9 total that's in there. So it's a big number but not
10 gigantic.
11 MS. DePARLE: And trying to be fair about it
12 though, I was interested in the studies that you cited. And
13 at least the one about the intensive nurse counseling, is
14 that a Canadian study? It's David Naylor, I think, and he's
15 a Canadian doctor, I think.
16 So that made me wonder how applicable it is,
17 number one? And number two, how much would that bundle of
18 intensive services cost? Is it almost like a home health
19 benefit post-admission?
20 MS. MUTTI: I'm not sure that it's a Canadian
21 study. I guess let me find out about that and get back to
22 you.

1 DR. MILLER: I just want to reinforce the
2 transaction that the three of you just had, so that nobody
3 in the public, or specifically the press, walks away with a
4 16 percent savings number here.
5 The readmissions, depending on the days,
6 readmissions could range from as low as 3 to as high as 16.
7 And then within those two numbers, we have not defined the
8 potentially avoidable admissions. So just to be clear, I
9 didn't want anybody to go off and write an article and say
10 there were 16 percent savings here.
11 DR. REISCHAUER: I think this is very interesting
12 and I hope we forge ahead on this.
13 I was looking at this chart and thinking would you
14 really set the payment level at the national average
15 payments? Presumably it's the folks who are below that are
16 providing high quality efficient care. And so the number
17 you would hope they end up with -- maybe not in the first
18 year -- is somewhat below that.
19 Then I'm wondering, if you're above this and this
20 isn't mandatory, why would you participate? And if you were
21 a hospital, I suppose you could participate and change the
22 way you provide care and have hospitalists do this. So

1 you'd have a change in really the structure of physician
2 employment within these markets.
3 Because I can't imagine how one could reach a
4 compromise here in, let's say going to Elliott's work, the
5 Los Angeles area where there's a steady flow of consulting
6 physicians in some of these medical centers.
7 And how do you bring about a change in that
8 situation unless you do it in a mandatory fashion? And then
9 you would need some way of controlling the numbers. And the
10 only way the hospital presumably would get this bundled
11 payment and could do that would be to turn to its own staff.
12 MR. MULLER: The world doesn't work that way. For
13 example, a lot of the admissions come from cardiologists on
14 the staff and the hospitalists may take the patient that
15 comes out of the ER and so forth, but they don't bring any
16 patients into the hospital. You can't say cardiologists and
17 gastroenterologists, go away -- if I understand what you're
18 saying -- and we'll substitute hospitalists for you because
19 they're a more efficient form of labor. It just doesn't
20 work that way.
21 I think the challenge is, and we saw this in the
22 CABG demonstrations seven or eight years ago, that they did

1 move it, in the chart here, below the $5,000 level and many
2 opted not to go in because basically the good performers, in
3 a sense, got economically penalized for being good
4 performers. And the lesser performers, as you indicated,
5 were better off staying out. So I think that's a critical
6 challenge.
7 In some ways, it almost forces you to go to
8 mandatory or have some other strong incentive. But again,
9 if you look at the range of numbers on that chart, $5,600,
10 so there's a 12 percent difference there. We're not talking
11 about any P4P numbers that are 12 percent.
12 So I think even P4P won't be sufficient to do
13 that, and John has indicated enough difficulties with the
14 centers of excellence because a lot of times, as we saw in
15 St. Louis, when United came in, they called a center of
16 excellence anybody that was at $4,400, with no quality
17 indicators.
18 So I think Nick made a very convincing argument as
19 to why we should go in this direction. I'm just saying that
20 we have enough experience with how these things come apart
21 by not looking at the numbers. I think it's very important,
22 therefore, to look at them so that the incentives are clear

1 to go in.

2 And obviously mandatory, and I think if I got the
3 import of some of Nick's comments, if you do it mandatory in
4 some of the areas that are high cost like congestive heart
5 failure, some of the respiratory diseases, that might be a
6 way of looking at it. But I think on a voluntary basis you
7 have all of the problems that you and other people have
8 indicated.

9 Again, I don't want to therefore say mandatory is
10 the way to go, but I think there is such a strong incentive
11 for the lesser performers to stay out. And then you
12 penalize the good performers. And then after a while they
13 say why am I doing this.

14 DR. CROSSON: Can I make a point on this? I think
15 Bob does raise the question that's going to have to come up
16 at the end of this, which is who gets the bundled payment?
17 Is it, in fact, the hospital? Because that shifts the locus
18 of control that Ralph described. Is it the physicians? Or
19 is it, as Nick implied, going to then bring about the need
20 for the creation of entities to receive these payments that
21 then can lead to perhaps other things?

22 DR. MILLER: We also had some of this conversation

1 internally, and I'm sure Anne can take you through it. But
2 some of the thinking here was if you start on a voluntary
3 basis, and there's 1,000 problems as we've noted, the notion
4 would be that the person who steps up to the plate creates
5 the legal entity that can accept the payment on behalf of
6 both the medical staff and the hospital. The notion would
7 be that that would be one way to blunt the concern on the
8 part of the physicians to say but you're just handing the
9 control to the hospital.

10 In some ways, that would have to reflect that
11 they've actually come to an agreement enough to step forward
12 and be able to make that.

13 Now in a mandatory world, you could mandate that
14 that be the case. But we were thinking if this started
15 voluntarily it might work that way, as one idea.

16 MS. BEHROOZI: Just a quick question and this is
17 kind of following up on Ralph's point. When you look at the
18 national average payment rate what all is that incorporating
19 or ignoring? If you took a national average that would also
20 smooth out the effect of the wage index adjustments for
21 different areas, right? So I guess we would want to think
22 about how to control for that, if that's true. I'm not sure

1 that that's true or not.

2 DR. MILLER: That's a technical question but you
3 would just either adjust for the differences across the
4 areas.

5 DR. REISCHAUER: Net all of these things and then
6 at the end, when the payment was made, add them back in
7 based on the characteristics of the hospital and the
8 geographic location.

9 MS. BEHROOZI: The other question is about home
10 health agencies and it goes back to Nancy's point earlier.
11 In the paper it seems like you would contemplate that the
12 influence on the home health agencies would be in the
13 hospitals or physicians selection of agencies that would be
14 good performers. But have you given consideration or should
15 we now give consideration to trying to incorporate the home
16 health agencies into this bundling mix? Especially if we're
17 going to accept some variability, some whiskers, and some
18 inconsistency in home health providers. Is this the time to
19 incorporate that in?

20 DR. MILLER: I'll go ahead and take this because I
21 have a feeling that at least I know some of the thoughts
22 that are running through your head at the moment.

1 We specifically, on this presentation, targeted it
2 and tailored it in a way because we talked about some of
3 these ideas -- I'm going to say two or three or four
4 meetings ago, somewhere in that range -- in which we talked
5 about potentially larger episodes. There was a fairly heavy
6 reaction like wait a minute, maybe that's not where we
7 should start.
8 And so this specifically, Anne came to this
9 discussion very cautiously with this is the inpatient
10 admission only. You know, could think down the line if you
11 wanted to get to that point.
12 But that's kind of the history. So she came
13 specifically to talk about the inpatient admission. So
14 that's not a big giant no, but the initial reaction when we
15 talked about that was for more caution on the length of the
16 episode.
17 DR. CASTELLANOS: In an ideal world without
18 medical liabilities and costs, dollars divided, it's an
19 interesting concept. I think, based on some of Nick's
20 comments, really I think this is the direction this
21 Commission is at least focusing in, especially with the SGR.
22 I think we can incorporate a lot of these issues.

1 I would only suggest that some of this is being
2 done already in clinical pathways in the hospital setting
3 under certain DRGs, especially the high-volume high-cost
4 DRGs. We have clinical pathways. We're not sharing with
5 the hospital, we're helping the hospital. And we're
6 aligning our incentive because we're working with the
7 hospital, with the patient and trying to do the best
8 quality.
9 My only real concern here is -- there's two
10 concerns, one about the readmission policy. I think we look
11 at the hospital, we look at the physician. But we're not
12 looking at the patient. Patient compliance is a big issue
13 there. A lot of patient compliance problems are causing
14 these readmissions. I didn't see that brought up.
15 I'm not familiar with the Leapfrog study but the
16 way I read it and I heard it this morning, any admission
17 within 14 days is considered a problem of the physician or
18 the hospital and I really not sure if that's correct. But
19 again, I'm not familiar with that study. But that
20 readmission policy really needs to be looked at very
21 carefully.
22 I would only suggest that again, if you're going

1 to implement -- I think we need to down this direction but
2 we need to go down it carefully and we need to go down it
3 together. And I would certainly not make it an all-
4 encompassing medical admissions. I would certainly limit it
5 very carefully, like they did with the CABG procedures,
6 looking specifically at the high-volume cost DRGs.
7 DR. KANE: I was reacting partly to the issue of
8 what's the difference between gainsharing and bundling, in
9 the sense that you can have some of the same inappropriate
10 incentives in bundling that you would have in gainsharing,
11 and that you would want to be sure that you had under
12 treatment and quality outcomes on anything that you tried to
13 bundle that were pretty good or you'd get the same backlash
14 that we got when we allowed large group practices to take
15 full premium risk and deny services to patients. So I think
16 there is that downside.
17 The gainsharing restriction are there for a reason
18 and you need to think about how to create measures that make
19 sure people are getting what they need to get.
20 I guess the other thing I was noticing or thinking
21 about is if it's only the DRG plus the physician component
22 that's bundled, then the only piece that's variable here is

1 the physician piece because the DRG is the same across the
2 country.
3 The variability in your slide on page six here,
4 most of that variability in payment is physician
5 variability. But yet there is probably -- so that may,
6 depending on how well the hospital does, but that focuses on
7 the physicians doing less or changing what they do, rather
8 than necessarily changing some of the other parts of payment
9 that vary.
10 And that argues to me that either the outpatient
11 or the post-acute does need to be in here to really give
12 them more payment -- the stuff that we pay variably for,
13 we've only put the physician piece in there and not the
14 post-acute and not the outpatient. But that's where some of
15 the bigger variability and cost is to the program.
16 So I guess we're just limiting what we can benefit
17 from if you're only doing inpatient. And I understand why
18 we should go slow and not put it all in at once, but I think
19 ultimately to get real savings you probably want to put more
20 of the variable payment components into the group.
21 I understand why we can't do it yet, but I think
22 that's really where the biggest improvement might be.

1 DR. MILLER: You're absolutely right in everything
2 that you said. And you're also right in the sense that this
3 is walk before you run. Some of that was based on the
4 previous conversations. We are definitely open to going
5 beyond this but sort of walking before we run.
6 To pull together Bob's point, depending on where
7 you set, start setting the average for the total bundle, you
8 can start putting pressure on the hospital side, as well.
9 So you can think about a couple of ways that you could move
10 down the road on this policy.
11 DR. KANE: That may be where they save the money
12 actually inside, but I'm just saying where your payment
13 variability is right now is not on the hospital payment.
14 MR. HACKBARTH: Okay, thank you, Anne. Good job.
15 Our last item is expanding the unit of payment in
16 the outpatient PPS system.
17 MR. WINTER: Good morning. Dan and I are going to
18 discuss ideas for expanding the unit of payment in the
19 outpatient prospective payment system.
20 We want to first thank Sarah Friedman for her help
21 on this project.
22 This chart shows that there has been strong growth

1 in spending for outpatient PPS services beginning in 2004.
2 The line on the chart, which is sort of hard to see, it's
3 the blue line, shows total spending which reached $26
4 billion in 2005. CMS projects that total spending will
5 increase by nearly $9 billion by the end of 2008, to almost
6 $35 billion.

7 The bars on the chart show annual percent change
8 in spending per capital, was doubled from 5.5 percent in
9 2003 to over 11 percent in 2004.

10 As we will show later, much of the increase in
11 spending from 2003 to 2004 was related to higher spending
12 for drugs that received separate payments. If spending on
13 separately paid drugs had stayed constant between 2003 and
14 2004, per capita growth during 2004 would have been much
15 lower, by 6.5 percent, instead of over 11 percent.

16 CMS projects that annual per capita growth will be
17 at least 10 percent from 2006 through 2008. This spending
18 growth raises question about whether the outpatient PPS
19 should be changed to encourage greater efficiency.

20 We are planning a broad long-term assessment of
21 the design of the outpatient PPS. Today, we will focus on
22 the concept of combining services provided during a single

1 outpatient visit into one unit of payment, which is called
2 packaging. Issues we plan to examine in the future include
3 bundling procedures and visits furnished over a period of
4 time for a related condition into a single payment, whether
5 there should be an expenditure target for outpatient
6 services, whether to discount payments for multiple imaging
7 services provided in the same session, and the method used
8 by CMS to determine relative weights for outpatient
9 services.

10 Over the next few months, we will focus on the
11 issue of packaging. An example of packaging would be to
12 create a single payment for a medical visit that includes
13 ancillary services such as x-rays and lab tests. Another
14 example would be to combine the cost of a drug with the drug
15 injection into a single payment.

16 If an ancillary service or a drug is packaged, the
17 cost is reflected in the payment for the primary service.
18 For example, if an ancillary service is performed for half
19 the patients who receive a given procedure, then about half
20 of its cost would be added to the payment rate for the
21 procedure. If the ancillary is provided by itself without a
22 procedure or a medical visit, then it would be paid

1 separately.

2 Currently, Medicare's outpatient payment system
3 has minimal packaging. Certain items are packaged with
4 surgical procedures such as anesthesia, medical and surgical
5 supplies, and implants. However diagnostic tests, such as
6 x-rays and lab tests, are always paid separately. This
7 creates an incentive to use more diagnostic tests.

8 In addition, Medicare pays separately for many
9 drugs that are used with procedures and visits. To main
10 categories of drugs receive separate payments. The first
11 category includes drugs that exceed a certain cost threshold
12 or meet certain other criteria, and these are called
13 separately paid drugs.

14 The second category includes drugs that receive
15 transitional pass-through payments for new technologies.
16 This is different from the first category because pass-
17 through payments are limited for a period of two or three
18 years.

19 Other drugs are packaged, which means their costs
20 are reflected in the payment rates of their associated
21 procedures.

22 Hospitals may have a financial incentive to

1 substitute a high-cost drug that is paid separately for a
2 low-cost drug that is packaged, as long as the separately
3 paid drug is profitable. In the next few slides, we'll
4 examine how this incentive might influence spending growth.
5 This chart shows spending for separately paid
6 drugs under the outpatient payment system, which includes
7 drugs that received transitional pass-through payments. In
8 2003, about 400 drugs were packaged with their associated
9 procedures and 20 drugs were paid separately. The MMA
10 mandated that CMS pay separately for more drugs beginning in
11 2004. Consequently, spending for this group of drugs
12 increased by about 80 percent, from $1.3 billion to $2.4
13 billion.
14 Now we'll examine what happened to a subset of
15 drugs that were subject to these changes. We identified 42
16 drugs that were paid separately as pass-through drugs in
17 2002. These drugs were packaged in 2003, which meant they
18 no longer received separate payment, and their volume dipped
19 by 4 percent in that year. In 2004 they were again paid
20 separately and their volume grew rapidly, by 20 percent.
21 It's plausible that the sudden volume growth of
22 these drugs in 2004 after a slight decline in 2003 was at

1 least partially related to their being paid separately in
2 2004.
3 Expanding the unit of payment to include more
4 drugs and ancillary services has advantages but also raises
5 some concerns. First, greater packaging should encourage
6 hospitals to provide care more efficiently. For example,
7 hospitals might use fewer ancillary services or fewer drugs
8 that are paid separately. Hospitals that use fewer
9 resources to provide a packaged service would be rewarded
10 because they would keep the savings.
11 Also, these efficiency gains would help control
12 growth of outpatient spending, beneficiary cost-sharing, and
13 premiums. One concern about greater packaging is that it
14 may lead to hospitals being underpaid for costly patients.
15 Payment rates for a package of services should, on average,
16 cover the cost of the entire package. However, some
17 hospitals may treat patients who require more ancillary
18 services or more costly drugs than average and these
19 hospitals may feel pressure to avoid sicker patients or to
20 sting on care because the payment rate would not cover these
21 patients' additional costs.
22 However, an outlier policy could limit hospitals'

1 financial risk. The outpatient payment system currently has
2 an outlier policy that provides additional payments for very
3 costly services.
4 The second main concern is that greater packaging
5 would create incentives to unbundle the packaged items. For
6 example, if a diagnostic test is packaged in the outpatient
7 PPS but paid separately in physician offices, the hospital
8 might send patients to a physician's office for the test.
9 Hospitals might also make patients come back for their tests
10 on a later date so they could get separate payment for it.
11 This behavior would inconvenience patients and increase
12 their cost-sharing.
13 There is another outpatient payment system called
14 ambulatory patient groups, or APGs, that does more extensive
15 packaging than the Medicare system. APGs were developed by
16 3M as a precursor to Medicare's current outpatient payment
17 system. APGs package low-cost frequently used items with
18 their associated procedures and medical visits. Examples of
19 the items they package are on the slide, including things
20 like drugs except for chemotherapy drugs, basic x-rays,
21 simple lab tests, and some diagnostic tests.
22 Although Medicare does not use APGs, some payers

1 do use the system, including Iowa Medicaid and Blue-Cross of
2 Washington and Alaska.
3 We plan to learn more about the APG approach to
4 packaging as we work on this issue.
5 Now we'll turn to Dan to discuss how we've begun
6 to identify items that could be packaged.
7 DR. ZABINSKI: Our first step in identifying which
8 items could be packaged in the outpatient PPS, we started by
9 answering the following question: should we package all
10 drugs and ancillary services with their associated
11 procedures? Our answer to that question is no because
12 packaging will sometimes result in substantial increases in
13 the financial risk faced by hospitals. That is, the
14 likelihood of experiencing a large loss from providing a
15 particular service.
16 So we went on and identified two criteria that
17 should be used to determine if packaging a drug or ancillary
18 will increase the financial risk of providing a particular
19 service. The first of these criteria is is a drug or
20 ancillary costly in relation to the associated service? The
21 first column in this diagram shows that if a drug or
22 ancillary has a low relative cost -- that is the cost of the

1 drug as a percent of its associated service -- it could be
2 packaged. An example is a pathology exam related to a
3 costly biopsy.
4 Packaging a drug or ancillary with relatively low
5 cost will have very little effect on the cost for providing
6 the service, so there would be little effect on the
7 financial risk facing hospitals.
8 However, if a drug or ancillary has a high
9 relative cost, such as the cost of a chemotherapy drug
10 relative to the cost of its infusion, we turn to a second
11 criteria: is the drug or ancillary frequently used with the
12 associated service?
13 Well, if a drug or ancillary with a high relative
14 cost is usually used with a service, the box on the very
15 upper right indicates that it could be packaged without a
16 significant increase in the financial risk because most or
17 all of the cost of the item would be reflected in the
18 payment rate for the service.
19 However, if a drug or ancillary with a high
20 relative cost is infrequently used with an associated
21 service, such as replacing a catheter in a non-chemo
22 infusion therapy, it could substantially increase hospitals'

1 financial risk. This could occur because only a fraction of
2 the cost of the drug or ancillary would be reflected in the
3 payment rate for the service. So in a small percentage of
4 the situations where a hospital does use the drug or
5 ancillary with that service, the hospital would bear the
6 full cost of providing the service, creating situations
7 where the payment rate would be well below the cost.
8 Consequently, we should not package in these situations, as
9 indicated in the lower right-hand box of this diagram.
10 So the take away point from the previous slide is
11 as we consider which drugs or ancillaries to package, key
12 issue is limiting increases in hospitals' exposure to
13 financial risk. That is we do want to increase hospitals'
14 financial risk but we don't want to increase it by too much.
15 So to limit increases in hospitals' financial
16 risk, we need to establish two thresholds. The first is how
17 constantly can a drug or ancillary be in relation to its
18 associated services? And secondly, if a drug or ancillary
19 is relatively costly, how frequently is it used with its
20 associated services?
21 Setting these thresholds is somewhat arbitrary,
22 and in our future work we will explore the appropriate

1 officials to set. To help in our exploration, we will
2 consult with the developers of the APGs that Ariel discussed
3 earlier, because they used relative costs and frequency of
4 use to identify their packaged items.
5 Once we identify which drugs and ancillaries
6 should be packaged, we asked the question should a drug or
7 ancillary be packaged with all associated services or should
8 it be packaged with some and separately paid from others?
9 Well, if a drug or ancillary is packaged with some
10 associated services and paid separately from others, some
11 problems could arise. For example, hospitals may face
12 complexities in explaining to their staffs which items are
13 packaged and in which situations they should be packaged.
14 Secondly, opportunities for hospitals to unpackage
15 could exist. Suppose, for example, an ancillary is using
16 two similar services and is packaged with one but paid
17 separately from the other. Hospitals may then have an
18 incentive to use the service with less packaging even in
19 situations where the service with more packaging is the more
20 appropriate thing to do.
21 So the concept of what's called uniform packaging
22 may be preferable. This option considers the cost and

1 frequency of a drug or ancillary relative to all associated
2 services. Based on its relative cost and frequency of use,
3 a drug or ancillary is either always packaged or always paid
4 separately. For example, a drug that has a low relative
5 cost to its associated services or is frequently used with
6 most or all associated services would be packaged with all
7 of them. So uniform packaging is preferable because it
8 avoids or reduces the problems I discussed at the beginning
9 of this slide.

10 Then as a first step in identifying possibilities
11 for packaging drugs that are currently not packaged in the
12 outpatient PPS, we analyzed the cost of separately paid
13 drugs relative to the cost of their associated services.
14 The first column in this diagram lists the categories of the
15 relative cost of drugs. That is, what is the cost of a drug
16 as a percent of its associated services?

17 In the second column, we show the percentage of
18 drugs that fit in the categories in the first column. Then
19 the third column shows the fraction of spending on
20 separately paid drugs that fit into each category in the
21 first column.

22 For example, the highlighted role includes the

1 separately paid drugs that have a relative cost that is less
2 than 50 percent of their associated services. This row
3 indicates that about 70 percent of drugs have a relative
4 cost below 50 percent and these drugs encompass about 6
5 percent of spending on separately paid drugs.
6 Based on the criteria of relative costs, this
7 table may appear to indicate that opportunities for
8 packaging separately paid drugs may be fairly limited.
9 However, this table does not fully reflect all opportunities
10 for packaging drugs because it does not consider how
11 frequently relatively costly drugs are used with their
12 associated services.
13 In the future, Ariel and I intend to examine how
14 frequently relatively costly drugs are used with associated
15 services, which will expand the apparent opportunities for
16 packaging.
17 On this diagram, we repeat the previous diagram,
18 except we analyze the relative costs of separately paid
19 ancillaries rather than separately paid drugs. An example
20 of an ancillary is a chest x-ray or a pathology exam related
21 to a biopsy.
22 Based on the criteria of relative costs, this

1 table suggests that opportunities for packaging ancillaries
2 are greater than for packaging drugs, but opportunities may
3 still seem a bit limited for ancillaries.

4 For example, 35 percent of ancillaries have a cost
5 that is less than 50 percent of the cost of the associated
6 service. These items encompass about 26 percent of the
7 spending on separately paid ancillaries.

8 Once again, however, we still need to examine how
9 frequently ancillaries with relatively high costs are used
10 with their associated services. This will again expand the
11 opportunities for packaging.

12 In addition, many of the ancillaries with high
13 relative costs have low absolute costs. For example, we
14 found that 25 percent of the ancillaries that have relative
15 costs above 50 percent cost less than $50 in absolute terms.
16 These ancillaries encompass about 46 percent of all spending
17 on all ancillaries. What's happening in these cases is that
18 an ancillary with a low absolute cost is used in conjunction
19 with a service that has a low absolute cost. For example,
20 many chest x-rays occur during a basic medical visit. That
21 doesn't cost very much. In these cases, we think packaging
22 the ancillary would be reasonable because it would not

1 present a great financial risk to hospitals.

2 A summary of our results and our next steps

3 include the following: we found that some separately paid

4 drugs and ancillaries are relatively inexpensive, so some

5 opportunities clearly exist for more packaging in the

6 outpatient PPS. However, most spending on drugs and

7 ancillaries is for relatively costly items. So we'll

8 examine how frequently these relatively costly items are

9 used with their associated services to determine if they can

10 be packaged.

11 Also, we need to identify thresholds for

12 determining whether a drug or ancillary can be packaged on

13 the basis of its relative cost or frequency of use with

14 associated services. We plan to consult with developers of

15 the APGs, as well as payers and hospitals that use the APGs

16 to help guide our decisions as well as getting information

17 on implementation issues and impacts on hospital spending.

18 And finally, 3M Health Information Systems, the

19 developer of the APG system, is coming out with a new

20 version of the APGs in the near future. We plan to learn

21 about this new version and determine whether the APG

22 approach can be adapted for Medicare and to use it to

1 estimate the potential impacts on hospital groups.

2 That concludes our discussion and we turn it over

3 to the Commission now.

4 MR. HACKBARTH: Questions?

5 DR. CROSSON: I have a couple of questions on the

6 thinking on slide nine. My intuition might take me to a

7 little bit different place, but I want to see if we're

8 thinking the same way. If the point of the packaging is to

9 try to improve the frequency of usage of pharmaceuticals or

10 ancillaries or make the usage as close to the appropriate

11 usage as science would dictate, and also save enough money

12 to make the whole thing worthwhile doing, if we look at this

13 4x4 table, the left-hand column where the cost of the drug

14 or ancillary is quite low relative to the service, I agree

15 that doesn't seem to be the target area. I suppose in

16 relative terms if the service is massively expensive the

17 ancillary could still be low and yet there might be absolute

18 dollars savings. But that's not what the other charts tend

19 to suggest.

20 On the right-hand side, where the use or the

21 frequency of use of the drug or the ancillary service is

22 high, that could mean that there is a lot of inappropriate

1 usage. It could also mean that this ancillary or this drug
2 pretty much has to be used and science would dictate that it
3 should be used most of the time.
4 The bottom column on the right, where it says that
5 the use is low and therefore we should not package, to me is
6 actually, I think, the area where there's the most
7 likelihood of benefit because I would probably label those
8 differently as the top right-hand column being
9 nondiscretionary use.
10 Again, I'm going back to what the science of
11 medicine would dictate. And the bottom right-hand one would
12 be the discretionary use of a drug or a procedure.
13 And that's really the area where you do want to
14 have the packaging; right? Because that's where the -- now
15 you have to then balance the risk to the hospital against
16 the utility of packaging and that's volume related. So that
17 if, in fact, that particular ancillary was extremely high
18 and only occurred rarely and the hospital was only dealing
19 with this diagnosis rarely, then the times that they got
20 paid the extra 10 percent or 2 percent or 5 percent in the
21 bundled payments, might not make up for the experience if
22 they had a bad year and they had three or four or five of

1 these patients. So there's a volume relationship.

2 But if you said we're not going to package in that
3 lower right-hand column, then I think you walk away from the
4 very point of the bundling.

5 MR. HACKBARTH: It all depends on what the reason
6 is for low frequency of use. Is it because there are clear
7 clinical guidelines and providers don't adhere to them? Or
8 is it because there aren't clear guidelines and it's
9 appropriate for some patients and not for others?

10 DR. CROSSON: And I'd argue that that is the
11 situation most of the time.

12 MR. HACKBARTH: The latter.

13 DR. CROSSON: The latter is the situation most of
14 the time. And that's where the inappropriate spending
15 occurs in areas where there's a lot of clinical discretion
16 because perhaps the science is not clear or perhaps there
17 are economic incentives to use the drug, as was pointed out
18 before, or to use the ancillary. So I'm not sure that I
19 agree with the way this is formulated.

20 DR. REISCHAUER: I was just going to point out
21 what you did, which is that bottom box under the separately
22 billable is an environment in which you have an incentive to

1 overutilize. And if you package it you have an incentive to
2 underutilize.
3 DR. CROSSON: But doesn't this get to the point of
4 packaging?
5 DR. REISCHAUER: Why is it being used? Which is
6 what you raised. Is it the top right-hand box because it's
7 clinically appropriate all of the time? The answer could be
8 yes. Or because the incentive is so powerful to overuse it
9 that it's used all of the time.
10 DR. CROSSON: So the difference really is, at
11 least to me the difference is when are you dealing with
12 nondiscretionary ancillaries or drugs? In which case, the
13 packaging doesn't make a lot of sense. I mean, you get into
14 other issues about volume purchasing and things like that.
15 But the area where you want to use the packaging is where
16 the cost is high and the use is discretionary.
17 MR. HACKBARTH: Right. You want to make sure that
18 you're talking about variations in practice for clinically
19 similar patients and not variations in practice that are due
20 to dissimilar patients.
21 DR. CROSSON: Correct.
22 MR. HACKBARTH: Why is there the variation? Is it

1 because of inefficiency and then failure to adhere to
2 guidelines? Or different patients with different needs? If
3 you're bundling things together, and it's different patients
4 with different needs, then you're imposing a risk on
5 providers that may not be within their control or
6 appropriate for them to change.
7 If there is variation among treatment of
8 clinically similar patients, that's the sort of behavior you
9 want to get at.
10 DR. KANE: My first reaction when I read this was
11 this is the kind of bundling that kind of makes you feel
12 like you're practicing medicine, as opposed to setting some
13 kind of target that at our level we can set.
14 I guess part of this chart that shows the minus
15 four and then the bundled and the unbundled might be an
16 example of why I'd be concerned. How do you keep up with
17 the change in practice?
18 This is at a level where the drug, the ancillary,
19 the lab, and the newness and the turnover of practice or
20 change in practice might be constant.
21 So how would you keep up with what should be
22 packaged and what shouldn't be packaged, as well as the

1 issues that Jay raised? I just felt this was almost too
2 close to actually telling people how to practice medicine,
3 as opposed to a higher target that's a little more stable
4 and long term in terms of a bundle.
5 DR. MILLER: My point was back on Jay's point, at
6 the risk of being extremely confused about it.
7 In the lower right-hand corner, you took it from a
8 clinical perspective and let me just take it from a payment
9 perspective. I think the concern there -- and you guys
10 might want to make sure this is all correct -- I think the
11 concern there is that if something is very expensive and
12 occurs very infrequently -- oh, and by the way, in an
13 unbundled world if that situation is true you do have this
14 incentive right now to bill for it. The data into that
15 lower right-hand corner, in a real-world example, is if it's
16 not happening frequently, they're not acting on that
17 incentive for some reason which might suggest that the
18 clinical concerns intervene.
19 But just put all that aside for a second. The
20 basic payment concern is if something happens only a little
21 bit of time but costs a lot of money and you build a little
22 tiny average into every bundle, then the times when this has

1 to happen you're really underpaying the provider and
2 disincenting the situation when presumably it needs to
3 occur. And in this world where you can make money off of
4 each time you've provided it, they hadn't been doing it.
5 So we were taking that as sort of prima facie
6 evidence of maybe this is a place where you have to move
7 carefully.
8 Now we can rethink this and none of this is a no
9 to your point, but that was what drove us in that corner to
10 say you want to be careful here because you would be most
11 frequently underpaying, is what I'm trying to say.
12 DR. CROSSON: And the difference, I think, between
13 what we're saying is sort of the interpretation of what high
14 is or low is in this context.
15 DR. MILLER: To these guys' point, that's kind of
16 an arbitrary boundary. In the examples that they showed
17 you, they just picked 50 percent to give you a sense, and
18 that's very much going to be a complicated decision.
19 Because there's nothing that's going to tell you the right
20 number is 51 and not 52. And then I think that gets right
21 back to your clinical conversation that you're having.
22 MR. MULLER: Ariel, can we go to the chart that

1 shows the distribution of payments? Could you do it on the
2 ancillaries please, rather than the drugs? Thank you.
3 I think for the ones we discussed very much in the
4 last years is the doctor's visit in an outpatient setting
5 with the MRI, CT and so forth, where there's been big
6 growth. And I would assume that's one of the areas in which
7 the ancillary is 200 or 300 percent of the procedure. I
8 think the chart on the right, there's big bucks there.
9 So if there are other ways in which to look at
10 that ancillary utilization; e.g., the kind of guidelines
11 that we discussed on imaging a few years ago or guidelines
12 one may have on diagnostic testing, though my guess is until
13 you get to the new biologics and so forth or the proteomics,
14 you're probably not in that 100 or 200 percent range.
15 There may be other ways of getting at this rather
16 than the packaging but I think the packaging has the
17 concerns that both Mark and Nancy spoke to, which is that
18 you may be dramatically underpaying for something that's
19 needed here and there.
20 So if we have concerns -- I'm assuming our concern
21 is in the bottom of this chart. Am I fair to say that? Or
22 is that inaccurate? The ones where it's 200 or 300 percent

1 of the cost of the associated procedure.

2 DR. ZABINSKI: That's where we get concerned about

3 whether the drug or ancillary is used a lot with the

4 associated service, when we got up to that range.

5 MR. MULLER: My question is just whether bundling

6 or packaging -- using the packing word here -- is the right

7 way to go about that or whether there are other ways of

8 looking at that such as we have in terms of guidelines,

9 critical pathways, and so on.

10 MR. WINTER: Part of our broad term plan is to

11 look at some other tools that might help address use of

12 expensive imaging like whether there should be a discount

13 for multiple imaging services done in the same session,

14 which is currently our policy on the physician side and was

15 proposed by CMS for the outpatient side, but they withdrew

16 it and are studying it further. So that's something we

17 could look at to address that issue specifically.

18 Another area we might want to look at is looking

19 at relative weights. There might be some distortions that

20 influence volume growth.

21 MR. MULLER: My sense is just this is one where we

22 need a little bit more, I think even with some of the

1 concerns that I and other people expressed about the
2 bundling on the outpatient side. I think we've thought a
3 lot more about that in a variety of ways over the last few
4 years. I think we need to have a better sense of what
5 exactly we're talking about here in terms of clinical
6 procedures and so forth and what we're trying to really get
7 it.
8 If it's imaging, which clearly could fall into the
9 bottom left of this chart fairly often, and diagnostic
10 testing is getting a lot more expensive, the imaging or
11 diagnostic tests coming in the next few years is not going
12 to be the simple basic lab cycles that doctors run in their
13 offices. And therefore, they would fall in the top of this
14 chart.
15 Maybe the work you're getting from 3M might give
16 you a little more clinical detail as to what exactly we're
17 talking about here in terms of procedures. But I think this
18 is one where having a little bit more clinical detail would
19 be at least quite helpful to my thinking and perhaps others.
20 For example, surgery doesn't fall into these
21 categories; right? That's the procedure. So what you would
22 put with the surgery would be the imaging. I'm trying to

1 figure what's the procedure and what's the associated
2 ancillary.
3 DR. ZABINSKI: Something like if you do a biopsy,
4 that would be a procedure. And the pathology exam related
5 to the biopsy would be the ancillary.
6 MR. MULLER: That's where there's a lot of
7 sophistication coming in that's going to put more in the 100
8 to 200 to 300 percent level in terms of the ancillary
9 associated with the procedures.
10 So I think we just need to get a little better
11 handle on exactly what kinds of things fall into this.
12 DR. MILLER: On that point, not necessarily the
13 clinical guidelines point -- and I don't want to put you on
14 the spot -- but we also had some conversation when we were
15 talking about this internally about what could, at the upper
16 end, be captured in bundling. Didn't we have something --
17 DR. ZABINSKI: One thing we found up here --
18 DR. MILLER: I feel like it's related to what he
19 said.
20 DR. ZABINSKI: One thing that we talked about,
21 Mark, is that a lot of the things up above the 100 percent
22 mark were actually pretty cheap ancillaries that are

1 associated with pretty cheap procedures. As I said,
2 particular chest x-rays, they're all following up above 100
3 percent because they're used wit other very cheap procedures
4 like medical visits. They only cost $40 each to do because
5 they're also used with things that cost $50.

6 MR. WINTER: The other point that Mark might have
7 been trying to get at is that these are often the ancillary
8 services that are below 50 percent in terms of relative cost
9 or below $50 in terms of their absolute cost, while they're
10 fairly low cost, they are high volume. So if you add them
11 all up it accounts for $900 million, according to our rough
12 estimate, $900 million out of about $26 billion total
13 spending on the outpatient payment system.

14 And that's not including clinical lab tests that
15 are paid under the clinical lab fee scheduled but are
16 provided in the outpatient department. And that's $2.5
17 billion. We're not suggesting by any means that all of
18 those should be packaged or it's appropriate to package all
19 of them. But if you were to include them in your thinking
20 about packaging, you can start thinking about bigger
21 dollars.

22 DR. KANE: But to get savings out of that package,

1 wouldn't you have to make some assumptions about how often
2 they should be provided so you're not just paying every time
3 they have a visit they're getting a chest x-ray? You have
4 to have some idea of what percentage of time they should be.
5 And that's where I'm getting nervous. I don't
6 feel we have that kind of -- I don't think data can tell you
7 that at the patient level or the hospital level.
8 MR. WINTER: Maybe if we explained a bit about how
9 packaging currently works, because CMS does some packaging
10 now in the outpatient PPS. It's based on sort of historical
11 patterns of use. So if they're packaging, let's say a
12 surgical implant, and it's used roughly a quarter of the
13 time with a given procedure, then the cost of that procedure
14 reflects about a quarter of the cost of the implant.
15 So it's a mechanical exercise rather than clinical
16 saying it should be used half of the time or 75 percent of
17 the time.
18 MS. DePARLE: I have one really basic question and
19 a couple of comments, I guess. What data did you use --
20 maybe this was in the paper but I don't remember it -- to
21 determine the cost of ancillaries and the cost of drugs?
22 DR. ZABINSKI: The cost of ancillaries came from -

1 - the payment rates for these things are supposed to reflect
2 the cost.
3 MS. DePARLE: But isn't that the charge, really?
4 DR. ZABINSKI: No, they take charges and adjust
5 them to cost using cost-to-charge ratios. There's some
6 question about how accurate that really reflects cost.
7 MS. DePARLE: That's based on the current
8 outpatient prospective payment system, which was based on
9 the historic charges for outpatient procedures; right?
10 DR. ZABINSKI: They use more recent data. Every
11 year they come up with new rates they use a new year's worth
12 of data to do it. Basically, the charge date is two years
13 older than the payment rate. In other words, for 2007 rates
14 they used 2005 charge data.
15 MS. DePARLE: I guess I'm just getting at, as I
16 recall when the outpatient prospective payment system was
17 put into place, the basic building block of it for the base
18 payment was historical charges, not some scientific
19 determination of how much does it really cost a hospital to
20 provide an image? For example, with imaging, the hospital
21 has already acquired the imaging equipment. I don't know
22 whether that was accounted for on the inpatient side or the

1 outpatient side. There's a lot of questions around that
2 data.
3 So I'm all for more bundling here, but I guess I'm
4 just curious as to how we know we're getting at the right
5 unit of payment or cost.
6 And the same thing for drugs. How did you guys
7 come up with -- is that based on ASP? Or what is the drug
8 data? Is that similarly, just what the hospitals are saying
9 they pay?
10 MR. WINTER: For 2004, we took the actual rate for
11 the separately paid drug. And that varied by type of
12 separately paid drugs. So pass-through drugs were based on
13 a percent of AWP, either 85 or 95 percent. Many drugs in
14 that sort of separately paid category, the non-pass-through
15 separately paid drugs, many of them were based on a
16 percentage of AWP, as well. Some were paid on charges
17 reduced to costs. And then over time they transitioned now
18 so they're all ASP plus 6 percent. But 2004 was a very
19 messy year. We're going to plan to extend this analysis --
20 perhaps not the detail type we're looking at now, but in
21 terms of total spending for separately paid pay drugs, we'll
22 extend that to 2005. And so we might be able to see some of

1 the effect of that transition.

2 We won't get to the endpoint of the transition

3 this year because that's data from 2006 and we won't have

4 that until next year.

5 MS. DePARLE: So if you had AWP data, presumably

6 those numbers will be much higher than what we would end up

7 with ASP, if our experience in other areas is the same. Are

8 we now moving to ASP for everything on the outpatient side?

9 DR. ZABINSKI: Yes, it's pretty much across-the-

10 board.

11 MS. DePARLE: That's the good news. Believe me, I

12 don't want to discourage this work because I think it's

13 important and I think it's the right direction to go in. It

14 just reminds me of how complicated this was and, in fact,

15 your bringing up the APGs reminds me of the process we went

16 through when we were implementing this -- and Mark will

17 remember this, as well. I don't remember the exact numbers

18 but let's say there were a lot of concerns about whether the

19 OPPS would be granular enough.

20 In fact, all of the emphasis from the industry at

21 least and from Congress was don't harm anyone, don't harm

22 any hospitals.

1 So we threw out a proposed rule that was 300 or so
2 APCs. And it came back, and our final rule was 500 or
3 something, and it's only gone up from there, I think.
4 So again, that was 10 years ago. Everything is
5 better now, maybe. Maybe everyone would be in a different
6 place about this is the right direction to go. But just as
7 a cautionary tale, there was an awful lot of concern around
8 some the things that Nancy is raising, but also just every -
9 - I mean how many hours did we spend in meetings with
10 individual companies about making sure that there was enough
11 in the APC to cover their whatever it was, drug, device or
12 whatever? It didn't lend itself to this kind of treatment
13 at that point.
14 And then finally just a comment, to follow up on
15 what Ralph said. Whatever we do here, I think it's really
16 important that we look at the incentives that we might
17 create for this to shift over to physician offices. I think
18 we've talked about that in a number of different settings
19 over the last two days, and frankly over the last two years.
20 But I do think we could solve one problem and
21 create another one, and we shouldn't do that. We shouldn't
22 create more incentives to shift all of this out into a

1 different setting.

2 MR. WINTER: If I could just make a quick point
3 about this, the chart we showed you about the relative cost
4 of drugs. This was done using 2004 data, where most of the
5 drugs in this chart were paid on an AWP basis. But if we
6 did it for 2006, I suspect you'd see a lot more drugs below
7 50 percent relative costs because the costs are lower and
8 the procedure costs probably went up since then.

9 MR. HACKBARTH: We've got to finish for today.
10 Thank you, Ariel and Dan.

11 We'll now have a brief public comment period for
12 the next 10 minutes.

13 MS. McILRATH: You're probably surprised that I'm
14 here today instead of yesterday.

15 I just wanted to make one clarification because I
16 think it's something that has been confused in the
17 discussion on the Hill. On the update for the physicians,
18 the recommendation said that it's input price increases
19 minus productivity. There was some discussion this morning
20 that was referring to the MEI minus productivity. And to
21 just clarify that the MEI already has the productivity taken
22 out of it. So it is the written recommendation, as opposed

1 to the MEI minus productivity.

2 MR. MAY: Hi, Don May with the American Hospital

3 Association.

4 I Really enjoyed the discussions today on the

5 inpatient and the outpatient bundling or packaging.

6 Just a couple of thoughts on the outpatient

7 system. In the work that we do with all the different

8 payment systems, I believe the outpatient is the most

9 complicated PPS we work with. And I think it's partly

10 because it is a combination of historical fee schedules like

11 physician services, but also historical bundles that we're

12 used to from the inpatient side.

13 It's made it very difficult to analyze whether

14 something should be packaged or not packaged. And I would

15 just maybe suggest we look at, as we talk about packaging,

16 it's going to be very difficult to look at clinic visits,

17 some of those low-level visits, and think about how to

18 package because a lot of the services that could generate it

19 are based on the complexity in diagnosing the patient, maybe

20 the severity of the patient. And a lot of those tests are

21 going to be driven by that complexity.

22 Where there may be more opportunity for packaging

1 is maybe in some of those historical procedures that have
2 been down on the inpatient side and now have moved to the
3 outpatient side. So we've historically paid for them in a
4 bundle and now we've got two or three different procedures
5 that are in different APCs that we're paying for.
6 We may be able to think about this in a way where
7 we start to look at packaging from a procedure base where it
8 was done on an inpatient side, where you're really talking
9 about a bundle of services, where it's very different than a
10 clinic visit or an ED visit that has lots of different
11 ancillaries together.
12 I would just encourage the staff to take a look at
13 those ideas.
14 MR. HACKBARTH: Okay, we're adjourned. See you
15 next time.
16 [Whereupon, at 11:42 a.m., the meeting was
17 adjourned.]
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