

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, March 9, 2006
10:03 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
JOHN M. BERTKO
SHEILA P. BURKE
FRANCIS J. CROSSON, M.D.
NANCY-ANN DePARLE
JENNIE CHIN HANSEN
NANCY KANE, D.B.A.
ARNOLD MILSTEIN, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
WILLIAM J. SCANLON, Ph.D.
DAVID A. SMITH
RAY E. STOWERS, D.O.
NICHOLAS J. WOLTER, M.D.

AGENDA	PAGE
Part D plan offerings for 2006 -- Rachel Schmidt, Niall Brennan	3
Medicare Advantage plan: bids and availability -- Scott Harrison	38
Special needs plans -- Jennifer Podulka	58
Public Comment	72
Care Coordination -- Karen Milgate, Cristina Boccuti	78
Physician resource use -- Niall Brennan, Karen Milgate	127
Quality measurement for hospital care -- Sharon Cheng	157
Home health process measures -- Sharon Cheng, Sarah Friedman	196
Clinical laboratory services: overview of issues -- Dana Kelley, Ariel Winter	216
Public comment	252

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

2 MR. HACKBARTH: Welcome to our guests. We're
3 beginning this morning with three sessions related to the
4 broad topic of private plans serving Medicare beneficiaries,
5 beginning with Part D plans, then moving onto Medicare
6 Advantage and special needs plans.

7 Rachel, Niall, who's going to lead the way Niall?

8 * MR. BRENNAN: Thanks, Glenn. Good morning,
9 everyone. We're here this morning to give you a work in
10 progress report on analyses that are underway for a chapter
11 about the prescription drug benefit in our June report to
12 Congress. As you all know, the Part D program began on
13 January 1 and the opening enrollment period continues
14 through May 15. Last November we gave you an initial look
15 at plans being offered under Part D, and now we're back,
16 after having had a closer look at CMS data on plan benefit
17 designs.

18 So this morning we'll try to give you a sense of
19 what plans are offering and the benefit structure of those
20 plans. We'll also give you some aggregate information about
21 enrollment to date in Part D.

22 Let me summarize our findings first and then we'll

1 go through them in some more detail throughout the rest of
2 the presentation. As we told you last December, despite
3 initial fears that no more organizations would be willing to
4 provide stand-alone drug coverage, there's been a
5 significant amount of plan entry into Part D. Over 1,400
6 stand-alone PDPs are available across the 34 regions, with
7 another 1,300 or so MA-PDs available in certain counties
8 around the country.

9 Those counts of plans are a little different from
10 what we told you about last November because they exclude
11 plans that are set up for specific employers, plans in U.S.
12 territories, and others such as special needs plans and cost
13 HMOs. We excluded these groups because we wanted to give
14 you a sense of the characteristics of plans that do not have
15 any restrictions on eligibility or enrollment.

16 One key thing we found is that about 17
17 organizations account for the vast majority of stand-alone
18 drug plans. In most cases, these organizations are offering
19 the same two or three benefit designs across some or all
20 regions of the country, and they typically use the same
21 formulary.

22 The premiums of those plans differ by regions

1 though, typically on the order of \$8 to \$11 per month, and
2 sometimes cost sharing requirements vary a little bit too.
3 Another key thing we found is that most plans are not using
4 Part D standard benefit design. They're using tiered cost
5 sharing rather than straight coinsurance. This is probably
6 because organizations believe that beneficiaries will want
7 the predictability of fixed dollar copays rather than paying
8 a straight 25 percent coinsurance. Also, many organizations
9 have designed their benefits to avoid the standard benefit's
10 \$250 deductible, which again reflects the fact that Medicare
11 beneficiaries generally prefer first-dollar coverage.

12 Finally, we found that prescriptions drug plans
13 offered by MA organizations are more likely to offer
14 enhanced benefits than stand-alone PDPs. They're also more
15 likely to charge zero or a reduced premium for the drug
16 portion of the benefit. This is because under the MMA, MA-
17 PDPs are allowed to apply a portion of the difference between
18 payment rates and the plan's bid, called rebate dollars,
19 towards lowering premiums or adding benefits.

20 I know you've all seen this chart before so we
21 won't dwell on it for too long. We're showing it again
22 though to remind you of some of the language we've used to

1 describe the standard benefit and how it's structured. This
2 will help us think about how organizations can vary their
3 benefit offerings yet keep the same actuarial value as the
4 standard benefit. You know the standard benefit includes a
5 \$250 deductible, then a range of spending where the enrollee
6 pays 25 percent coinsurance.

7 The point at which the 25 percent coinsurance ends
8 and the coverage gap begins is called the initial coverage
9 limit, which for 2006 is \$2,250 in total drug spending.
10 Then there's another range of catastrophic benefit coverage
11 once an enrollee's out-of-pocket spending reaches \$3,600 or
12 total drug spending reaches \$5,100.

13 For the purposes of talking about actuarial
14 equivalents we're going to focus primarily on the lower part
15 of this slide, the white area beneath the coverage gap.
16 This is what many organizations are varying, yet keeping the
17 actuarial value of their benefits the same as the standard
18 benefit.

19 So what can an organization offer? Of course,
20 they could offer the standard benefit, and some are. But a
21 lot of beneficiaries are used to copays rather than
22 coinsurance, and copays can be an effective way for a plan

1 to steer its members toward using preferred drugs. So one
2 thing an organization could do is offer a plan that keeps
3 the standard benefits deductible at \$250 and its initial
4 coverage limit, but swap tiered copays for the 25 percent
5 coinsurance.

6 Another thing an organization could do is to
7 charge no deductible but keep the same initial coverage
8 limit and charge somewhat higher cost sharing. Similarly, a
9 plan could have no deductible or a reduced deductible and
10 keep cost sharing at about 25 percent of drug spending, but
11 it would need to lower the initial coverage limit to have
12 the same actuarial value.

13 All of these variations are called basic benefits.
14 Once an organization has offered at least one basic plan in
15 a region, it may also offer what's called an enhanced
16 benefit. This means that the plan includes both basic and
17 supplemental coverage. That supplemental coverage doesn't
18 necessarily take the form of filling in the coverage gap.
19 It could be anything that raises the actuarial value of the
20 benefit beyond that for the standard benefit.

21 This next chart illustrates that a relatively
22 small number of organizations account for the majority of

1 PDP offerings nationwide. The blue portion of the pie chart
2 represents plans offered by the 10 organizations that have
3 at least one plan in all 34 regions, what we call national
4 plans. The yellow portion of the chart represents seven
5 other organizations that offer 20 or more plans in many, but
6 not all, regions; what we call near national plans. And the
7 green portion of the chart represents all other plans.

8 I'd just note here that these percentages of PDPs
9 are not weighted by enrollment, they're just simple shares
10 of all 1429 PDPs on offer.

11 We also wanted to give you a sense of what types
12 of plans these organizations are offering, so we've taken
13 the previous pie chart and shown what types of plans are
14 offered by the national, near national and other
15 organizations. So you can see that the 62 percent of PDPs
16 offered by organizations with a national presence is
17 comprised of 34 percent that are actuarial equivalent to the
18 standard benefit and 28 percent that are enhanced plans. So
19 you can see here that no national plans chose to offer the
20 defined standard benefit.

21 Similarly, for near national plans, you can see
22 that their 27 percent share of the market is comprised of 6

1 percent standard benefit plans, 10 percent actuarial
2 equivalent plans, and 11 percent enhanced plans.

3 Overall, 9 percent of plans are the standard
4 defined benefit, 48 percent are actuarially equivalent to
5 the standard, and 43 percent are enhanced.

6 Among all 1,429 PDPs about 57 percent are basic
7 plans, whereby basic I mean either the standard benefit or
8 plans with the same actuarial value but somewhat different
9 benefit designs. The remainder are enhanced plans that
10 include supplemental benefits. Again, these figures are not
11 weighted by enrollment.

12 The bar chart of the right shows the distribution
13 of premiums for basic plans in orange and for enhanced plans
14 in gold. You can see that there are some enhanced plans
15 with lower premiums than basic plans, and there's a fairly
16 broad distribution of premiums for both. But you can also
17 see that the mean and median monthly premiums for basic
18 plans are about \$10 to \$12 lower than those for enhanced
19 plans. Basic plan premiums are in the \$30 to \$35 range,
20 whereas enhanced plan premiums are generally in the \$40 to
21 \$50 range.

22 You may have heard recent reports by CMS that

1 average premiums for Part D are closer to \$25 per month.
2 The reason the premiums in this chart look higher are that
3 they are not yet weighted by enrollment. We don't yet know
4 how many beneficiaries have signed up for each plan. But if
5 people are gravitating towards the lower premium plans then
6 we'll see a lower weighted average premium than you would
7 for the simple distribution we have here.

8 One interesting thing we found is that the median
9 premiums for the standard benefit package are about \$5 lower
10 than for those benefits that are actuarially equivalent to
11 the standard benefit. So among all of those orange bars on
12 the chart, the ones on the left-hand side tend to be the
13 standard benefit and the ones on the right-hand side tend to
14 be actuarially equivalent. We're still looking into this
15 but one explanation may be that actuarially equivalent plans
16 tend to be structured with copays and they have higher
17 premiums because beneficiaries are willing to pay more for
18 the predictability of copays.

19 Now I'm going to turn it over to Rachel.

20 DR. SCHMIDT: This map gives you a sense of the
21 geographic variation and average monthly premiums for basic
22 Part D coverage around the 34 PDP regions. Regions that

1 have the highest average premiums for basic coverage, which
2 are the ones in red, cost about \$10 more per month than
3 regions with the lowest premiums, which are the ones in
4 yellow. This is somewhat less variation than we predicted
5 last year where we were conducting a simulation of Part D
6 premiums we developed using drug claims for privately-
7 insured individuals who were also in Medicare. However,
8 most of the specific regions with higher or lower premiums
9 are the ones we expected and they correspond to where drug
10 spending by Medicare beneficiaries tends to be higher or
11 lower than average.

12 MR. HACKBARTH: Rachel, does this include the
13 actuarially equivalent packages, or is this strictly the
14 statutory?

15 DR. SCHMIDT: By basic benefits, I mean both the
16 standard one and actuarially equivalent, but not enhanced.
17 So this is excluding plans that have supplemental coverage.

18 MS. BURKE: But I'm interested in why you believe
19 this pattern exists. You indicated that we had anticipated
20 some of this, but I wondered about the sort of unique
21 characteristics of those states that are on the high side.
22 Is it statewide? Does it tend to be largely urban driven?

1 It's an interesting pattern, not entirely what I expected.
2 They're not very urban areas as a general matter.

3 DR. SCHMIDT: I know John has an answered he's
4 used before.

5 MR. BERTKO: Sheila, we had almost the same
6 pattern show up on the FEHBP geographic stuff, which is the
7 million or so federal retirees, and this was more or less an
8 identical map to usage. It's probably weighted somewhat,
9 like on the West Coast by the prevalence of managed care and
10 the spillover of patterns. Then I think I personally
11 referred to that middle section of the reds and blues as the
12 fried food belt in terms of having a general higher
13 prevalence of drug use. And it's not urban versus rural.
14 It's regional as far as I can tell.

15 DR. SCHMIDT: Right. Again, it's consistent --

16 DR. REISCHAUER: In Louisiana they take a lot of
17 prescription drugs.

18 MS. BURKE: That one didn't surprise me but so of
19 the others did.

20 DR. REISCHAUER: It would be more interesting I
21 think to look at what the numbers are just for the national
22 plans because then you're washing out a whole lot of very --

1 and I see how close that is to what we predicted last year.
2 What we predicted last year was much greater variation than
3 has appeared here, but what you see going on here could have
4 to do with the way they designed the particular plans that
5 are not offered across the board everywhere.

6 DR. SCHMIDT: That's true, and there's kind of a
7 hint of that sort of thing by looking at tables one and two
8 in your mailing materials. You can see the range of
9 premiums for the same benefit offered around -- and it does
10 look fairly wide in some cases.

11 MS. BURKE: How does this track what we know about
12 Medicare Advantage plans?

13 DR. SCHMIDT: Thank you for the segue because that
14 leads to my next point. Some of the states in the West have
15 average premiums for basic benefits that are lower than we
16 predicted last year. One reason for this is probably that
17 stand-alone drug plans have to compete with MA drug plans
18 there, more extensively in that part of the country. And
19 MA-PDs are able to buy down their Part D premiums with some
20 of their rebate dollars, as Niall described earlier. So in
21 parts of the country where MA penetration is higher, which
22 includes the West largely, organizations offering stand-

1 alone drug plans probably felt a lot of competitive pressure
2 to keep their premiums low.

3 Let me summarize some of the cost sharing
4 requirements that we see among all of the stand-alone drug
5 plans. Nearly 60 percent of all PDPs charge no deductible,
6 and 91 percent of them use tiered cost sharing, typically
7 with three or four tiers, rather than the standard benefit's
8 25 percent coinsurance. As Niall mentioned, organizations
9 have probably done some market research and found that
10 beneficiaries don't particularly deductibles and want the
11 predictability of fixed dollar copays.

12 However, it's important to note that even when
13 plans used tiered cost sharing they often use a combination
14 of fixed dollar copays for the lower tiers, the ones that
15 usually cover preferred generics and preferred brand name
16 drugs, along with coinsurance on the higher tiers. Median
17 copays for the lower tiers are what you might expect based
18 on what you see among commercial plans, on the order of \$5
19 for preferred generics, \$23 to \$29 for preferred brand name
20 drugs, and something on the order of \$50 to \$55 for non-
21 preferred brand prescriptions.

22 CMS allows plans to charge higher cost sharing for

1 specialty drugs and many plans are doing so. They are often
2 using 25 percent to 31 percent coinsurance on a tier that
3 covers biologicals or other higher cost specialty drugs.

4 Most of the PDPs offer mail-order pharmacy
5 services, which is probably not surprising. As we told you
6 last November, relatively few offer coverage in the coverage
7 gap and such coverage is generally limited to generic drugs.

8 Now let me switch gears for a minute to talk about
9 Part D's low income subsidy because it has important
10 implications for both beneficiaries and plans. Under the
11 low income subsidy, full duals are eligible for extra help
12 that covers the entire premium for qualifying Part D plans
13 as well as greatly reduced cost sharing and coverage in the
14 coverage gap. Other beneficiaries with incomes of less than
15 150 percent of the federal poverty level who have limited
16 assets may also qualify for the low income subsidy.

17 You can see the relevant income and asset levels
18 for 2006 on this slide. Note that the asset test does not
19 count a beneficiary's primary residence and vehicles, but it
20 does count other assets such as the cash surrender value of
21 life insurance policies.

22 Individuals with incomes of up to 135 percent of

1 the federal poverty level have their entire premium paid so
2 long as it's with a qualifying Part D plan. Those
3 individuals also only pay nominal copays and get coverage in
4 the gap. People with limited assets and incomes between 135
5 percent and 150 percent of the federal poverty level get
6 sliding scale premium assistance and reduced cost sharing.
7 So Part D's low income subsidy is a very good deal for those
8 individuals who qualify for it and enroll in a plan.

9 Beneficiaries who qualify for the low income
10 subsidy may also be attractive enrollees to organizations
11 who are offering Part D plans. One reason is that CMS is
12 auto-enrolling these beneficiaries into qualifying plans,
13 that is, randomly assigning them. They've already done this
14 for full duals who officially lost their Medicaid drug
15 coverage as of January 1, and may do so for other people who
16 are enrolled in the low income subsidy this spring if those
17 individuals have not yet picked a plan themselves.

18 As we've been seeing, there can be problems in
19 transmitting data for auto enrollment. It's extremely
20 important to transmit eligibility and enrollment information
21 quickly and accurately to all the parties involved. And
22 beneficiaries who are auto-enrolled are permitted to change

1 plans, so the timing of those changes and ensuring that CMS,
2 beneficiaries, plans and pharmacies all know about those
3 changes is very important.

4 Nevertheless, auto enrollment has some desirable
5 features, particular for a population that can be hard to
6 reach through a traditional enrollment process. Auto-
7 enrollment is also desirable from a plan standpoint because
8 it helps them avoid some marketing costs and helps assure
9 them of a steady payment for premiums by Medicare. CMS also
10 uses a special risk adjustment factor for plan payments on
11 behalf of low income beneficiaries to provide more
12 incentives to enroll them.

13 However, not every plan may qualify for auto-
14 enrollees. In order to qualify, PDPs need to have premiums
15 that are at or below certain regional threshold values that
16 are calculated by CMS. Those threshold values are based on
17 average bids from both PDPs and MA-PDs, but they are also at
18 least as high as the lowest PDP premium in a region. In
19 other words, the low income subsidy thresholds are designed
20 to make sure that the eligible beneficiaries have access to
21 at least one PDP.

22 In 2006, 29 percent of all PDPs qualified for

1 auto-enrollees, which is a total of 409 plans. There are at
2 least six PDPs that qualify for auto-enrollees in each PDP
3 region. Again, CMS assigns individuals randomly among those
4 qualifying plans and enrollees are allowed to switch up to
5 once a month if they prefer a different plan. If a
6 beneficiary switches to another plan that does not qualify
7 they must pay any difference in the premium between the plan
8 they picked and the low income subsidy amount.

9 The PDPs that qualify for auto-enrollees are more
10 likely to use Part D standard benefit design than the plans
11 that didn't qualify. This might be cause for concern
12 except, remember, that the low income subsidy covers much of
13 the enrollee's cost sharing. So the really important
14 question is whether the formularies of the plans that
15 qualify for auto-enrollees are somehow different from the
16 ones that did not qualify. We're taking a look at plan
17 formularies in more detail and we'll be back to you in April
18 with hopefully an answer to that question.

19 It's also important to note that since CMS will
20 recalculate low income subsidy threshold amounts each year
21 there could be likely turnover among plans that qualify for
22 auto-enrollees. Using an auto-enrollment process again next

1 year means that some of the transition problems that we've
2 seen this year could recur in future years.

3 Now let's move on to describe the Medicare
4 Advantage prescription drug plans. This chart shows the
5 distribution of drug plans offered by MA plans that are
6 local HMOs, local PPOs, private fee-for-service plans and
7 regional PPOs. Again, these are not weighted by enrollment.
8 This shows a simple distribution of the plans.

9 As you can see a larger portion of the MA-PDs
10 offer enhanced benefits than was the case for the stand-
11 alone PDPs, 64 percent here versus 43 percent shown in the
12 pie chart a few slides back. Also, a large proportion of
13 MA-PDs charge no premium for the prescription drug portion
14 of their benefit. Now to be fair, one should really look at
15 the entire premium that a beneficiary would have to pay to
16 join an MA plan. You can't just join the prescription drug
17 part of an MA plan. Still it's clear that MA-PDs have used
18 a portion of their rebate dollars to enhance their
19 prescription drug plans or to buy down Part D premiums.

20 MA-PDs are also more likely than PDPs to charge no
21 deductible in their benefit structure. About 80 percent of
22 the MA-PDs are doing so versus 58 percent of PDPs. Like the

1 stand-alone plans, they tend to use tiered cost sharing
2 instead of 25 percent coinsurance, and the MA-PDs are also
3 using a combination of fixed dollar copays and coinsurance
4 for higher tiers.

5 The levels of copays and coinsurance are
6 comparable to those used by PDPs. MA-PDs are somewhat more
7 likely to use a four-tiered cost sharing structure than
8 PDPs. Again virtually all MA-PDs are offering mail-order
9 pharmacy services. About 28 percent of them are coverage in
10 the coverage gap, which is higher than what we observed
11 among the stand-alone plans, 15 percent.

12 As Niall said, we do not yet have information
13 about enrollment in individual Part D plans to learn about
14 which types of plans are more attractive to beneficiaries.
15 However, let me give you a sense of aggregate enrollment in
16 Part D. CMS has released figures as of the middle of
17 February, which are bit dated now, and at that time they
18 said that about 25 out of 43 million beneficiaries have drug
19 coverage either through Part D plans, through TriCare and
20 FEHBP, or through former employers that are getting Part D
21 retirees drug subsidy. CMS has talked about signing up 28
22 million to 30 million people in Part D's first year. That's

1 lower than the initial projections of enrollment by CBO and
2 OACT but roughly in line with expectations that have been
3 set by some investment research firms.

4 As you can see, there are groups of beneficiaries
5 who don't necessarily need to make a choice about drug
6 plans. For example, dual eligibles are auto-enrolled into
7 plans, and individuals with retiree drug coverage can
8 usually keep the same coverage they've had. However, there
9 are a couple of groups of Medicare beneficiaries to which
10 Part D plans need to actively market themselves: individuals
11 who have no supplemental coverage to Medicare at all and
12 those who have a Medigap plan since most Medigap policies
13 don't cover prescription drugs. Those two groups made up
14 about 30 percent of all the non-institutionalized Medicare
15 beneficiaries in 2002.

16 One area where people have expressed concern is
17 enrollment in Part D's low income subsidy. Enrolled in the
18 low income subsidy is made up of two groups: beneficiaries
19 who have Medicaid and Medicare coverage, so that includes
20 the full duals, SLIMBs, QMBs, QILs, and other individuals
21 who have low income but no Medicaid. Enrollment in this
22 latter group has been difficult. The Social Security

1 Administration announced in January it had determined that
2 about 1.4 million such people qualified for the low income
3 subsidy, after receiving about 4 million applications.
4 Initial projections suggested that there could be as many as
5 3 million to 4 million enrollees in this category.

6 In conversations with beneficiary assistance
7 groups we've learned that many of these individuals share
8 some of the same characteristics as duals in terms of the
9 socioeconomic problems that are associated with low income,
10 and they can be hard to reach. Anecdotally, we've also
11 heard that although the SSA has tried to streamline the
12 process, documenting one's eligibility can be difficult.
13 We've heard some speculation that, for example, some
14 beneficiaries have a hard time finding their life insurance
15 policies and figuring out the cash surrender value of those.

16 So there may be several reasons that enrollment or
17 take-up of low income subsidy is lower than expected,
18 whether it's simply a difficult-to-reach population, whether
19 it's difficult to establish eligibility, or both.

20 We'll be back to you in April with more work on
21 Part D. As Joan told you in January, she'll present
22 findings from a nationwide survey we're sponsoring, as well

1 as focus groups and structured interviews we're conducting
2 to find out how Medicare beneficiaries are gathering
3 information about Part D.

4 As I alluded to earlier, we've also got an
5 analysis of Part D formularies underway. We're taking a
6 look at whether plans tend to use open versus closed
7 formularies, the systems of therapeutic classes they're
8 using, where particular categories of drugs are placed on
9 cost sharing tiers, and to what extent plans are using
10 management tools such as prior authorization and step
11 therapy. We also hope to address the issue of whether plans
12 that qualify for auto-enrollees have different formularies
13 from ones that do not.

14 In addition, we will present any information we
15 obtain about enrollment in specific plans as those data
16 become available. That will help us understand whether
17 beneficiaries or gravitating toward lower premium plans or
18 plans that are offered by organizations that have broad name
19 recognition or that sort of thing. Seeing plans that are
20 the most popular for 2006 will help us to think about how
21 the Part D program might look for next year when Part D
22 subsidies begin to reflect bids that are weighted by plan

1 enrollment.

2 Now we're happy to take your questions.

3 MS. HANSEN: I wonder if in the next study that we
4 have that we'll have a little bit more detail about the
5 hard-to-reach, low income subsidy group in greater detail,
6 whether more is forthcoming?

7 DR. SCHMIDT: In terms of our next steps you mean?
8 There may be a bit of information perhaps associated with
9 some of Joan's work in terms of some of the focus groups, we
10 may be able to get a bit of information. We're discussing
11 having some discussions with beneficiary advocates and that
12 sort of thing. But I'm not sure that we'll address it as
13 directly as you might like. We will be looking at the
14 formularies, again, of the plans to take a look at that.
15 But in terms of steps for trying to get at the hard-to-reach
16 population, we will do our best but I'm not sure that it's
17 maybe right as much on point as you might like.

18 MR. BRENNAN: But I do think that CMS is taking
19 some steps on try to focus on alternative outreach
20 strategies for that population.

21 MS. HANSEN: I realize it's not really our
22 jurisdiction, per se, but I wonder if we could just have

1 that as, whatever the CMS side is doing, just to give the
2 context to this enrollment Roman population. Thank you.

3 DR. SCANLON: Thank you very much. I found this
4 incredibly helpful in terms of understanding where we are
5 with Part D. I had spent time both last year and the
6 beginning of this year working with a coalition of
7 associations of people with chronic diseases about how they
8 can help their members choose a drug plan. To be frank, I
9 think what we came to was the idea that all you can do is
10 slog through an incredible amount of information, try to be
11 systematic about what you are seeing and make comparisons,
12 but that is an incredibly laborious effort.

13 What emerged for me out of this was the idea that
14 maybe there are some thing that can be done in terms of
15 helping beneficiaries choose among plans. In particular the
16 chart that you had which showed the distribution of premiums
17 for basic and enhanced plans was kind of the trigger for
18 this. I recognize this as a national chart and so anybody
19 in a single region is facing a different distribution but
20 that within a region there's still going to be a fairly wide
21 distribution.

22 Maybe it's my economics background, my instinct

1 when I looked at a distribution of traditional plans would
2 be, why would I look at the high-cost ones? This is a
3 market. If they're all offering something comparable, why
4 not get the best deal? But yet we see that there are
5 enhanced plans out there. Just telling beneficiaries which
6 are the enhanced plans so that they might actually consider,
7 I'll look at some of the more expensive ones because maybe
8 there's something more there that I'm going to get that is
9 worth it for me. Now the problem is that enhanced plans can
10 be enhanced in a wide range of ways and so it doesn't tell
11 you a lot, but it tells you something.

12 The other thing is the issue of a basic benefit
13 package versus the standard versus an actuarial equivalent.
14 Just knowing that also helps you sort out when you're facing
15 a choice of 40 plans.

16 So I think what we might want to consider is what
17 we could encourage CMS to do in terms of providing
18 additional types of information to beneficiaries than they
19 have to date to help them narrow the choices to begin with
20 and then do their shopping, because right now it's a very,
21 very difficult task.

22 MR. HACKBARTH: I guess if I were looking at this,

1 if you had a graph like this for the plans in your market
2 I'd say, one thing I want to do is look at those enhanced
3 plans in the lower end of the distribution, there may be a
4 particularly good value there. It's a starting point for
5 your analysis.

6 DR. NELSON: A similar question. Are there
7 differences in common between the actuarial equivalent plans
8 and the standard plans? Among those actuarial equivalent
9 plans are there certain characteristics that they all have
10 in common?

11 DR. SCHMIDT: They tend to use tiered cost
12 sharing. That's the primary characteristic they have. A
13 large proportion of them have no deductible as well. So
14 those seem to be the key features. Remember, the standard
15 benefit has this \$250 deductible, 25 percent coinsurance.
16 Many of them use the same initial coverage limits, so they
17 must be varying cost sharing by tiers in order to get at the
18 same 25 percent equivalent.

19 DR. NELSON: I take it there aren't huge
20 differences in the number of alternative drugs on the
21 formulary and stuff like that?

22 DR. SCHMIDT: Again, our formulary work is

1 underway so that's another key dimension, you're right, that
2 isn't really reflected in the data that you're seeing today.
3 So have to ask you to told your question for next month.

4 MR. MULLER: Again I commend you for this very
5 helpful work. If I can take you to slide 15. I have two
6 questions. On slide 15, how many of those categories
7 actually had to take a step to enroll as opposed to -- I
8 understand the duals or auto-enrolled, but is that just the
9 first and the third? Which of these 25 million actually had
10 to take a specific action to enroll?

11 DR. SCHMIDT: Certainly the first are the ones
12 that are for open enrollment. Some of those in MA-PDs also
13 elected to go into MA plans. Some of that may have been MA
14 enrollees in prior years and decided to stay with their
15 plan. But yes, it's primary those first and third
16 categories.

17 MR. MULLER: Do you have any sense then of the 18
18 percent still to go whether -- you probably would have the
19 same take-up rate since some of these came more
20 automatically. Is there some sense yet of how many of the
21 18 to go -- I'm taking the difference between 25 and 43.

22 DR. SCHMIDT: I hesitate to speculate. I know

1 there may be a last-minute rush to enroll depending on
2 people's perceptions about whether the May 15 cutoff is
3 going to stay around and their knowledge of the late
4 enrollment penalty and that sort of thing. So I think it's
5 difficult to speculate.

6 MR. MULLER: The second part is, remind me again
7 in terms of the payments that CMS makes to the MA -- you
8 pointed out that in the drug coverage they use some of the
9 rebate to help write down some of the coverage. Remind me
10 the payment that the MA plans get.

11 DR. SCHMIDT: You mean that enables them to buy
12 down?

13 MR. MULLER: Yes.

14 DR. SCHMIDT: So now they're bidding, as of this
15 year, on the package of A and B services, Medicare A and B
16 services. There is a payment rate that's established in
17 their operating area. They get to keep 75 -- not keep you,
18 but use 75 percent of the difference between the plan's bid
19 and that payment rate towards buying down Part D premiums,
20 Part B premiums.

21 MR. MULLER: That was very clear the chapter.
22 What's the payment rate though?

1 DR. SCHMIDT: What is the payment rate?

2 MR. MULLER: Where they're taking the 75 and 25
3 off?

4 MR. HACKBARTH: The benchmark.

5 DR. MILLER: Which we've discussed on -- right.

6 MS. DePARLE: This may be for Scott and it may be
7 something just we don't know yet but is there any sense of
8 how much the 25 percent amounts to in terms of money that's
9 going back to the Medicare program from this payment
10 calculation we've just been discussing?

11 DR. SCHMIDT: I don't think that we can say yet
12 because we don't know enrollments in plans at this point.

13 DR. MILLER: The arrival of the enrollment data
14 will allow us to do a lot of things to get a better sense
15 of, as you looked at those premiums across the country and
16 proportions of people in plans, but also to determine how
17 much on the MA side we're spending relative to the
18 benchmarks and exactly those kinds of things.

19 MS. DePARLE: When will we know what plans are
20 going to do for next year? Is that a May kind of thing?

21 MR. BRENNAN: June.

22 DR. SCHMIDT: Plan bids are due in June, I think

1 June 5.

2 DR. REISCHAUER: I've got a couple of factual
3 questions and then a more important consideration. If
4 you're an MA-PD plan and you have enhanced benefits that you
5 charge no premium for, which is the vast majority, do you
6 also have to offer a standard benefit too?

7 MR. BRENNAN: Yes.

8 DR. REISCHAUER: So you can get the Cadillac free
9 or the Chevrolet?

10 MR. BRENNAN: Every plan has to offer a standard
11 benefit in order to be able to offer enhanced benefits but
12 what you said is --

13 MR. HACKBARTH: It's an anomalous situation where
14 you could either have a Cadillac for free or a Chevrolet for
15 free which would you really like?

16 DR. SCANLON: But in terms of the accounting of
17 the 75 percent that you have to offer back, you get a
18 Chevrolet plus a dinner at a restaurant or something like
19 that. They have an obligation to return money to you.

20 MR. HACKBARTH: So you have to use those dollars,
21 if you're not using it for enhancing the drug benefit,
22 you've got to use it for vision care or something else.

1 Good point.

2 DR. REISCHAUER: The extent to which these plan
3 offerings have differed from the standard benefit design
4 probably shouldn't be surprising because in two respects
5 they are dimensions that try to appeal to healthy people,
6 number one, where you're going to a reduced or zero
7 deductible, what you're saying is folks who have very small
8 expenditures, we're going to give you something. And the
9 extent to which you go from the 25 percent coinsurance to
10 tiered copayments of -- what you're saying is, people who
11 use expensive drugs are going to pay more than otherwise
12 would be the case. That these are two aspects where within
13 that actuarial equivalence you're shifting the fraction of
14 the benefit that goes to healthy people in the direction of
15 people who are healthy as opposed to those who are sicker.
16 I knew this was going to get your attention, John.

17 And so the question that I would like us to look
18 at it is how good is the risk adjustment mechanism at
19 offsetting what is otherwise an inherent bias towards
20 attracting well people to these plans? I think we should
21 devote some effort to that.

22 MR. BERTKO: Can I just respond to a part of Bob's

1 comment here? The \$3,600 out-of-pocket max applies across
2 the board to any plan. So in the case of the 25 percent
3 part, people who are taking very expensive drugs will get to
4 \$3,600 rather quickly and then they go down to a 5 percent
5 cost sharing. So they are protected, in the insurance
6 catastrophic sense of the word, across all levels of plans.

7 DR. REISCHAUER: But the vast majority of people
8 are below this level and what you're doing is redistributing
9 the attractiveness among those people is all I'm saying.

10 MR. BERTKO: That's a true statement on the
11 surface, but for the people who take the very expensive
12 drugs those will be disproportionately into the catastrophic
13 category.

14 MR. HACKBARTH: John.

15 MR. BERTKO: First of all, I wanted to
16 congratulate Niall if this is your work on slide six. The
17 graphics were amazing in terms of trying to put this in
18 there.

19 MR. HACKBARTH: I think Joan has been passed in
20 the animation derby. You have to pick your game up here to
21 stay with them.

22 MR. BERTKO: Then I wanted to make at least one

1 observation. I think, first of all, you've done a good job
2 by characterizing most of the plans as being national or
3 near national plans. And then I'd say one more thing, from
4 press reports, publicly available information on the PDPs
5 only, there is in fact even more clustering. There's a
6 report, I think it was in the L.A. Times, and if you added
7 up the amount of membership in the top five plans -- those
8 are big vendors national and near national -- you come up to
9 perhaps about two-thirds, maybe even three-quarters of all
10 of the category one and three enrollees that Ralph --
11 actually maybe one, two and three enrollees. Out of the
12 10.5 million people who are in stand-alone PDPs, not in MA,
13 not other --

14 So people have voted with their pocketbooks and in
15 fact it's actually maybe simpler to analyze than it seems
16 with the bewildering number of 1,400. It's much more
17 condensed than that.

18 DR. CROSSON: Just a thought about what we're
19 going to be looking at in April around the formulary stuff,
20 I had two questions. Is it going to be possible, or when
21 would it be possible to correlate enrollment with the
22 benefit design and formulary design, sort of as a triple

1 analysis? Is that going to be possible to say, we think
2 formulary design is moving enrollment this way or to this
3 degree, and the benefit design in terms of out-of-pocket
4 costs is moving it? Or is that something that's just too
5 complex?

6 DR. SCHMIDT: In terms of timing of data that
7 we'll be able to obtain, I don't think it will be feasible
8 for the June chapter. The open enrollment period ends May
9 15. We effectively have these chapters written in May so
10 we're constrained in that manner.

11 In terms of the general issue of thinking about
12 whether beneficiaries are looking at formularies versus
13 benefit structure itself, I guess it depends on how
14 enrollment works out and the degree to which relatively open
15 formularies correlate differently in terms of cost sharing
16 structure from others, and we don't know the answer to that
17 yet.

18 DR. CROSSON: The question though, Rachel, is do
19 you think we, say later in the year we would be able to have
20 information like that to analyze?

21 DR. SCHMIDT: I certainly hope so. This is going
22 to be a many year effort, we hope, in looking at patterns of

1 why beneficiaries are picking certain plans. We might get a
2 little bit of information from Joan's focus groups, and I
3 know David has been a part of those, to get a sense of
4 whether they are thinking mostly about premiums and benefit
5 structure versus formularies.

6 DR. CROSSON: The second part of the question is,
7 somewhere in the chapter you talk briefly about restrictions
8 on formulary design. CMS, I guess, has authority to approve
9 or not approve formularies. Are we going to have some
10 information about how that process is going, what criteria
11 are being used, where the thought processes are?

12 DR. SCHMIDT: We hope to give you an overview in
13 the chapter of what we are at least observing for this year.
14 We've told you in the past about the USP approach, their
15 therapeutic categories and the safe harbor provisions and
16 the coverage of a couple drugs in each of the therapeutic
17 classes. According to what CMS has put out, they don't
18 necessarily follow the USP's therapeutic classes but they do
19 tend to look at that, look to see whether USP categories are
20 being used or not, and the number of drugs covered. We'll
21 try to outline what we know about that process.

22 DR. MILLER: If I could just say something to

1 follow up on this. I don't want you to feel like you're
2 hearing a reluctance to do this. The way I organize this
3 problem in my mind is, one, we have to get the enrollment
4 data, and it's happening in real-time. There been some
5 complexities, and when we're going to get that and get it
6 comprehensively is an issue.

7 Second, I think the notion of enrollment versus
8 benefit design is probably within reach. Again, if we get
9 the data, I'm not sure by June, but the notion of analyzing
10 that, relatively more straightforward.

11 Then you get to formularies. The way I organize
12 it in my mind, and you should object if this isn't right,
13 the first thing we have to do is figure out, in a sense, a
14 typology to capture what's happening before you can then
15 correlate it with something. I think right there we're all
16 a little nervous about what we're going to see and what
17 we're -- not nervous. Just as analysts, we've never been in
18 the middle of this before, so we're waiting to see that.
19 Then we'll have to figure how do to even describe what's
20 happening to relate it to something.

21 The other part of it is, depending on how dynamic
22 this is I think that could be a little -- but we should be

1 able to capture something at a point in time and look at it,
2 I would hope. So the reluctance or the hesitation you heard
3 was no, we don't want to do it. It's, we don't know exactly
4 what we're going to walk into on the formulary front.

5 DR. SCHMIDT: Yes, let me assure you, we're
6 absolutely very interested in this stuff and we will be
7 following it closely and keep coming back to you with more
8 information as we get it.

9 MR. HACKBARTH: Thank you. Good job.

10 Next Scott is going to talk to us about Medicare
11 Advantage plans.

12 * DR. HARRISON: Today we will quickly review the
13 challenges the Medicare Advantage program has undergone for
14 2006 and show the resulting plan bidding and availability.

15 This was the first year plans bid to provide
16 Medicare benefits. Their bids were compared with benchmarks
17 and established by the MMA at the county rates that were
18 previously used to pay plans. I'll go back over those
19 details in just a minute.

20 New plan types were allowed this year. Regional
21 plans were introduced. They are required to be PPOs and
22 must serve entire regions built up from states. All other

1 plans are referred to as local plans. In return for the
2 challenge of covering an entire region, the regional PPOs
3 are allowed to have looser networks of providers than the
4 local PPOs.

5 Another new type of plan is the special needs
6 plan. They may restrict their enrollment to one of three
7 types of beneficiaries: Medicare-Medicaid dual eligibles,
8 beneficiaries living in institutions, and beneficiaries with
9 certain chronic or disabling conditions.

10 A third big change is the introduction of the
11 Medicare Part D benefit. Beginning in 2006, almost all MA
12 plan sponsors have offer a plan that includes the Part D
13 benefit or an equivalent or enhanced version, and they are
14 paid for the Part D portion of the benefits by Medicare
15 separately from their MA payments just as if they were
16 providing a stand-alone plan.

17 The stand-alone PDPs represent a new form of
18 competition for the MA plans, that have often provided drug
19 benefits. The PDPs will offer a relatively affordable way
20 for beneficiaries to remain in fee-for-service Medicare and
21 still obtain prescription drug coverage. Rachel and Niall
22 have just given you some idea of the drug offerings of the

1 MA plans and how they compare with the PDPs.

2 Bids for 2006 were submitted by plan sponsors last
3 year. There were more than 2,000 bids submitted to provide
4 Medicare coverage to beneficiaries in the plan service
5 areas. Medicare non-drug payment to the plan is based on
6 the plan's bid for the standard Medicare Part A and B
7 benefits, or in other words, all Medicare benefits except
8 for Part D. For this presentation the term bid will mean
9 the non-drug bid.

10 Payments to the plans are determined by the plan's
11 bid and the payment area's benchmark. The benchmarks for
12 2006, as I said, were the 2005 rates updated by a national
13 growth rate. The plan's bid is compared with a benchmark.
14 Then for those plans that bid higher than the benchmark, the
15 plan is paid the benchmark and the plan enrollees would have
16 to make up the difference with a premium for the basic
17 Medicare benefits.

18 If the bid is below the benchmark, the plan is
19 paid its bid plus the 75 percent rebate. The plan must pass
20 the rebate along to its members in the form of either
21 reduced cost sharing, a reduction in premiums, or other
22 supplemental benefits. Ninety-five percent of the plans

1 have bid below the benchmark and thus have rebates to
2 distribute to their members.

3 Just for example, if a plan faced a benchmark of
4 \$1,000 per month and bid \$900 per month it would receive its
5 bid of \$900 to provide the non-drug benefits plus \$75 to
6 rebate to its members in one of a few ways.

7 We've begun examining the 2006 bid data that has
8 been provided by CMS. Unfortunately, we have not been able
9 to obtain plan-level enrollment data so the analysis of the
10 bids is unweighted. When we get enrollment data we will
11 redo the analysis so that bids can be properly weighted.

12 For this analysis we divided plans into five
13 groups: local HMOs, local PPOs, private fee-for-service
14 plans, regional PPO plans and the special needs plans. We
15 found that the bids tended to differ by plan type. Other
16 than the special needs plans, the local HMOs were most able
17 to bid below the benchmark and had the largest average
18 rebates. Ninety-eight percent of local HMO bids came in
19 below the benchmark, and when they did, the average rebate
20 was about \$80 per month.

21 Local PPOs were not as likely to beat the
22 benchmark, and even when they were they received

1 substantially lower rebates than HMOs. Private fee-for-
2 service plans were able to bid below the benchmark in most
3 cases but their average rebates were about half that of
4 HMOs. And regional PPOs had more trouble with the
5 benchmarks, with only 69 percent of their bids being below
6 the benchmarks.

7 Because the special needs plans target certain
8 subsets of beneficiaries and are affected differently by the
9 risk adjustment system they look different on these
10 measures. Jennifer will discuss these plans in more detail
11 in the next session.

12 I want to caution you, I've refined this chart
13 from what you saw in your meeting materials so it's a little
14 different, but mostly the same.

15 We examined the bids to see how the plans used
16 their rebate funds. The bid data divided the rebates into
17 five benefit groups. The plans could use their rebates to
18 lower standard Medicare cost sharing, or to reduce the Part
19 B premium or the Part D premium, or to enhance the drug
20 benefit above the standard Part D benefit, or they could
21 offer other supplemental benefits such as dental or vision
22 coverage. We used the unweighted bids to see where plans

1 put their rebates. Again will redo the analysis once we get
2 enrollment data.

3 Preliminarily, we found about two-thirds of the
4 rebates would be used to lower cost sharing on Medicare non-
5 drug benefits. The next largest use of rebates went to
6 cover the supplemental services such as dental or vision
7 services, but reducing the Part D premium and supplementing
8 the Part D benefit also were used substantially to
9 distribute the rebates. Rachel and Niall just showed you
10 that it resulted in MA plans being able to offer lower
11 premiums than the stand-alone PDPs.

12 Now let's look at how the bidding and rebates have
13 translated into availability for Medicare beneficiaries.

14 2006 will be a record year for plan availability.
15 Virtually all Medicare beneficiaries will have a Medicare
16 Advantage plan available to them. Even though we saw that
17 regional PPOs were not always able to bid below the
18 benchmarks, they are the most widely available plan type,
19 reaching 88 percent of the Medicare population.

20 We see here that many of the choices have zero
21 premiums and provide enhanced benefits. Again terminology
22 here, zero premium means no premium in addition to the

1 standard Part B premium. Zero premium MA plans are
2 available to 84 percent of Medicare beneficiaries in 2006.
3 The most widely available plan type is the zero premium HMO.
4 Although premiums for the private fee-for-service plans and
5 regional PPOs tend not to be as low as the premiums for the
6 local HMOs, about one-third of beneficiaries do have access
7 to zero premium private fee-for-service plans, and a similar
8 share have access to zero premium regional plans.

9 Not all zero premium plans include Part D coverage
10 but zero premium plans that provide drug coverage are also
11 available. Either because plans are able to effectively
12 manage benefits or because the benchmarks are high enough to
13 support generous benefits, 67 percent of beneficiaries have
14 access to zero premium plans that include Part D benefits
15 with the most common plan type being the HMO, but zero
16 premium private fee-for-service plans with Part D coverage
17 are also available to 25 percent of Medicare beneficiaries.
18 Even more generous, 25 percent of beneficiaries will have
19 access to zero premium plans with Part D that offer some
20 coverage in the coverage gap.

21 Now for April we will examine some other benefit
22 characteristics. It is often difficult to categorize these

1 different benefits, but for right now I think we will look
2 at out-of-pocket caps and copayments for a six-day hospital
3 stay. If you have other benefits you'd like me to summarize
4 please let me know.

5 But first I want to leave you with a final picture
6 of how many MA choices beneficiaries now have. This chart
7 shows the percentage of beneficiaries that have a different
8 number of plan choices. For example, if you look at the bar
9 above one to five plans, you will see that about 8 percent
10 of beneficiaries have between one and five plan choices. We
11 find that virtually all beneficiaries have a choice of two
12 or more MA plans.

13 If we add the two bars on the left side of the
14 graph we find that only about 10 percent of beneficiaries
15 have five or fewer MA plan choices. If we look at the right
16 side we see that 15 percent of beneficiaries have the
17 opportunity or challenge to choose from over 31 plans.
18 Beneficiaries in Broward County, Florida have the most
19 choices available, 63 plans. Now bear in mind, these plan
20 choices are in addition to the stand-alone PDP choice
21 offerings discussed by Rachel and Niall.

22 Enrollment data will allow us to further examine

1 plan bid and availability. We hope to have that data
2 shortly and we'll proceed to look at enrollment growth and
3 look at Medicare payment costs relative to fee-for-service
4 costs once we get that data.

5 Thank you.

6 MR. MULLER: This is a variant of the question I
7 asked Niall and Rachel. With 95 percent of the plans
8 bidding below the benchmark, in M+C we had an erosion of
9 beneficiaries because -- they didn't call it benchmarks then
10 but the payments were too low. What's our estimate of where
11 the benchmarks are compared to the old M+C levels? I seem
12 to remember we'd been estimating 7 percent to 10 percent but
13 they may come in lower with these bids. What's our sense
14 where the benchmarks are against the old comparable M+C
15 number?

16 DR. HARRISON: We don't think the 7 percent number
17 has changed much. However, the risk-adjusted portion,
18 remember there was this budget neutrality policy that's been
19 going on. That added 13 percent to the risk side scores for
20 this year. We don't know what that would be in the future.
21 That tends to vary this year, but for this year they added
22 13 percent.

1 DR. MILLER: But isn't the answer to the question,
2 we'll be able to calculate that, where the bids are relative
3 to the benchmark and where the payment rates are relative to
4 fee-for-service once we get the enrollment?

5 DR. HARRISON: That's correct, we can give a
6 summary figure to that.

7 DR. MILLER: So I think the way to come back to
8 you is, we are headed toward being able to know that but it
9 does require to know, across the country, how people are
10 enrolled.

11 MS. DePARLE: When you think you're going to have
12 enrollment data?

13 DR. MILLER: I really don't know. We're trying to
14 work with the agency now to get it.

15 MR. HACKBARTH: Ralph's question was simply about
16 the benchmarks, per se, and the starting point.

17 MR. MULLER: Obviously, with 95 percent bidding
18 below, there's a signal there.

19 DR. REISCHAUER: I had basically the same
20 question. I was wondering why, forgetting about enrollment,
21 if you look at this chart that is preliminary percent of MA
22 plans bid below, why for local plans you can't compare the

1 bids now to the AAPCC and see how many of them are below.

2 MS. BURKE: I had the same question.

3 DR. REISCHAUER: Does that depend on enrollment?

4 DR. HARRISON: Local plans don't only serve one
5 county and they'll have enrollment for more than one county
6 so the ratios may be slightly different. It gets a little
7 tricky, but once we get enrollment we'll be able to do that.

8 MS. BURKE: I was going down the exact same road
9 as Ralph. If we were looking at hospital margins that
10 looked like this, I can imagine what our policy suggestions
11 would be. If we're beginning to see a trend where they're
12 all coming in below the benchmark or largely below the
13 benchmark it does raise questions about the benchmark, I
14 would assume.

15 DR. MILLER: But we've been pretty clear as a
16 Commission what we think of the benchmarks. We've made that
17 statement. Unless again I'm misunderstanding the question.
18 We think that the benchmarks are set too high and that this
19 is -- your point is this may be additional --

20 MS. BURKE: Exactly.

21 MR. MULLER: Your answer on the 13, is that seven
22 plus 13 or 13?

1 DR. HARRISON: It could very well be seven plus 13
2 but the seven was a past enrollment-weighted number so that
3 is hard to get at.

4 MR. BERTKO: Ralph, this 13 that Scott referenced
5 is before coding intensity adjustments so it's less than
6 that, and then it's phased in at a 75 percent level for
7 2006. So you can't just add them up. It's really 8 percent
8 and then 75 percent of the 8 percent at the top end.

9 DR. REISCHAUER: Is there going to be a test on
10 this at the end?

11 MR. HACKBARTH: Once we have the enrollment
12 information we'll be able to do the next analysis which I
13 think Mark started to talk about, which is what is the net
14 effect on federal spending after you take into account that
15 25 percent of the difference between the bid and the
16 benchmark goes back to the Treasury? So our old numbers of
17 107 percent, all that stuff is going to be outdated.
18 There's a new dynamic and we need to have new metrics.

19 MR. MULLER: As pointed out, 75 percent is going
20 into the rebates and all that so even if you start doing
21 some simple math on this and even having the 13, you save 25
22 percent of the 15 or so, it's four or five -- still a

1 spending increase of 12 percent or whatever.

2 DR. CROSSON: I guess I just have to caution
3 against simple numbers, as Ralph said, because in fact I
4 don't think you can just say, the bids were this far below
5 the benchmark, therefore that's an indication of what
6 previous margins were, because there's a lot more that goes
7 into that. For example, I think it's entirely likely that
8 some plans right now are bidding below cost perhaps to get
9 market share.

10 Secondly, I think some of this may be based on an
11 intention to reduce payments to the provider side, perhaps
12 even below some of the ideas that we have in the fee-for-
13 service environment.

14 I think the analysis is complicated and I would
15 probably caution against just jumping to a conclusion based
16 on the bidding process in its first iteration.

17 MR. MULLER: But that may be, the bidding below
18 cost may be the cost of an efficient plan, as we've use that
19 term elsewhere.

20 MR. SMITH: Jay made the point I wanted to make.
21 I think we need to be careful with 2006 behavior, both by
22 enrollees and by plans. We're going to know a lot more in

1 May of 2007 than we're going to know in May of 2006. I
2 don't know how many of the 2,700 options will still be
3 around next year but it won't be 2,700. It will be less,
4 precisely because -- partly because people are bidding for
5 market share and partly because people didn't get enough
6 market share even if they were bidding at a price they
7 thought would work.

8 So I think, Ralph, I share your concern about the
9 benchmark, and, Mark, you're absolutely right, we've been
10 clear about our objections to the benchmark. It is bad no
11 matter what behavior is. But behavior is not only
12 influenced by the bad benchmarking but by marketing
13 considerations as well.

14 DR. WOLTER: I don't know how possible this will
15 be as we do our further analysis, but the penetration
16 obviously of a rebate is very high, it looks like, across
17 all types of plans. But I wonder if it will be possible to
18 make some assessment eventually about whether or not there's
19 a fair amount of inequity in terms of what benefit is
20 available to beneficiaries in different parts of the country
21 and that sort of thing, because the level of rebate will
22 vary quite a bit depending on the benchmark, et cetera.

1 With the incredible diversity of what's happening here,
2 obviously there's going to be quite a difference perhaps in
3 what an enhanced benefits are available depending on what
4 part of the country you live in. I think that would be
5 worth tracking, if we could.

6 One other comment, I think -- I don't know when we
7 would get to it -- the appropriate attention here is being
8 paid to what's available to beneficiaries. I'm hearing a
9 lot of concern in the provider community about not
10 understanding these various plans. Some have to contract
11 very specifically with the full network. Others do not.
12 Many of the hospitals are not really sure what relationship
13 they're in because they haven't necessarily been contacted
14 by all of plans and yet for various reasons they will start
15 seeing patients who are in plans.

16 A specific area I think where there's a lot of
17 concern is critical access hospitals and how this is all
18 going to play out in that world in terms of interim payment
19 and those sorts of things. I don't even know if that's on
20 our docket in this first wave of analysis but at some point
21 it probably should be a little more --

22 MR. MULLER: If I can speech to that point. As we

1 know, a lot of states stepped in and I think it's up to 90
2 days now versus the first 30, to exactly that point, a lot
3 of the beneficiaries who are coming are still under this
4 broad state -- I don't know what the right term is -- waiver
5 or whatever, transition. So you're basically saying, the
6 state kind of gave a blanket on the stuff and you don't yet
7 know what plans you're actually going to be contracting with
8 and so forth. So I think a lot of this might become much
9 more obvious once the 90-day transition period is over and
10 you actually see who has communicated with whom on April 1.

11 DR. SCANLON: This in part relates to Jay's and
12 Dave's point about being cautious, but at the same time I
13 guess I would argue that there is a lot to learn from this
14 experience, particularly is we take Nick's suggestion and go
15 below the national level. In terms of our criticisms of the
16 benchmark in the past, a lot of it's been focused on the
17 floors. I think finding out what's happening in floor
18 counties of different types, when you get enough of them
19 together that some of the aberrations in terms of planned
20 strategy and behavior average out. And it may help buttress
21 some of the arguments we've made about the benchmarks in the
22 past by doing the sub-national analysis, because I'm

1 assuming for like \$80 average rebate for HMOs we've got a
2 wide range that may exist. It could be very informative to
3 know about that.

4 MR. HACKBARTH: One of the more striking numbers
5 to me in Table 4 is the private fee-for-service column,
6 where 93 percent of the bids were below the benchmark and an
7 average rebate of \$40. In general, and correct me if I'm
8 wrong, John, we're talking about plans that by design, by
9 definition are offering something very similar to fee-for-
10 service Medicare, they don't have exclusive networks,
11 limited networks, and they're typically, I would think,
12 paying providers at or near the Medicare rate. A growing
13 portion of the country is having the opportunity to join a
14 private alternative to Medicare that's basically mimicking
15 the Medicare program and getting expanded benefits for it.
16 And they're doing that because they're going into areas
17 where the Medicare Advantage rate is higher than the
18 underlying fee-for-service costs; i.e. the floor counties.

19 So that particular column flashes to me, is this
20 really what we want to encourage?

21 MR. BERTKO: May I respond to that just briefly?
22 I agree with everything you said with the one add-on that

1 competing with fee-for-service Medicare in some ways is low
2 hurdle. If there is any care coordination at all that can
3 be put in, and we've got some comments on that, you then
4 begin to have about that much money available to use. So
5 just keep that in mind.

6 DR. REISCHAUER: Showing that I'm capable of being
7 on both sides of the same issue within a short period of
8 time let me just do some arithmetic that sort of supports
9 Jay's point, which is the HMO column, the average rebate is
10 \$80 a month, and that's 75 percent presumably of the
11 difference, per month. That's \$1,280 a year would be the
12 difference, which I don't know what the average Medicare
13 beneficiary cost is but if it were \$8,000 it's 15 percent,
14 suggesting that the costs are about 15 percent below, which
15 is then about where the Medicare fee-for-service average is.
16 The suggestions that some of us might have laid out on the
17 table that this is a whole lot different from what Medicare
18 fee-for-service is might turn out not to be the case. That
19 supports you.

20 MR. BERTKO: Just to respond to Bob again on this
21 and to repeat my last comment, that in the HMO markets,
22 which tend to have been squeezed earlier by the BBA, beating

1 Medicare fee-for-service, particularly in some of the high
2 payment counties, is a low hurdle. There is a lot of use of
3 inappropriate care. If you can have appropriate care,
4 squeezing that 15 percent isn't that difficult.

5 DR. REISCHAUER: But the question is where should
6 the benefit get from running a more efficient system, and
7 shouldn't you encourage the private sector in a sense if
8 it's doing that and shift the enrollment as a result? And
9 then you can talk about ratcheting it down.

10 MR. BERTKO: Right, but in fact virtually all of
11 the money goes to one of two places: to beneficiaries or
12 back to Treasury.

13 MS. BURKE: Or it could stay with Treasury.

14 MR. BERTKO: But if it stayed with Treasury then
15 you wouldn't have anybody enrolled in it because then you'd
16 have a fee-for-service benefit, because the bid is on fee-
17 for-service level benefits. So if 100 percent of the rebate
18 was returned you'd have a fee-for-service benefit and nobody
19 would enroll.

20 MS. BURKE: My point wasn't the rebate returning.
21 My point was pricing it right the first time.

22 MR. BERTKO: I'm responding to that.

1 MR. HACKBARTH: John, you and I actually agree a
2 lot on this and I specifically agree with your statement
3 that at least in many areas of the country beating fee-for-
4 service Medicare is a low hurdle because of the underlying
5 utilization patterns. It's that very point that makes me
6 question why we then have to have benchmarks that are higher
7 than Medicare fee-for-service.

8 MR. BERTKO: I wasn't responding to that. But on
9 the HMO side, they are pretty much level. There's no higher
10 or very little higher that I know of.

11 MR. HACKBARTH: Any others on this? Nick?

12 DR. WOLTER: This is the discussion we had before.
13 I guess my concern, again, for the rural low cost areas is
14 that to the extent that the floors allow some reinvestment
15 in other things, whether it's chronic disease management or
16 other enhancements, that isn't possible if the benchmark is
17 left at the low fee-for-service rate in those very low cost
18 areas, whereas it's very possible when you can bid against
19 the high fee-for-service rates in the high cost areas.

20 So the question is, do you try to bring some
21 balance into this discussion and narrow the bell curve
22 rather than stay at the county by county fee-for-service

1 level? That's been my concern. Then also this inequity
2 issue in terms of what's available to beneficiaries in some
3 parts of the country versus others I think is worthy of
4 discussion.

5 MR. HACKBARTH: Those are important issues and you
6 present them very well. If in fact though what we want to
7 buy for Medicare beneficiaries in those rural areas is more
8 of those good things, coordinated care and the like, I'm not
9 sure why we shouldn't do that in fee-for-service Medicare as
10 opposed to saying the only way you can get those things is
11 through a private plan which we're supporting through
12 floors. So I think there's an equity issue there in saying
13 that to get this you have to go a certain route.

14 We've gone over this ground recently so we don't
15 need to rehash it right now. I'm sure we will be back.

16 So thank you Scott. Well done.

17 We have one more presentation before lunch and
18 that's on the special needs plans.

19 You can go ahead whenever you're ready, Jennifer.

20 * MS. PODULKA: I heard the magic words that I'm the
21 last one before lunch so I will keep that in mind.

22 Today I'm here to provide you an update on our

1 examination of the special needs plans and provide some
2 preliminary information from the first three of our four
3 site visits. First I'd like to thank Scott Harrison and
4 Sarah Friedman as well as Jim Verdier and Melanie Au of
5 Mathematica Policy Research for their help on this project.

6 As I told you back in January, SNPs are a new type
7 of Medicare Advantage plan. They're targeted to
8 beneficiaries who are either duly eligible for Medicare and
9 Medicaid, residing in an institution, or chronically ill or
10 disabled. SNPs offer the opportunity to improve the
11 coordination of care for these special beneficiaries, and
12 dual eligibles SNPs, in fact any SNP that covers Medicaid
13 services offers the ability to improve the coordination of
14 Medicare and Medicaid.

15 When the MMA created SNPs it established few
16 additional requirements for them compared to regular MA
17 plans. SNP must cover drugs plus additional services
18 tailored to their population, and SNPs are allowed to limit
19 their enrollment to their targeted population. SNPs are
20 paid on the same basis as regular MA plans, including the
21 same risk adjustment method to account for differences in
22 expected beneficiary costs. In 2007 payments will be fully

1 risk adjusted using the CMS HCC model, and risk adjustment
2 generally results in plans being paid more for special needs
3 beneficiaries than for the general Medicare population.

4 The Commission in the past has expressed a desire
5 to seek out opportunities for delivering high quality
6 coordinated health care for dual eligible and other special
7 needs Medicare beneficiaries. To describe how SNPs are
8 taking advantage of this opportunity we chose to conduct
9 site visits in four locations: Baltimore, Boston, Phoenix
10 and Miami. As a whole, these areas show us SNPs in markets
11 where there are many competing SNPs, there are existing
12 special plans that converted into SNPs, Medicare managed-
13 care enrollees were passively enrolled into dual eligible
14 SNPs, organizations chose to offer multiple dual eligible
15 plans, and there are all three types of SNPs, dual eligible,
16 institutional and chronic care.

17 SNPs' goals and strategies for the future vary.
18 Some SNPs plan to gain more experience before attempting to
19 significantly increase their enrollment, also their benefit
20 packages, or expand their service areas. Other SNPs are
21 considering expanding their service areas, adding new plans,
22 pursuing partnerships with states, and increasing their

1 marketing efforts.

2 SNP organizations can be characterized as falling
3 into one of two groups. First, organizations that have
4 experience providing services to special needs beneficiaries
5 through a Medicare demonstration, Medicaid plan, or similar
6 specialized plan. These organizations view SNPs as a
7 natural extension of their mission.

8 Secondly are organizations that have experience
9 operating MA plans and view SNPs as an opportunity to expand
10 their selection of products for their members.

11 SNP relationships with states varied. Some have
12 very close and long-standing established relationship with
13 states while others have none at all. It is important to
14 note that SNPs, even dual eligible SNPs, are not required to
15 contract with states, and in fact CMS does not consider or
16 track which ones do.

17 In our interviews we found that some dual eligible
18 SNPs receive payment from states to include Medicaid
19 benefits in their benefit package, but many do not. States
20 may have little incentive to partner with SNPs, especially
21 now that prescription drugs are covered under Part D, and
22 about one-third of states have chosen to set their Medicaid

1 rates at or below 80 percent of the Medicare fee schedule to
2 limit their cost sharing liability.

3 When we spoke with SNPs that do contract with
4 Medicaid they noted many conflicts between the Medicare and
5 Medicaid rules. They are eager for CMS and states to work
6 to reduce these administrative barriers to better
7 integration of the two programs. However, to date it
8 appears that the bulk of any integration is occurring at the
9 plan level. For example, several plans told us that they
10 had to deal with separate Medicare and Medicaid officials at
11 CMS and that rarely did they find that these two groups know
12 what the other one was doing.

13 Specific to the coordination of separate Medicare
14 and Medicaid funding streams, some dual eligible SNPs
15 indicated that it was somewhat burdensome but, surprisingly
16 to us, several SNPs told us that it was not a problem at
17 all. SNPs all agree that the accounting requirements had no
18 effect on their clinical care, coordination efforts, or on
19 their relationships with providers.

20 CMS central office is primarily responsible for
21 reviewing and approving MA plan applications, but because
22 SNPs, especially dual eligible SNPs, are significantly

1 affected by state and local conditions it may be appropriate
2 for regional offices to have a more active role in this
3 process. SNPs generally said that CMS approved most
4 applications with few changes. However, in contrast, SNPs
5 expressed frustration over CMS's ongoing guidance for the
6 program's rollout.

7 SNPs have mostly opted for targeted marketing with
8 little emphasis so far on broader efforts. SNPs' approaches
9 to outreach and enrollment differ significantly depending on
10 their target populations and whether they receive passive
11 enrollment.

12 Of course, individual SNP's marketing strategies
13 varied but generally we heard that dual eligible SNPs had
14 the broadest marketing strategies aimed at physicians,
15 hospitals, community organizations and advocacy groups.
16 Institutional SNPs market primarily to nursing facilities
17 and families of residents. Chronic condition SNPs focused
18 primarily on physicians, other chronic care providers and
19 beneficiary advocacy groups.

20 SNPs with passive enrollment focus on retaining
21 their current enrollees. You may recall that Medicaid
22 managed care plans that converted into Medicare SNPs were

1 allowed to passively enroll their members. These
2 beneficiaries then had to choose to either remain in the new
3 dual eligible SNP, switch to another type of MA plan or
4 return to fee-for-service.

5 Organizations that offer SNPs along with other MA
6 products may be focusing on shifting members into the new
7 product. And if they offer a commercial product line they
8 may also focus on marketing to beneficiaries who are aging
9 in and gaining eligibility for Medicare.

10 We've heard that the CMS web-based plan finder
11 tool is difficult for the SNPs to take advantage of since
12 their specialized focus and benefits do not fit well into
13 the plan finder format. For example, SNPs who contracted
14 with Medicaid to cover the plan premium, so that in effect
15 beneficiaries were getting a zero premium plan and they
16 weren't paying out-of-pocket, were still required to list
17 the premium amount in the plan finder, so it was
18 indistinguishable from other plans.

19 Congress must act to extend the SNP authorization
20 beyond 2008. The MMA mandated that CMS report to Congress
21 by 2007 on the impact of SNPs on the cost and quality of
22 services provided to enrollees. However, there may be

1 limited data available upon which to evaluate SNPs. 2006
2 data may be muddied by startup issues, including incorrect
3 enrollment data, and plans designed to improve care
4 coordination and quality while reducing unnecessary costs
5 may not exhibit measurable differences within just a year.

6 SNPs told us that they recognize the importance of
7 quality monitoring to demonstrate that they add value, but
8 several expressed concern that CMS's existing MA quality
9 monitoring and reporting system is not as applicable to
10 their special population. Some SNPs already have additional
11 significant quality monitoring and reporting systems in
12 place, either because they are Medicare demonstration plans
13 in the past or because they have state Medicaid
14 requirements. However, other SNPs do not appear to have any
15 special quality efforts underway at this point.

16 Based on our very preliminary information we've
17 focused our interest on a few key issues going forward. One
18 is how many eligible beneficiaries will enroll in the SNPs?
19 Will SNPs actually attract new beneficiaries or will they be
20 shifting members from other plans and other product lines?
21 In addition, will more SNPs establish relationships with
22 states, and which Medicaid services will they cover in their

1 benefit package? Finally, how successful will SNPs be at
2 streamlining conflicting Medicare and Medicaid processes?

3 As I mentioned we have one more site visit to
4 conduct and we'll be coming back with more information in
5 April, but I appreciate any questions and comments on the
6 state of the work.

7 MS. HANSEN: Thank you and thank you also for the
8 invitation to participate. I'm sorry that I couldn't
9 attend.

10 Relative to the key issues, the relationships with
11 states and realizing the complexities of the dual eligible,
12 the two forms of both Medicare and Medicaid. One of the
13 thoughts that I would suggest is, many of the PACE programs
14 throughout the country have dealt with about 20 states
15 already dealing with both the Medicare side and the Medicaid
16 side. That may be just useful as a backdrop perhaps to talk
17 to some of the national PACE association organization staff
18 to learn a little bit about that whole format.

19 Going back to the other area though of enrollment,
20 the passive enrollment of dual eligibles to some of the
21 plans, that's a little bit different for a Medicare piece
22 because usually on the Medicaid side there is enrollment

1 that's required by the state. But since there was passive
2 enrollment in this case for the dual eligibles, as I
3 understand, are the beneficiaries really informed about what
4 that process is? I know they have the ability to opt out,
5 but just to understand what this program is fully about.

6 MS. PODULKA: Unlike auto-enrollment in the
7 prescription drug area, passive enrollment is a little
8 different. These were beneficiaries who had actively opted
9 to join a Medicaid managed care plan and when that exact
10 plan converted and took advantage of the new Medicare SNP
11 opportunity, rather than making those beneficiaries re-
12 enroll in what to them is essentially the same product, it's
13 just offered by a new government now, federal rather than
14 state, they wanted to streamline the process.

15 DR. SCANLON: On that last point, I guess I had a
16 different impression of passive enrollment. It was that you
17 were in a Medicaid managed care plan, which may not have
18 been a choice because in order to get your Medicaid benefit
19 you had to be in managed care in some states. Then you were
20 transferred --

21 MS. PODULKA: That's absolute correct. In some
22 instances you may have been assigned at the state level, but

1 you had been in that plan. So you had at least a year's
2 worth of experience in that setting.

3 MS. BURKE: But not necessarily getting your
4 Medicare benefits.

5 MS. PODULKA: Correct.

6 DR. SCANLON: That's the issue.

7 Two different points. One actually goes back to
8 Scott's presentation and the number and the table that shows
9 that the special needs plans, 100 percent are below the
10 benchmark, and \$130 is the average. I guess what that
11 raised for me was a question of, is there a problem with the
12 risk adjusters here that we haven't fully recognized. That
13 we know how risk adjusters are performing on average, but
14 for the kinds of targeted populations that are being brought
15 into special needs is the predictive value of the risk
16 adjuster as good? I don't know if you've looked at that yet
17 or if we could look at that at some point.

18 DR. MILLER: Yes, we can look at it and actually
19 this thought has occurred to us in our own conversations,
20 when you see both the growth in the plans, the number of
21 special needs plans that are being offered, this question
22 that we're asking ourselves -- we're not saying that all

1 plans are engaged in this but there does seem to be some
2 differentiating among populations which then raises that
3 question.

4 Then finally the benchmark point. All of this has
5 come up in our conversation. In the past, we have looked --
6 this predates you -- we have looked at this issue of the
7 risk adjuster and how well it does. We have not circled
8 back to it in a year or more but it's certainly something
9 that this is starting to raise the question on. So, yes, we
10 can look at that.

11 DR. SCANLON: The second point was with respect to
12 the relationship with the states. Since Dave Durenberger
13 isn't here today I'll talk for a second about a conference
14 that he ran three weeks ago in Minnesota about long-term
15 care and the future of long-term care. At least in the
16 upper Midwest there is interest in Medicaid managed long-
17 term care, very strong in both Minnesota and Wisconsin, and
18 the idea of integrating the two through special needs plans
19 I think is something that is worth following for the future.
20 It's not a dimension for the very short-term but as we move
21 out with these plans.

22 DR. MILSTEIN: Not all providers are likely to be

1 equally skilled in managing special needs patients and one
2 of the ways in which special needs plans might be able to
3 provide better value and perform better would be by more
4 aggressively narrowing their networks than regular Medicare
5 Advantage plans. When CMS was reviewing applications from
6 special needs plans, were those special needs plans held to
7 the same standard of network-width as regular Medicare
8 Advantage plans or were they given a little bit of leeway in
9 terms of narrowing the network to focus on providers in
10 their communities that were able to demonstrate superior
11 capability or skill in managing special needs patients?

12 MS. PODULKA: It's my understanding that the
13 special needs plans were still required to meet network
14 adequacy requirements. From speaking to several of the
15 plans, what they actually opted to do was take their
16 existing network, if they had an existing MA plan, and
17 augment their network with additional providers. But one
18 point I'd like to get across about our work is that I'm
19 coming to the conclusion that when you've seen one SNP,
20 you've seen one SNP, and so I don't know how generalizable
21 those findings are.

22 DR. MILSTEIN: My question was more about how CMS

1 administered the network access requirement and whether more
2 leeway was given rather than the plan results.

3 MS. PODULKA: As I said, I believe they are still
4 subject to the same network adequacy. Although they get to
5 tailor services, they still have to fulfill all MA services.
6 So therefore, they need a complete network. But I'll check
7 more with CMS on this.

8 MR. MULLER: Just following on Bills's question on
9 risk adjustment, how did the cognitive impaired
10 institutional beneficiaries make -- did they make a choice
11 or were they selected against? Do you know anything about
12 that?

13 MS. PODULKA: It's not something that we've looked
14 at specifically yet.

15 MR. MULLER: Because they tend to be the higher
16 cost, institutional members, and if they -- I'm just going
17 back to our specialty hospital stuff, if they're the ones
18 that are selected against because you can't figure out how
19 to move them over and you get the payment on the average.

20 MR. HACKBARTH: Okay, good job, Jennifer.

21 We'll have a brief public comment period before
22 lunch. Please keep your comments brief.

1 * MS. WILBUR: I'm Valerie Wilbur. I'm the co-chair
2 of the Special Needs Alliance. We represent about half of
3 the special needs plans that have been approved to date
4 including virtually all of the demonstrations, the Wisconsin
5 partnership, the Minnesota senior health options, Evercare
6 which used to be a demonstration, the social HMOs, the whole
7 gamut. I wanted to just make a couple comments.

8 First, I wanted to compliment Jennifer on her
9 presentation. I think she did a really nice job
10 summarizing, and was very interested in a number of the
11 comments that have been made around the table. I
12 specifically wanted to address one that was raised about the
13 integration of Medicare and Medicaid through the SNPs.

14 Our alliance happens to think that the SNP is a
15 great vehicle for doing that. It's important to understand
16 though that although about three-quarters of the SNPs are
17 duals, very few of them are dually decapitated. So most of
18 them just have Medicare capitation, they don't have a
19 Medicaid capitation. Therefore they're only responsible for
20 Medicare and acute care risk, not for long-term risk. So
21 there's only a handful of the SNPs that are dually capitated
22 like the demonstrations that have the ability to really

1 coordinate the whole package of service and be at risk for
2 it.

3 So some of the members of our alliance, like the
4 Wisconsin and Minnesota folks, actually have had somewhat
5 different experience with respect to the accounting issues
6 and the separation of the funding streams. It was mentioned
7 that this didn't appear to be a problem. But for plans that
8 historically have been able to take Medicare and Medicaid
9 capitation, put it in one pool so to speak, and then
10 allocate those resources based on individual patient needs
11 that's a challenge that they're facing now. They're able to
12 use their waiver authority to continue doing what they've
13 been doing pretty much, although some things have changed,
14 but they're real concerned about what happens in 2008 when
15 they lose their demonstration authority. So it's really
16 important to think about the dual issues in terms of the
17 funding streams and the capitation.

18 What we have suggested to CMS who, by the way, has
19 had a great open-door policy in working through some of
20 these issues with us, is a couple of things. One, if you
21 could have -- for the programs that are dually capitated, if
22 you could have an integrated bidding process so that you

1 could take into account all of the different services that
2 are being covered and the funding that comes from Medicaid
3 as well as Medicare, that would be very helpful.

4 The other thing is, if you look at the accounting
5 rules and the audit process in particular and take something
6 like care management, where it's not always easy to figure
7 out whether you put your dollars on the Medicare side or the
8 Medicaid side of the ledger, and look at the plan's
9 historical experience. So that if historically they've
10 spent about 60 percent of their resources on Medicare
11 services and maybe 40 percent on Medicaid services, go ahead
12 and use that standard when you're doing the audit process
13 instead of taking each particular care management item and
14 trying to allocate it to one side or the other.

15 We're talking about some other things too. I'll
16 move on quickly to the second issue I wanted to raise and
17 that has to do with the performance evaluation, which you
18 all know CMS has to report to Congress at the end of 2007 on
19 the SNPs.

20 We're concerned about the requirement that the
21 SNPs be evaluated for cost effectiveness and quality within
22 this brief period of time because most of them didn't even

1 come online until January of this year. CMS acknowledges
2 that we actually need to use a different set of performance
3 measures because it's a different population, and if you
4 want to distinguish whether these SNPs are doing a different
5 or better job than regular MA plans, CMS acknowledges you
6 need to use some different measures. But yet we don't have
7 them and they don't have time to put them in place before
8 the evaluation starts.

9 The other thing is, even if we had the evaluation
10 measures they would need to collect most of the data before
11 the end of the year in order to develop their report and vet
12 it through CMS before it got to the Hill at the end of the
13 year. So there isn't really an adequate time to measure
14 performance and cost effectiveness in the data collection
15 period, especially when they're all starting up and they
16 don't even have all their clinical systems and data systems
17 in place.

18 The third point about the evaluation is, we are
19 concerned about looking at cost effectiveness in relation to
20 the current bidding process for two reasons. A number of
21 the demonstrations in particular that have the two funding
22 streams have the advantage of having Medicare and Medicaid.

1 They're under demonstration authority. They can do things a
2 little bit differently.

3 Also, they still get the frailty adjuster, they
4 still have the full budget neutrality adjuster. So just
5 because they came in under the bid this year doesn't mean
6 that they're going to be able to continue to do those things
7 once the budget neutrality goes away, and if they don't get
8 the frailty adjuster, because that's still an open issue.
9 So we think to try to do cost effectiveness evaluation in
10 this year is premature.

11 We suggest the following. What if we go ahead and
12 keep that report to Congress at the end of next year but do
13 profiling, I think which is what MedPAC is going to do.
14 There's a tremendous amount of information that could be
15 gained in terms of looking at the plans, what incentivizes
16 them to come into the market, what the benefit packages are,
17 what the character the beneficiaries are. There's a whole
18 series of information that would be very helpful to everyone
19 in understanding this market. Then go ahead and get the new
20 performance measures we need in place, spend this year
21 working on that, collect data for a couple years and maybe
22 have a cost effectiveness and quality report at the end of

1 2009 or 2010 when we've had time to do it right.

2 Thank you very much.

3 MR. HACKBARTH: Thank you. We will reconvene and
4 1:15.

5 [Whereupon, at 12:15 p.m., the meeting was
6 recessed, to reconvene at 1:15 p.m., this same day.]

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

1 hope that the chapter will stimulate further discussion on
2 the topic.

3 So why is care coordination needed? Because
4 beneficiaries see multiple providers, the opportunity for
5 poor coordination is great in the Medicare program. Also,
6 because of improvements in diagnostic testing and treatment
7 for those with chronic conditions, beneficiaries are living
8 longer with those conditions and that means that the
9 prevalence of those conditions are increasing in the
10 Medicare program. And those with chronic conditions are a
11 high proportion of Medicare expenditures, and we know that
12 evidence continues to mount that many do not receive high
13 quality care.

14 So why do these probes persist? One of the
15 primary barriers is the payment system. The current fee-
16 for-service payment design focuses on acute illness and
17 injury, not care planning over time, is focused on providing
18 payment directly to individual providers and not looking
19 across patient settings.

20 It's also face-to-face reimbursement. It doesn't
21 reimburse physicians or others for the care that they may
22 deliver between visits such as education or patient self-

1 management training.

2 In addition, given the multitude of services
3 complex patients need, it may not be possible for physicians
4 to do all that they need to in the office visit as it's
5 currently designed and some of the services that these
6 beneficiaries need are not services that physicians have
7 been trained to provide such as patient education.

8 And finally, clinical information systems so key
9 for keeping track across settings are not widely used by the
10 health system.

11 So our research in the last six months to a year
12 has been to identify key care coordination tools and
13 strategies that Medicare could use to support their use in
14 the fee-for-service program. Our analysis has been based on
15 interviews with those that have care coordination programs
16 and others who have developed tools to coordinate care, as
17 well as those that have measured the success of programs and
18 those at CMS that are working with their various programs to
19 coordinate care. We also have performed several claims
20 analysis to look at patterns of care for those with chronic
21 conditions and to look at the effectiveness of care
22 coordination, looked at the published literature.

1 We found that there were two key tools for care
2 coordination. The first was a person, often called a care
3 manager and usually a nurse, who would monitor patient
4 progress and educate the patient for self-management.

5 And then the second key tool was an information
6 system, and there are a variety of uses for information
7 systems. First, the programs would use the information
8 systems to identify the most needy patients. And then the
9 care manager would use the information system to track their
10 progress and share information with physicians or other
11 settings of care that may need it for clinical care.

12 We found that programs are more effective if the
13 patient's primary physician is involved with the care
14 management program. And we also found through our
15 interviews that most programs are paid on a risk basis.
16 That is not to say that they have any insurance risk, that
17 is risk for the overall health services of the patient. But
18 they do have risk for the cost of the interventions and
19 usually they have to guarantee some level of savings in
20 order to get paid. So because the programs need to show
21 savings, the programs were very careful about who they
22 actually target their services to. And so they often target

1 complex patients, often those with multiple chronic
2 conditions.

3 Based on a literature review as well as our
4 interviews, we found that cost savings were difficult to
5 quantify but when cost savings were achieved they often
6 varied, depending on the type of patient, the intervention
7 used, and the time frame used for measurement. We did find,
8 however, that in general both the literature review as well
9 as interviews said that quality did improve on a variety of
10 different process and outcomes measures due to the care
11 coordination programs.

12 So what is Medicare currently doing to encourage
13 care coordination? There actually are some efforts under
14 way, actually they have been underway for a while, but then
15 there are some new thoughts on how it might be supported in
16 the fee-for-service program. First, the Medicare program
17 has the Medicare Advantage program and there you have a
18 capitated payment. Because the plans are at risk for all of
19 the health services, there are incentives within that
20 program for care coordination.

21 There's a new type of program, as you heard
22 described this morning, the special needs plan, and one of

1 those can be targeted at those with chronic conditions. So
2 this is another option in the Medicare program for care
3 coordination.

4 On the right hand side of this table you see
5 physician pay for performance. And while that's not yet in
6 place officially as a program, many of the clinical measures
7 that are contemplated for that program would improve care
8 for those with chronic conditions. However, it's not really
9 focused on the most complex patients or necessarily expected
10 to improve care across settings.

11 The two in the middle, the Physician Group
12 Practice demonstration and the Medicare Health Support pilot
13 are other models that are being tested currently and I'm
14 just going to briefly describe them because it's a nice
15 basis to two potential models we're going to describe in a
16 moment.

17 The Physician Group Practice demonstration is a
18 demonstration where CMS contracts with a group of providers
19 and it could be a group practice or it could also include a
20 larger system which might have a hospital in it. That group
21 of providers takes responsibly for coordinating the care of
22 their patients. If, as a result of their care coordination

1 activities they achieving savings for the program, the group
2 of providers can share in those savings.

3 The Medicare Health Support pilot was mandated in
4 the MMA, and in that model CMS contracts with organizations
5 whose sole focus is care management. They don't necessarily
6 have any formal affiliations with providers. In that model,
7 CMS identifies beneficiaries with certain chronic conditions
8 for whom the program will be responsible. They are paid an
9 up front per member/per month fee, but if they don't achieve
10 savings for the population they have to pay some or all of
11 that fee back to the program.

12 For the rest of the presentation we will describe
13 two potential models that draw from those two in between
14 models, and then we seek your input on the design features
15 we describe in the two potential models.

16 MS. BOCCUTI: So for these potential future
17 models, the first of these we'll call the provider-based
18 organization model. In this model, providers are really
19 large enough to be able to maintain their own care
20 coordination programs. Specifically, group practices and
21 integrated health systems have the infrastructure needed to
22 employ the nurse case managers and other staff and purchase

1 information technologies.

2 These main components of care coordination,
3 therefore, would be housed within the provider organization.

4 Payments for the care coordination program could
5 be at risk or in the shared savings model to the provider
6 organization. But smaller fees for the physician activities
7 related to care coordination could be paid to the group or
8 the health system.

9 In the second model, we examine ways for care
10 management organizations to work collaboratively with
11 smaller physician offices. In this model, the same kinds of
12 risk-based payments would be paid to the external care
13 management organization but physicians and nurse
14 practitioners could also receive monthly fees for their
15 interactions with that care management organization. These
16 interactions could include regular communications, referrals
17 and forwarding test results, for example.

18 So in both these models we also need to discuss
19 ways that patients could designate a personal medical home.
20 This designation would imply an agreement between the
21 patient and the physician that the physician's office would
22 serve as the patient's central source of medical care and

1 case management.

2 MS. MILGATE: So here we want to talk just a
3 little more detail about the financial incentives of the two
4 models that Cristina just laid out. Both models assume the
5 care management program, whether it's a group of providers
6 or a stand-alone program, would be paid on an at-risk
7 program. There's really two reasons for this and it
8 primarily comes out of our interviews.

9 The interviewees said that it was important for
10 the care management programs to have "skin in the game" to
11 ensure cost effective interventions and that they thought
12 that that gave them also the flexibility to design
13 interventions and change interventions as they saw they
14 needed to be more effective and to also perhaps change who
15 they targeted the interventions to.

16 So we saw, through the pilots, two potential ways
17 of having at-risk care management performed. The first was
18 shared savings, and that was the example that we gave that
19 the Physician Group Practice model is using. Here again
20 there's no up front fee to the organization but they can
21 share in any savings that they generate for the Medicare
22 program or at least they're eligible for those savings.

1 In the second, you could pay an at-risk care
2 management fee. And again this is based on the Medicare
3 Health Support pilot. And there is a fee that's paid up
4 front to the care management program, but if they don't meet
5 their savings targets they would have to return some or all
6 of those.

7 Lastly, as Cristina mentioned, to provide
8 incentives for physician involvement and to pay for their
9 time involved with interacting with the program there could
10 also be a fee paid by CMS to physicians for such things as
11 their referrals, entering information into the information
12 system, as well as returning phone calls to the care
13 management program.

14 We envision that in model one that fee would go to
15 the group of providers and the group would determine how to
16 distribute it further to the individual physicians within
17 that group. And in the second model that the payment would
18 go directly to individual physicians. The physicians would
19 have to have contacts with an organization to provide the
20 services and it would be limited to patients that were
21 eligible for these types of services.

22 Another question is how eligibility and enrollment

1 would be determined in both models. Currently, the programs
2 we found that CMS is contracting with both rely on CMS,
3 first of all, identifying beneficiaries that are eligible
4 for the program. However, it's done in a couple of
5 different ways which could apply here as well.

6 In the Physician Group Practice demonstration
7 basically what CMS does is identify which beneficiaries use
8 that group of providers as their primary home essentially
9 for care. And then the program is really responsible for
10 that overall population. However, underneath that the
11 organization can choose to target their efforts in a much
12 more targeted way. But in the end the savings calculations
13 are done on the whole population.

14 In the Medicare Health Support pilot, as well as
15 another demonstration, the high cost demonstration, CMS's
16 efforts to identify beneficiaries are more focused on
17 certain complexity level of patients. But even underneath
18 that identification of a population, again the organization
19 can further target their efforts if they so choose.

20 In addition in the program we see that physicians
21 could identify and refer additional eligible patients in
22 either model, that would be in either the group of providers

1 or if they were working with an external care management
2 organization. As Cristina said, it would also be important
3 for beneficiaries to designate the physician office in both
4 models as their medical home.

5 Accountability would be important in both
6 programs. For the care management program accountability
7 for savings is built directly into the risk-based payment
8 mechanisms. It doesn't seem there would need to be any
9 separate mechanism for accountability on the cost factors.
10 We would also expect though that the organizations would
11 report information on quality measures, both process and
12 outcomes, to CMS. There are several different patient
13 experience of care surveys being developed or have been
14 developed for these types of programs, and those could also
15 be used.

16 In model two we think it would also be useful for
17 physician offices to report on additional clinical quality
18 measures that would be associated with care for these
19 beneficiaries.

20 MS. BOCCUTI: And then to step away a little bit
21 from those models on this last slide, we've brought up some
22 issues related just to the fee schedule. When we're

1 thinking about what we were just discussing before, we were
2 looking a little bit more at the non-face-to-face kind of
3 coverage and care coordination activities. But if we look
4 also for chronic care management, we want to think about
5 also valuing the face-to-face time that the patient and the
6 physician are having.

7 So for care associated with face-to-face visits,
8 current E&M codes technically do cover the care coordination
9 activities but may not adequately account for the needs of
10 the complex patients. That concern is really compounded for
11 practices with high shares of complex patients so that would
12 occur repeatedly.

13 Two mechanisms that we can discuss within the fee
14 schedule that could address these issues are to first,
15 increase E&M payments for selected codes say for high-level
16 codes or for codes associated with prolonged face-to-face
17 visits.

18 A second mechanism could be to establish new fee-
19 for-service billing codes for face-to-face time spent
20 specifically with complex patients.

21 That concludes what we have here today. We can
22 answer questions certainly on this and you may want to

1 discuss other issues.

2 DR. NELSON: I think this is really good work and
3 I appreciate where you're going with it.

4 But I want to urge us to think more broadly about
5 care coordination and go beyond just conceptualizing it as
6 reminding a diabetic patient to measure their blood sugar or
7 a patient with congestive heart failure to weigh themselves
8 every day with the accompanying education that goes with
9 that, and acknowledge that a lot of care coordination that
10 Nick does and that I did involves advising patients on when
11 they should get an imaging study done or when they should
12 see a surgeon, under what circumstances, and matching them
13 up with a surgeon that's best suited to their personality
14 and so forth.

15 So care coordination is the kind of thing that
16 happens in the diad between the patient and the doctor in
17 the offices every day. We don't want to you lose that. We
18 certainly want to make it better than it is now, but we
19 don't want to lose it.

20 It seems to me that the two essential features of
21 a care coordination effective program, and not only the
22 information technology that you mentioned, but think more

1 broadly than just a care manager and think in terms of a
2 care team. It seems to me then that since most care in this
3 country is still conducted in practices of five or less that
4 we need to conceptualize a model that utilizes that and
5 think in terms of one model being a virtual group, which the
6 IOM is talking about, where small practices all decide to
7 get together and invest together in information technology
8 and hiring the monitoring and education capability that is
9 currently being conducted by disease management firms,
10 perhaps having disease management firms contract for that or
11 perhaps hiring the group itself, building that capability.

12 So let's think beyond just disease management and
13 the way that's conducted now and think about new
14 organizational models.

15 The third piece of which, besides information
16 technology and a team approach, would be some sort of
17 certification or credentialing -- let's see, that's too
18 strong -- some means of determining that the physicians in
19 their practices have the capability and have established the
20 team capability to carry this out. And perhaps of reward
21 through pay for performance then would go to the physicians,
22 as long as they created that other capability.

1 DR. CROSSON: I would just like to congratulate
2 both of you, too, for continuing to advance this ball.
3 Every iteration of this is more thoughtful and helpful.
4 We're still working in this netherworld between Medicare
5 fee-for-service and then prepaid Medicare, particularly
6 Medicare prepayment where there's a delivery system
7 organized in the way that you have described it. And
8 obviously among your two models I have an inherent bias
9 towards model one.

10 Two of the things that made prepayment to delivery
11 systems in the past difficult have been number one, the
12 actual ability to bear risk and manage risk because of not
13 having capital reserves or sophistication or the like. And
14 then another one is just in terms of modeling it is the fact
15 that in fee-for-service you don't really have enrolled
16 patients. You don't have members, as we would say.

17 It sounds to me like you're getting close to the
18 second one with what you're calling medical homes, so I'd be
19 some more interested in to what extent is that agreement
20 that you talked about between the patient and the medical
21 group or integrated system like a lock-in or not? Because
22 that ties back into the risk piece. Obviously if you're not

1 in charge of everything you can't really be at risk for it.

2 To just go back to the first point, have you begun
3 to think at all or model about the amount of financial risk
4 inherent here? And is that likely to be within the ability
5 of target delivery systems to manage?

6 MS. BOCCUTI: We'll start with the medical home
7 issue that you brought up. I don't know that it would just
8 be limited to model two. Model one, with a group or a
9 system, if there's going to be some sort of designation
10 going on potentially with the beneficiary doing the
11 designating, so you can think of it has a responsibility
12 that the provider has as well as the beneficiary to be
13 seeking that organization first say, or to discuss care
14 management.

15 Not the lock-in, whether soft or hard, I think we
16 need to discuss that. We haven't really brought that up for
17 the Commission and I don't think we're going to make that
18 decision but perhaps you want to comment on that. I think
19 we can see the pros and cons that Medicare has been dealing
20 with that on other issues, on how hard the lock-in needs to
21 be. It's easier for planning purposes, but it may not be
22 exactly what beneficiaries want.

1 We should also mention that the ACP, the American
2 College of Physicians, has been working on the advanced
3 medical home model. They have issues that -- and these are
4 related similarly to that. They are now working out all the
5 details too, but they are discussing the issue that that
6 relates to, too.

7 MS. MILGATE: I just wanted to comment on his
8 second question.

9 MR. HACKBARTH: If I could just chime in on the
10 lock-in issue. I was making a note so I missed the first
11 part of what you said, Jay, and stop me if I'm wandering off
12 into the wilderness.

13 As I think about this general area, I've been
14 anxious that we explore non-lock-in models that are in
15 keeping with the basic format and guiding principles of
16 traditional fee-for-service. We have Medicare Advantage for
17 beneficiaries who are willing to choose a more restrictive
18 system and they've got a wide array of options to choose
19 there now, at least in many markets. That's not perfect,
20 but we've got some action over there on the lock-in side.

21 I think the void right now is traditional fee-for-
22 service Medicare, which one of its guiding principles is no

1 lock-in. And so that's why I've been thinking we ought to
2 be focusing here principally on no lock-in models.

3 Now the middle ground is a voluntary designation
4 by the beneficiary of a medical home, some people call it
5 sort of a soft lock-in, where they retain their freedom of
6 choice. But they've made a voluntary decision that I'm
7 going to go to this physician or this organization as my
8 counsel on where to go for my medical care.

9 MS. MILGATE: Could I add to that? One of the
10 ways that came up wasn't so much as to make it less risky
11 for the organization managing it. It actually came up in a
12 sense of making sure the beneficiary was really committed to
13 the process, because there was a lot of discussion on how
14 important beneficiary commitment to the program was for
15 effectiveness of the program.

16 So I don't think that even in that context they
17 saw it as a lock-in at all, that they could only go to that
18 physician for care related to that condition or for anything
19 else.

20 But the concept was really that it was very
21 important for the beneficiary to actually be committed to
22 the program and committed to that physician for it to work

1 effectively.

2 DR. CROSSON: So I think I can understand the
3 concept of a moral commitment on the part of the patient.
4 But what I still can't figure out, and maybe I'm just
5 missing it here, is if you're going to say okay, we'd like
6 you to manage these 100 diabetic patients for a year and
7 we're going to pay you in the end or reward you or whatever,
8 based upon the total cost of care for those 100 diabetics.
9 But the 100 diabetics can go anywhere they want for care
10 services, including other physicians, hospitals or entities
11 that aren't part of this operation.

12 How do you then managed that risk?

13 MR. HACKBARTH: It depends in part of the nature
14 of the risk. Nick, help me out here but as I understand the
15 Group Practice demo, there's an opportunity to share in
16 savings but I don't recall there being a penalty if the
17 costs are higher than expected. So it's an asymmetrical
18 risk. It's an opportunity that's being taken, as opposed to
19 the sort of insurance risk that Kaiser Permanente bears.

20 DR. CROSSON: They're not really risks.

21 MS. MILGATE: You're at risk for the dollars you
22 put in as investment to manage the beneficiaries. That's

1 what you're at risk for.

2 DR. REISCHAUER: You're at risk of winning the
3 lottery.

4 MR. HACKBARTH: Did I describe that correctly,
5 Nick?

6 DR. WOLTER: Yes, I think though that I would say,
7 in terms of the Physician Group Practice demo, I think
8 they're some real flaws in the financial design which would
9 take a little longer to explain than we have here. But in
10 terms of the question you're asking, we're assigned a panel
11 of patients. Many of them get a good part of their care a
12 couple of hundred miles away. They might have
13 hospitalizations that are outside of our organization.

14 And so the issue there is what Jay is raising,
15 which is that whatever protocols or evidence-based medicine
16 standards we put in place to reduce variation, don't manage
17 to penetrate the whole population that we're then
18 responsible for. So that's an issue that I think in future
19 designs needs to be addressed.

20 MR. HACKBARTH: But it is -- you have an
21 opportunity to gain, as opposed to an exposure to loss if
22 projected expenditures are higher -- if actual expenditures

1 are higher than projected; is that right?

2 DR. WOLTER: That's theoretically the case.

3 MR. HACKBARTH: Do you want to elaborate?

4 DR. WOLTER: There's issues with how it was
5 designed because you have to, first of all, save 2 percent
6 compared to the increase in cost to a comparator population,
7 but you don't share in that 2 percent. You only share in
8 savings beyond the 2 percent. This is over three years.

9 So if you net good performance against the cost of
10 the interventions and then compare that to what you would
11 have made had you just gone on in standard fee-for-service
12 with regular numbers of admissions, the guarantee in my view
13 -- and we've modeled this -- is we probably will see less
14 reimbursement than if we had not participated in the
15 program.

16 That's because we have a hospital in our system.
17 I think if you don't have a hospital in your clinic and you
18 reduce admissions, then it's a different -- so that's why I
19 say it's complex.

20 MR. HACKBARTH: Do you want to address Jay's other
21 question?

22 MS. MILGATE: I think it's related, I think, to

1 this discussion. Because you asked about risk and the
2 ability to bear. Just to say again, the risk is generally
3 for the cost of the interventions, not that that's a small
4 risk but it's smaller than costs for all of the health
5 services like insurance risk.

6 And I think that that's one of the interesting
7 questions as to how many patients need to be eligible for
8 the program for it to be reasonable for either a group of
9 physicians or maybe Alan's virtual group to actually take on
10 the risk of the care management functions themselves. And
11 that, to me, is sort of another analysis of how many
12 patients need to have to feel like it's worth it for you to
13 take on even the risk of the care management costs?

14 The other thing I'd like to say though, in terms
15 of groups of providers taking this function on, I think
16 there's also kind of a fine line between investment that
17 would be useful for good clinical care anyway and then the
18 extra investment we may be talking about here. In some of
19 the PGP demos, for example, they told us that -- these were
20 practices that were fairly evolved -- that they were
21 planning on doing some of these things anyway. But this
22 just really gave an extra incentive to go beyond where they

1 were planning on going with their care management functions
2 that they were thinking about expanding into.

3 I don't know if that gives you enough information.
4 We don't really know what's the right size but I think
5 that's an area for further discussion.

6 DR. MILLER: Isn't there also one other mechanism,
7 just by way of risk, just to complete the picture that Jay
8 is asking about is in this situation where you have the care
9 management organization, at least the way it's working in
10 the disease management model, those organizations have some
11 risk for their administrative fee. So it's not an insurance
12 benefit risk. All your issue still attach, now do I manage
13 it.

14 But they have been assigned populations, or at
15 least given populations that they can go after. Then they
16 have some kind of targeting even within those populations
17 that they may use to sort through who is going to go into
18 the program. And what's at risk for them is the
19 administrative fee that they're getting, not the insurance
20 benefit. Is that all correct; guys?

21 MS. MILGATE: Yes, definitely. And you can see
22 also, in that model, they even have less control over where

1 beneficiaries go in terms of providers. So they have a very
2 strong incentive to try to work with physicians to the
3 extent possible that's even, I would think, harder for them
4 than it would be for your organization for example.

5 DR. CROSSON: But the risk to the administrative
6 fee, which is why those organizations are in it in the first
7 place, isn't that in the end a function of how much the care
8 costs for the patients that they're supposed to be managing?

9 MS. MILGATE: That's right. They are at risk.
10 Basically there's a 5 percent target. Let's just throw out
11 the Medicare Health Support pilot as the example here. CMS
12 and the programs negotiated. I don't know how much power
13 was on the either side. But there was a target that was set
14 at 5 percent of savings.

15 So CMS hands the organization what they have
16 designated in the particular region as an eligible group of
17 patients and then the organization can target below that.
18 But they are measured on cost savings different of actual
19 costs versus expected costs for that population of 5
20 percent.

21 I'm sorry, I probably didn't explain that as
22 clearly as I needed to.

1 MR. HACKBARTH: Just a clarification on that. The
2 target against which the organization is measured is 5
3 percent of the total eligible population assigned by CMS?

4 MS. MILGATE: Right.

5 MR. HACKBARTH: If they choose to go to a smaller
6 subset, then they've got to proportionately save more.

7 MS. MILGATE: Exactly but it's still calculated on
8 the whole population. And it's compared to a control
9 population in that region. So they're hoping to actually
10 have some really robust findings from that design.

11 DR. CROSSON: One last point and then I'll stop.
12 So I can understand, in that model, how the care management
13 organization, the disease management company, which
14 presumably has the ability to influence the care of that
15 patient no matter where the patient is taken care of, I can
16 understand how that might make sense.

17 It's somewhat diluted if, in fact, you have a
18 model where the care management organization works
19 cooperatively with some physicians but not others. So I
20 don't think it's a perfect play.

21 But I still have problems understanding how that
22 applies to the first model, where you have a designated

1 physician group but that physician group or integrated
2 delivery system doesn't actually have the ability to
3 influence all of the care, even though their risk is limited
4 to the care management fee and not insurance risk.

5 MS. BURKE: Unless I'm missing something, why
6 wouldn't they have the same authority or relationship any
7 other physician group would have in terms of where they
8 admit patients, what they order?

9 MR. HACKBARTH: The way I would envision this is
10 this is a voluntary program, and so there may be many
11 physician organizations or integrated delivery systems that
12 say looking at how our practice works, how this community's
13 referral patterns work, this is not a business that we want
14 to get into.

15 But Wennberg and company have found that when you
16 look at Medicare claims data that there are, at least in
17 some places, de facto delivery systems where even though
18 there's no lock-in the referral patterns in the community
19 are such that they are pretty tight in terms of where people
20 get their care. If you go to so-and-so as a primary care
21 physician, the probability that you're going to use this
22 group of specialists and this hospital is pretty high.

1 DR. CROSSON: It's a long drive from Duluth
2 anywhere else.

3 MR. HACKBARTH: Right. So in that circumstance,
4 and I don't know how common that circumstance is around the
5 country, it may feel like hey, this is a risk that we can
6 reasonably take on, especially if our risk is properly
7 constrained. We're not talking about being on the hook for
8 the total overage of Medicare expenditures but a much
9 smaller piece.

10 And all of these variables, whether it's 5 percent
11 or exactly what the characteristics of the Group Practice
12 demo, they're all subject to negotiation and adjustment.
13 There they are continuous variables. There's nothing set in
14 stone about any of them.

15 MS. BURKE: Can I ask a question so that I
16 understand why there would be a question about this? As I
17 understand the patients that they envision participating
18 these are fairly complex chronically ill patients; correct?
19 Who arguably have a series of comorbidities that are
20 managed.

21 And the savings arguably comes from either the
22 avoidance of institutional services, the better coordination

1 of testing and of treatment that would largely be done by
2 either the coordination among a group of specialists who are
3 managing the patient, or through an internist or a primary
4 care physician who essentially is sort of moving this person
5 around.

6 So to a certain extent, a physician in a physician
7 group has, as we have at least traditionally believed, an
8 enormous amount of control over a number of those decisions.
9 Now they don't have control over the costs in the hospital,
10 per se, that is what the hospital's base is. But they do in
11 terms of the admissions, they do in terms of managing the
12 patient and keeping them out of the hospital, they do in
13 terms of the follow-up care, they do in terms of the testing
14 or the referral patterns that they have with their
15 colleagues.

16 So I guess, Jay, what I'm trying to understand is
17 why you don't imagine that, even in that not locked in non-
18 traditional HMO system, there isn't some authority? Because
19 Wennberg tells us, in fact, that there is.

20 DR. CROSSON: And I would agree with you but
21 that's a qualitative argument you're saying. Isn't it
22 likely that those physicians or that group will have a

1 significant amount of ability to influence where those
2 patients go for their care? and I would agree with you.

3 And if you pick the places where for geographic
4 reasons or traditional reasons a particular group or
5 integrated practice does, in fact, hold onto all those
6 patients it holds true. But it doesn't necessarily hold
7 true.

8 MS. BURKE: Sure it does.

9 DR. CROSSON: No, it doesn't.

10 MS. BURKE: More than it does that you don't lock
11 a person into an HMO for life. They can walk.

12 DR. CROSSON: I'm sorry if we're getting off here.
13 But if you're talking about relatively small improvements in
14 costs it doesn't take very many of your 100 diabetic
15 patients to decide to go off to the next state to get some
16 services, which are fully paid by Medicare, which then
17 change the numbers for that group significantly. Five
18 patients, three patients, two patients out of 100 with renal
19 transplants or -- that's a bad example, but other high-cost
20 examples, then change the dynamics.

21 So the at-risk administrative fee on any given
22 year disappears. But completely out of the control -- and

1 I'm using a small example but a larger example would hold
2 true, too.

3 So I'm doing sort of a purist quantitative
4 approach. I don't disagree with you more qualitative
5 approach.

6 DR. SCANLON: It seems to me that between these
7 two models that the independent care management company is
8 dealing 100 percent with strangers. They've got no control
9 over these people and they're at risk for something for it.

10 The group practice starts off dealing at least
11 with some people that they know. You may lose some. But
12 when they start off, they're at an advantage relative to the
13 independent care management organization.

14 The real issue comes down to what Glenn was saying
15 is what's the formula for this risk in terms of how much
16 you're at risk and what you have to accomplish in order to
17 keep the fee? Because the group practice, you've got the
18 advantage of knowing and influencing the care of some of
19 those patients directly. Whereas the care management
20 organization as to work through moral assuasion with every
21 one of the physicians that these people deal with.

22 MR. HACKBARTH: And I think that the beneficiary

1 designation may also play a role in here. We don't know to
2 what extent but it seems logical that if the beneficiary is
3 involved in designating this group practice as my medical
4 home that may also alter their tendency to go outside even
5 without a lock-in.

6 MS. BOCCUTI: Can I say one short small thing? I
7 think also that the second part which is the fee to the
8 physician group, the second fee that's not really at risk I
9 think is related a little bit more to the medical home
10 designation. It's that that physician is getting the
11 payment. So the relationship between the beneficiary and
12 that physician, if they're going to get the monthly
13 payments, rather than the external care organization that
14 may not know the patient as you're saying.

15 So I see the connection as relating to the second
16 payment stream rather than the first.

17 DR. KANE: One of the questions I had was what's
18 the time frame? Because to me if it's a one year settling
19 of accountability for the risk of -- your savings, you may
20 actually cost more because you're doing the right thing.

21 So I was getting confused as to what risks are we
22 talking about? And it's talked about in the form of savings

1 but it could actually be that you're doing the right thing
2 and it costs more.

3 So the whole thing of tying it to savings seemed
4 kind of confusing to me, unless you're just going to limit
5 yourself to COPD at the last stages of life before you hit
6 the ER.

7 MR. HACKBARTH: I think that's an important point
8 and again it's a dimension of this that needs to be worked
9 out. We're talking a very high conceptual level, whether
10 the right duration is a year or longer, I don't know the
11 answer to that.

12 DR. MILLER: I think that was one of the points
13 that Nick didn't go into in his comments, is that when you
14 look at the effects over the course of this, whether it's
15 one year or three years or five years that you expect to
16 look it. I know in other conversations that's one of the
17 points that Nick has made and he just didn't want to detail
18 it here. But certainly the time frame is one of the issues.

19 DR. KANE: I think that means maybe we shouldn't
20 just call it cost savings but maybe there should be other
21 parameters by which people get rewarded around hitting
22 protocols or compliance rather than costs.

1 DR. REISCHAUER: Isn't there a quality threshold
2 you have to meet? I mean, in Nick's thing, and it's three
3 minimum, I think.

4 DR. KANE: And if you hit it you get paid, whether
5 the costs went up or down.

6 MR. HACKBARTH: And there are a variety of
7 different ways that you might factor in the quality. But I
8 think it's very important to have that as part of the
9 evaluation process. In the Group Practice demo, not that
10 it's a perfect model but it's one that's developing. As I
11 recall Nick, you have to hit certain quality targets to be
12 eligible for a financial bonus? Is that the way it works?

13 DR. WOLTER: Actually it's the opposite. You have
14 to hit the financial targets. Once you hit those then a
15 portion of the savings is given to you based on the savings
16 and a portion is given to you based on the quality measures.
17 And the percentage that's based on quality increases over
18 the three years.

19 MR. HACKBARTH: Okay.

20 MS. MILGATE: One more comment on the time factor.
21 There clearly is evidence that for some chronic conditions
22 savings can be achieved much more quickly than others. And

1 so that is, in some ways, the key factor, I think, for CHF.
2 Programs told us over and over again they felt like they
3 could show savings within a year. For diabetes more like
4 five years.

5 So the two programs we talked to most about are
6 looking at over a three year period but then measuring it
7 each year at least to give some benchmarks to the programs.

8 MS. HANSEN: First of all, I appreciate the
9 education in the whole aspect of care management in the fee-
10 for-service world because this is something that is
11 relatively new to me. But a couple of things that were
12 raised earlier, one is what's the right number in which to
13 get some impact? And again I just offer the ROI to some of
14 the PACE programs that have clinically complex people with a
15 profile of say eight comorbidities and about eight
16 medications, polypharmacy along with cognitive.

17 It took like 150 people to really make it work to
18 include kind of the whole case management model. But there
19 are financials that you could get from the National PACE
20 Association that would offer that.

21 I have three areas. One is quickly the whole
22 aspect of the E&M aspect of coding and the incentives. I

1 appreciated the chart that you had about the non-face-to-
2 face reimbursement. And now that we're moving more toward
3 the knowledge assessment of complexity and how to judge that
4 rather than strictly the face-to-face, because I'm thinking
5 about how we use that and whether or not there is some
6 coding that goes to that weightedness of complexity. So
7 when people have those many comorbidities, is there either
8 an embellished code or a new code issue we talked about. I
9 don't know quite how to figure that out and other people can
10 do that, but it just seemed to merit that kind of added
11 weight.

12 The other one is looking at the -- so it has to do
13 with electronic.

14 The other thing I wanted to just talk about when
15 Alan spoke about let's look at care coordination more
16 broadly, and I would like to kind of stretch beyond the
17 physician, as well, and look at what happens to the
18 beneficiary with the issues that require that.

19 There are three things that I think about. One
20 are the things that become care transition points. That's
21 when things go wrong and how things happen. So how to build
22 that into a process and then eventually maybe an outcome

1 measure.

2 The other one is medication management, which does
3 fall squarely on the physician. But there are patients, I
4 think I may have mentioned before, that get 20 to 25
5 medications which clearly any commonsense way of looking at
6 it is an issue for quality and potential poor management.

7 The third one is when people start developing
8 symptoms, you mentioned congestive heart failure is a very
9 easy one to oftentimes catch. But there are other symptoms
10 that we can catch early. And how does care management in
11 any model, whether it is one or two, capture this so that
12 people get the treatment they need quickly to basically
13 avoid that?

14 So those are just some of the textural issues of
15 look at it, whether it's one or two. It seems like the
16 relationship with the physicians would be stronger just
17 because of the degree of influence. But I know that the
18 disease management companies have been quite effective even
19 with "strangers."

20 MR. BERTKO: I'm going to go back to what Jenny
21 and Alan said about looking at this more broadly. I was
22 originally thinking of it in terms of the timing of data

1 availability but I would also say that it could be looked at
2 as an issue of is this really a kind of disease management
3 registry model? Or could it be a broader model, including
4 management of acute conditions such as discharge planning
5 and prevention of readmissions and reductions of ER use.

6 You either may want to say something about it or
7 say no, this is just a chronic care management one.

8 I think, and maybe Jay and Nick would agree, that
9 in integrated delivery systems, whether they're groups of
10 providers or whether a plan or group practices you may have
11 some opportunity for this. In a totally fee-for-service one
12 where there is no personal contact, as we heard earlier
13 today, the timing of the data coming in on these people is
14 so late -- days, months, even years -- that you might not be
15 able to do that if they weren't already in a chronic
16 circumstance.

17 And yet this is fairly important in managing care
18 and keeping people basically out of the hospital to save
19 money.

20 MS. MILGATE: On your first point, the various
21 programs we talked to some of them, those that particular
22 were centered or at least had in the mix a hospital actually

1 identified people that they could really do a lot of good
2 for within the hospital and then would actually integrate
3 the care management right into the discharge planning and
4 then on beyond.

5 So I don't know that that was available to every
6 single person that was discharged but they certainly did
7 target some people like that as well as then we talked to
8 models that were similar to your other examples. So I
9 wouldn't want to limit it to one or the other really. So
10 just make that clear.

11 MR. BERTKO: I agree, and flesh that out, make it
12 clear. It's almost like model one and model 1A. Or model
13 one applies to two streams or two kinds of patients -- I'll
14 call them acute or acute episodes within chronic -- and then
15 pure chronic.

16 MS. MILGATE: So just be a little clear about
17 that?

18 MR. BERTKO: Yes.

19 MS. MILGATE: In terms of timing of data, I would
20 actually ask Nick this. It's my understanding that there's
21 a fairly quick turnaround on administrative data that's
22 given to these programs so that they can kind of update how

1 to target their interventions and their progress. As that
2 true?

3 DR. WOLTER: I think they're trying to be quicker.
4 We were a half-year go live into the program before we saw
5 the base year data, for example.

6 Just quickly, I kind of agree with the distinction
7 John and Alan were drawing. There's a coordination care
8 that around patients that maybe aren't as deeply
9 complicated, whether that's preventive care or acute care.
10 And that may be something we'd look at slightly differently
11 in terms of payment mechanisms. Maybe it's through the E&M
12 codes. Maybe it's a way to address some of the primary care
13 manpower issues that have come up here. But that is maybe a
14 slightly different bucket.

15 My comments are more addressed to the more complex
16 chronically ill patients. As many times as we've seen the
17 concentration of Medicare payments into a small group of
18 patients, it still struck me in your paper -- which I agree
19 was very excellent by the way -- that 61 percent of
20 inpatient payments were for three diagnoses or some
21 combination of the three. Which just strikes me as a huge
22 opportunity.

1 And that's why I feel that, for example, in pay
2 for performance we have a great opportunity to focus our
3 efforts in these early years rather than go the broadly
4 applicable to every physician or every diagnosis. If we're
5 serious about tackling where the high concentration of
6 chronically ill patients and high costs are. And I think
7 that would be a very helpful message to CMS and others, that
8 we should create some focused efforts in pay for performance
9 around these kinds of patients because I think there will be
10 a lot of early successes as opposed to 300 measures that
11 cover plastic surgery and allergy and everything under the
12 sun. That's just a bias that I have.

13 Also, I think this is an area where there's a
14 tremendous as opportunity, as Alan said, to create
15 incentives that create new organizational approaches to
16 health care delivery, whether that be virtual physician
17 groups or physician groups that now don't work with
18 hospitals, perhaps the eligibility for per member/per month
19 payment for chronic disease management in these conditions
20 is made available only to physicians in hospitals that come
21 together and agree that they're going to tackle these
22 issues.

1 And maybe that's part of looking down the road 10
2 or 20 years from now when these kinds of incentives do
3 create models of health care delivery that are more
4 synergistic.

5 The IT issue is a big one. You emphasize that
6 very nicely in your paper. I think though that the state of
7 the art in IT is very immature. Even for group practices
8 who have their own patients assigned to them in these
9 projects, creating disease registries that get all of your
10 diabetics enrolled is somewhat of a heroic effort. It's
11 amazing what's not currently the state of the art in IT,
12 even when you've made the commitment to put those systems in
13 place.

14 And then how do you sort out which of your 1,800
15 CHF patients would be good to enroll in the program? Even
16 when they're your own patients you have to enroll them in a
17 way, you have to seek them out, identify them, get them to
18 participate. That's not a simple task, even in the case of
19 a group practice.

20 The IT issue I think, in terms of looking at
21 creating linkages between physicians and hospitals, we have
22 the sort of countercurrent things going on right now in

1 health care where hospitals are prohibited, for the most
2 part, in terms of placement of IT in physician offices
3 because some of the Stark kickback and those kinds of
4 issues.

5 I know there's a conversation going on about
6 trying to relax those things. But maybe there's a way to
7 create dollar caps or transparency that would allow those
8 kinds of things to happen so the IT portion of this could
9 move more quickly.

10 So those are my thoughts.

11 MR. HACKBARTH: I'll go back to Nick's first point
12 and the one made by Alan at the outset. There is, in fact,
13 as we speak, a lot of care coordination that goes on largely
14 uncompensated. And one idea is well, let's develop new
15 codes that identify that and reward it and maybe we'll get
16 more of it.

17 But looking at this from a budgetary perspective,
18 that means paying for stuff that we now get for free as
19 opposed to other models where if you put the administrative
20 fee at risk you're only paying out the new dollars if, in
21 fact, you get offsetting program savings.

22 So there's a different -- as we look through these

1 options we need to be sensitive to the fact that there are
2 very different sorts of budget implications among them.

3 DR. SCANLON: This relates somewhat to what you
4 were just saying. In looking at the payment mechanisms that
5 you described, the goal of involving physicians is obviously
6 key. Though I guess I'm somewhat in the context of what
7 Glenn just said, I worry about creating kind of an
8 identifiable payment for this involvement.

9 In the first model, in some ways, I think the
10 bigger question is the risk issue that we talked about.
11 What's going to be the trade-off in terms of how much is
12 being paid versus the risk that the organization is going to
13 take? Because if I pay a group practice to involve their
14 physicians the money gets lost. There are already financial
15 flows within that group. And where these dollars impact is
16 not totally clear to me as the Medicare program as the
17 payer.

18 So the bigger issue is the money that goes to the
19 group and what the group has been asked to do for it and how
20 accountable it's going to be for that and then whether they
21 can accomplish that.

22 In the second model, yes, there is no relationship

1 between the care management organization and the physicians
2 and there potentially needs to be one in terms of the
3 physicians being responsive. But there's a question of
4 whether that's best engendered by Medicare making a payment
5 with a set of requirements for the physician to respond to
6 or it's better to think about changing again the risk/reward
7 relationship with the care management organization and
8 allowing them to make payments to the physician so that they
9 have a direct relationship and they have better control and
10 there's more accountability for their cooperation in terms
11 of the care management that the organization is trying to
12 accomplish.

13 I think it would be good if we, in some respects,
14 talk about these options here as a range of things, that we
15 don't know which one might be most effective, and that there
16 are, in some ways, pros and cons to different choices within
17 this.

18 I'm particularly interested in knowing what we
19 will learn from the Medicare Health Support as well as the
20 Group Practice demo in terms of answering some of these
21 questions because it's not obvious how, particularly the
22 model where the care organization -- I've kind of always

1 thought, physicians, the last thing in the world they're
2 going to want to hear is this care organization is on the
3 phone saying what are you doing for these people that I've
4 enrolled?

5 So how we're going to be effective in that is
6 something that is very challenging, given that the care
7 coordination, if we could get make it work, would be very
8 beneficial.

9 MS. HANSEN: Bill, if I could just build on that,
10 before I left in San Francisco that's one of the things we
11 did as the care management provider. We paid, we had a
12 small demo with private physicians in the community. And we
13 paid for their time. They would actually participate on a
14 case-by-case basis for that.

15 What was more difficult though in this care
16 management, and I don't know how to solve this, is when the
17 care management system or your geriatrician specialty people
18 who perhaps know that a practice should be done differently,
19 there's a best practice in medication treatment but the
20 local physician may not be up on the latest, is how to
21 influence that level of practice because of the
22 sensitivities involved from physician to physician to bring

1 it to another level of quality. That we never solved
2 easily.

3 DR. MILSTEIN: Some of these comments at this
4 point build on prior comments. Maybe they can be thought of
5 as a reinforcement.

6 First, while it's clear that any form of care
7 coordination that doesn't provide for physician input is
8 doomed, that said if one of our collateral goals in making
9 any program change is not to stimulate innovation in health
10 care, particularly in the methods of health care delivery, I
11 think we're in trouble. So with that in mind, I just wanted
12 to really endorse this idea of widening eligibility for what
13 might constitute the primary medical home or the care
14 management organization beyond the range of organizations
15 we've cited so far.

16 Just to give an example, community pharmacists.
17 We have some very nice examples in the private sector now,
18 the Asheville experiment being one, in which other
19 categories of health care personnel have been shown to be
20 very successful in being the lead primary manager -- primary
21 care coordinator.

22 I'm not sure we need to limit the list to them.

1 I'm thinking medical social workers probably. When you
2 think about care coordination, it's something quite above
3 and beyond anything I was ever taught in medical school.

4 The second point is a reinforcement about this new
5 code for face-to-face coordination. I think again, if our
6 interest is in stimulating innovation, I think acknowledging
7 Glenn's point about paying for things that we're not
8 currently paying for, that said I think by not paying for
9 these things we're not getting enough of this stuff.

10 And so I personally would be supportive of
11 considering the expansion of the basis of this new code to
12 include non-face-to-face care, whether it's via e-mail or
13 telephone or whatever, because the longitudinal management
14 of patients has got to enable the physician or care
15 coordinator to expand beyond the 0.01 percent of a patient's
16 waking time that's face-to-face with the physician. And
17 these other modes are already proving successful and in some
18 cases really a documentation of reduction in total PM/PM
19 spending associated with some of them.

20 Last but not least, to weigh in on this last
21 question about how do we deal with this level of risk or
22 lock-in. Could we consider, in the next draft, the pros and

1 cons of a multilevel patient designation in which patients
2 would have the ability to designate various degrees of
3 delegation to their care coordination manager, including
4 selecting the specialist and hospitals who they might see
5 but not limiting to them if they prefer more freedom than
6 that.

7 DR. MILLER: I know we're out of time so I'm going
8 to say this really fast. Remember on the fee thing and
9 getting the physician involved, you do have the ability, and
10 even under the demonstration now, the disease management
11 organizations do have the flexibility to do something with
12 the physician. And so that is certainly one mechanism.

13 The second thought is this new fee and the
14 inherent risk of paying for what we're already getting and
15 the budget implications and that. Remember, assuming an
16 adequate payment -- and I recognize there's an SGR issue out
17 there -- but we make recommendations across the board. One
18 could talk about within the fee schedule and moving money
19 around within the fee schedule.

20 Last thing on the face-to-face point, another way
21 to think about that issue is if you make this payment as in
22 okay, here is something tied to the patients that you are

1 managing, it doesn't have to be reimbursing for every e-mail
2 as much as it's sort of saying here is a fee that covers
3 that stuff. That way you're not at as much financial risk.

4 MR. HACKBARTH: Okay, much more on this later.
5 Good job.

6 Next is physician resource use.

7 * MR. BRENNAN: Today we are presenting the latest
8 in a series of presentations on our work in the area of
9 physician resource use and our use of two commercially
10 available episode groupers which group claims data into
11 clinically distinct episodes of care on a set of Medicare
12 claims.

13 The two groupers we're using are Episode Treat
14 Groups, created by Symmetry Data Systems and the Medstat
15 Episode Grouper created by Medstat.

16 In addition to the resource use component of the
17 analysis, we're also calculating a set of claims-based
18 quality indicators for the same population on the same set
19 of claims.

20 At the March and April meetings we'll be
21 presenting the results of our analysis using a 5 percent
22 sample of Medicare claims and once this report cycle

1 concludes we'll begin analysis of 100 percent of claims in
2 selected geographic areas, permitting us to build on the
3 lessons we've learned from the 5 percent analysis and begin
4 to constructive physician level case loads, resource use
5 scores, and quality scores.

6 I just want to quickly go over some of the
7 technical results from the analysis. We ended up grouping
8 approximately 204 million claims from calendar years 2001,
9 2002 and 2003. This is a 5 percent sample. The ETG group
10 assigned approximately 90 percent of these claims to
11 episodes while the MEG grouper assigned approximately 80
12 percent of these claims to episodes.

13 While this represents a not insignificant
14 proportion of claims, upon further examination we found that
15 the claims that could not be grouped were ancillary services
16 such as tests and they did not represent a large proportion
17 of dollars. With The ETG grouper the group's claims
18 represented 94 percent of all dollars and with the MEG
19 grouper the group claims represented 96 percent of all
20 dollars.

21 In addition, both groupers had some trouble
22 grouping home health records, although again they represent

1 a small share of both overall claims and dollars.

2 Once the episodes were created, we subsequently
3 deleted any episodes that did not have a clean start or a
4 clean finish. The clean period concept essentially means
5 that a certain period of time, for example 60 days, needs to
6 have elapsed before an episode can be considered to be
7 closed. It's important to only have clean complete episodes
8 in your analysis because you don't want to bias the results
9 of your analysis by including potentially low resource use
10 non-complete episodes.

11 Finally, we deleted any episode that had resource
12 in the top or bottom 1 percent or had total payments that
13 were \$30 or less.

14 As we outlined to you in November, we're focusing
15 our analysis on a subset of episodes that are particularly
16 relevant to the Medicare population and we're also
17 standardizing payments in order to facilitate comparison
18 across geographic areas.

19 For the purposes of this presentation we don't
20 intend doing an exhaustive comparison of the two groupers.
21 Instead, we'll present some high level comparisons in the
22 next few slides, but for simplicity we'll focus on the

1 results from the MEG grouper for the remainder of the
2 presentation. We have, however, generated the same analysis
3 using both groupers and where appropriate we'll note any
4 differences or similarities between the two.

5 This table presents a comparison of the ETG and
6 MEG groupers for some of our selected conditions. Going
7 from left to right the first two columns indicate the number
8 of episodes created by the MEG and the ETG groupers
9 respectively, while the second two columns indicate the
10 average number of dollars associated with each episode for
11 the two groupers.

12 As you can see, for certain episode such as
13 hypertension -- which we've abbreviated to HBP in the table
14 -- and breast cancer there's broad agreement between the two
15 groupers both in terms of the number of episodes created and
16 the average resource use in those episodes. However, for
17 other conditions some anomalies exist.

18 For example, congestive heart failure, while the
19 number of episodes created is broadly similar between the
20 two groupers, the average resource use for CHF episodes
21 created by the ETG grouper is more than twice that of the
22 MEG grouper.

1 Now obviously these differences in results between
2 the two groupers for these conditions are enough to warrant
3 further examination and we're looking into these
4 differences. We've also spoken with the people at both
5 Symmetry and Medstat to find out a little more about the
6 clinical underpinning of their two groups and under what
7 circumstances claims could group differently and lead to
8 result such as the one you've just seen.

9 However, it's also important to note that the ETG
10 and MEG groupers do differ in some very fundamental ways
11 which may make explicit comparisons between the two groupers
12 difficult. Perhaps the biggest difference between the two
13 groupers is in how they create episodes. The MEG grouper
14 relies solely on ICD-9 codes to create episodes, whereas the
15 ETG grouper relies on both ICD-9 codes and procedure codes
16 to create episodes.

17 To go back to the congestive heart failure example
18 again, and on the last side there was a difference on
19 average costs, I can say you that CHF episodes created by
20 the ETG grouper have a much higher proportion of costs
21 attributable to inpatient hospital stays than the MEG
22 grouper. Additionally, in the MEG grouper CHF is found in

1 over 40 episode groups in addition to the stand-alone CHF
2 episode group, reflecting the fact that it's not a disease
3 but a condition that can be the result of many diseases.

4 In other research, Medstat has found that among
5 all patients with CHF about 20 percent were found in
6 severity stages of other episodes and it's possible that
7 these are more likely to be related to inpatient stays which
8 could account for the cost discrepancies between ETGs and
9 MEGs, although as I said we're continuing to check into
10 this.

11 Ultimately the test will be less about absolute
12 differences between the two groupers and more about whether
13 or not the groupers rank physicians differently.

14 This table illustrates in some more detail some
15 episodes created by the MEG grouper that present each
16 episode by disease stage. Disease staging is a concept used
17 by the MEG grouper that assigns different stages to episodes
18 depending on the overall severity of the episode.

19 Stage zero or one represents the lowest severity
20 stage and stage three represents the highest. It's an
21 important concept because ideally you don't want to compare
22 physicians who predominantly treat patients with stage one

1 of a particular episode with physicians who predominantly
2 treat patients with stage three of a particular episode.

3 Going from left to right the first column
4 represents the selected episode, the second the episode
5 stage, the third the percentage of episodes that fall into
6 that stage, the fourth the percentage of payments that fall
7 into that stage, and the fifth is the coefficient of
8 variation associated with each stage.

9 DR. NELSON: I have a point of clarification. The
10 staging is according to the temporal stage? That is, along
11 a time sequence? Or is it on a severity stage?

12 MR. BRENNAN: It's severity, so based on specific
13 ICD-9 codes and subcodes and the like.

14 As you can see, stage three episodes tend to
15 account for a disproportionate amount of resource use
16 relative to their size. For example, stage three coronary
17 artery disease, or CAD, accounts for only 19 percent of CAD
18 episodes but 53 percent of total payments associated with
19 CAD.

20 Similarly, stage three colon cancer episodes
21 account for 41 percent of payments but only 16 percent of
22 colon cancer episodes.

1 You can also see that the coefficient of variation
2 also tends to decline with the progression in severity of an
3 episode. For example, the coefficient of variation for
4 stage one CAD is 262 compared to 109 for stage three CAD.
5 We think that this may be because there's more discretion in
6 treatment options during less severe stages of an episode,
7 although we'll be discussing this with our expert panel in
8 the near future in order to solicit their opinions.

9 We also examined episodes according to the types
10 of services that accounted for all of the resource use
11 within an episode. This table presents for selected
12 episodes the percentage of resource use that was associated
13 with hospital inpatient care, evaluation and management
14 care, post-acute care, procedures, imaging, tests or other
15 not classified. Again, the results are quite interesting
16 and again they confirm that the groupers do appear to be
17 grouping claims appropriately. I say groupers plural
18 because we have created a similar table using the ETG
19 grouper and the results are broadly consistent with the
20 exception of those CHF episodes that I mentioned earlier.

21 The table highlights particular areas of interest
22 for some episodes. As you can see, CAD and pneumonia

1 episodes feature high levels of inpatient use. In contrast,
2 more than 50 percent of resource use for hypertension and
3 sinusitis is associated with evaluation and management care.

4 With that I'll turn it over to Karen, who will
5 walk you through some of the results associated with
6 attribution to physicians, both in terms of resource use and
7 quality.

8 MS. MILGATE: So now we're going to switch gears a
9 little. Niall has just described what the groupers can tell
10 us about physician resource use, but in order to reach the
11 goal of differentiating among physicians based on resource
12 use we first have to be able to identify the physician most
13 responsible for that use. And in that analysis, we'll be
14 attributing episodes to individual physicians.

15 And further, because the ultimate goal is to also
16 tie quality indicators to the analysis, we'll also be
17 looking at how we would attribute performance on quality
18 indicators to physicians.

19 This is critical when we turn to our 100 percent
20 analysis later this year where we'll need to actually choose
21 an attribution method, so we used our 5 percent sample to
22 explore the various methods.

1 To do so we talked with our expert panel who have
2 run these groupers, as well as the panel has two clinical
3 experts, to ask them about attribution methods for both
4 resource use and quality. And then we also looked at the
5 variety of different programs in the private sector that
6 have created there own attribution methods to get advice
7 from them and identified the following issues.

8 First, it's important to decide if you want to use
9 dollars versus contacts with physicians as the unit of
10 analysis. The advantages of dollars is you can get a sense
11 of the intensity of the visits that the beneficiary had with
12 the physician. The advantage of contacts is you can really
13 look at the physician who saw the patient the most and maybe
14 more likely the one to have actually managed that patient's
15 care.

16 After you decide whether you want to use dollars
17 or contacts, there's also questions of whether you want to
18 look at all dollars, which could include hospital dollars,
19 procedures, tests, labs, et cetera, or if you should just
20 limit it to evaluation and management codes given that they
21 might be more likely to identify the physician who actually
22 had some responsibility for managing the patient's care.

1 And further, particularly for episodes where a lot
2 of the care is delivered in the ambulatory setting, you
3 might actually want to limit your attribution rules to
4 evaluation and management that occurs outside of a hospital
5 setting.

6 One of the key questions is what is the
7 appropriate threshold? And by that we mean what percentage
8 of visits or dollars are you talking about is enough to
9 attribute the actual episode to any single physician? And
10 there the range we looked at were anywhere from 30 percent
11 to 50 percent, which seemed to cover most of what various
12 programs do.

13 In addition, beneficiaries often see more than one
14 physician in an episode of care, so should the episode be
15 allowed to go to more than one physician? And we looked at
16 that, as well.

17 And finally, are the methods the same for resource
18 use and quality? And you'll see, as we talked this through,
19 we found the answer is no, they are slightly different.

20 So these are our findings on resource use. What
21 you see here is a table that looks at the percent of
22 episodes that are attributed to an individual physician.

1 And this is using the MEG grouper, as Niall said we were
2 going to talk about those results.

3 Down the left-hand side you have the various
4 attribution methods we looked at. Just one note, we first
5 of all, took off looking at all types of dollars or
6 contacts. The expert panel said that in most cases most
7 programs really look at E&M dollars or contacts, so we took
8 that out from the beginning.

9 And then across the columns, the column we're
10 going to focus in on here the most is the all column where
11 we basically have the percentage of episodes across all the
12 selected episodes that we chose that could be attributed to
13 a single physician. The other episode types there are
14 really to give you a sense of the variation but we're not
15 going to go through those in any great detail.

16 On the first row you see the evaluation and
17 management visits where we set a threshold of 30 percent.
18 In that case we found that 90 percent of all selected
19 episodes could be attributed to a single physician. So that
20 means we found that 90 percent of all episodes you could
21 identify one physician that was involved in that episode for
22 30 percent of the visits in the episode.

1 I'll keep going through this and I'll say it more
2 clearly as we go along.

3 When we increased the threshold to 50 percent,
4 that is that for an episode to be attributed one physician
5 had to be responsible for 50 percent or more of the E&M
6 visits, that number went down -- which you would expect,
7 that's a more conservative test -- to 75 percent.

8 When we looked at dollars to see if you used
9 dollars if it would change the percentage of episodes that
10 could be attributed we found that, in fact, it didn't do
11 much to change the percentage that could be attributed,
12 particularly at the 30 percent threshold. Still we found
13 that 90 percent of episodes could be attributed to an
14 individual physician who had 30 percent or more of those
15 dollars.

16 When we move that threshold up to 50 percent the
17 number again went down, but it did not go down as much as it
18 did when we looked at visits. So that went down to 82
19 percent of all episodes.

20 We then looked at if we used evaluation and
21 management visits or dollars outside of the hospital setting
22 only, if that would change our attribution results. We

1 found again a fairly high number, at a threshold of 30
2 percent, of the episodes could be attributed to a single
3 physician. The 86 percent there is a little lower than the
4 90 but it didn't go down that much.

5 We also, although it's not on the chart, did look
6 at multiple attribution and again found that it didn't
7 matter that much, that there were some episodes that could
8 be attributed to more than one physician but still it was a
9 very high percentage were attributed to a single physician.

10 So we found really across the board that we could
11 attribute a high percentage of all selected episodes to an
12 individual physician.

13 So we found that the episodes could be attributed
14 to physicians, but did they get attributed to the right
15 physicians was the next question we tried to get some
16 information on. here we looked at the percent of episodes
17 that are attributed to a physician by specialty and in
18 general found that the type of specialty to whom the
19 episodes were attributed seemed to make clinical sense.
20 Again we wanted to go back to our expert panel to what they
21 thought. But for example, we find that 38 percent of
22 coronary artery disease episodes were attributed to a

1 cardiologist. And if you look at prostate cancer, going on
2 down the side there, that 64 percent of those episodes were
3 attributed to a urologist.

4 I want to make one note about a category here
5 because it shows up in a lot of our rows, even in the
6 broader charts that were attached to your mailing materials,
7 and that's the outpatient specialist. That refers to any
8 care that was delivered by a physician in the outpatient
9 setting. There's not a designation on the claim that tells
10 us what type of physician, so it just becomes an outpatient
11 specialist.

12 Now we turn to our quality analysis and our
13 ability to identify individual physicians who were
14 responsible for the quality of care. So remember again that
15 the ultimate goal is to put together both measures of
16 resource use and quality in the end of the analysis. For
17 this we're using a set of claim-based quality indicators
18 that has been developed and revised over the years for
19 MedPAC. And we've talked about this set in previous
20 meetings but it's the Medicare Ambulatory Care Indicator Set
21 for the Elderly.

22 Some examples, just to get you oriented to the

1 type of indicators we're talking about, is for example for
2 diabetes the percent of eligible beneficiaries that received
3 eye exams or Alc tests within a certain time frame. And for
4 CHF whether eligible beneficiaries receive appropriate lab
5 tests or get timely follow up after a hospitalization for
6 CHF.

7 So here the goal is to identify the physician that
8 is most able to affect the beneficiary quality for specified
9 indicators. Remember that the indicators are all associated
10 with a specific condition so here what we do is physicians
11 are assigned based on the level of involvement with the
12 beneficiary for that specific condition.

13 So for example, for the beneficiaries that are
14 eligible for Alc tests for diabetics, then we look at all of
15 their evaluation and management visits and contacts that
16 were associated with their care for diabetes. And then we
17 test our various attribution methods on those dollars and
18 contacts.

19 So for example, we found that for 91 percent of
20 diabetics needing an Alc test, we could identify a single
21 physician who delivered 35 percent or more of that
22 beneficiary's evaluation and management for that condition.

1 So we only looked at the care that was related to the
2 condition that made them eligible for the indicator, not all
3 of their care.

4 The overall results here were that when we used a
5 method of using 35 percent as our threshold, and we came
6 upon that by looking at what we found in the resource use
7 the analysis frankly, of E&M visits that 78 percent of all
8 the indicators could be attributed to an individual
9 physician. When we increased that threshold to 50 percent,
10 that number went down to 63 percent.

11 Again, we wanted to look at whether this method of
12 attribution was assigning the beneficiaries' care to
13 appropriate type of physician. Again, we found similar
14 results. It seemed to make clinical sense. And further, we
15 found that both the resource use analysis attribution method
16 and the quality rules assigned beneficiaries to the same
17 types of physician. For these particular conditions the top
18 four that you see there were exactly the same in both the
19 resource use analysis as well as the quality analysis.

20 MR. BRENNAN: Over the next few weeks, we'll be
21 going over some of these results in conjunction with an
22 expert panel, as we've mentioned, and at the April we'll

1 present you with further results from the 5 percent analysis
2 including variation in resource use by MSA and variation by
3 specialty.

4 We'll also have incorporated additional analyses
5 that will permit us to risk adjust episodes and we will
6 examine specific procedures that appear to drive resource
7 use. Once the 5 percent analysis is completed, we will move
8 on to the 100 percent analysis where, as I noted at the
9 beginning of the presentation, we'll be able to build
10 physician-level case loads and deal with technical issues
11 like what is the appropriate number of cases a physician
12 needs to have in order to qualify to be counted.

13 We'd be happy to answer any questions on these
14 matters.

15 MR. BERTKO: A couple of questions or comments
16 here. I think, Niall, the first one goes to just what you
17 talked, the number of episodes being real important here.
18 You had the 5 percent sample rather than 100 percent sample,
19 so it means for a given physician in a given state or GPCI,
20 wherever you did this, you don't really know this.

21 I guess what I would comment on here with the
22 threshold is a 50 percent threshold is better to use if you

1 have enough episodes. Maybe that number is 100, which would
2 be really good. But it's better to get enough episodes. So
3 if you're not getting 100, then you settle as a good enough
4 30 percent threshold for that. At least that's my bias on
5 this.

6 MS. MILGATE: 100 per physician?

7 MR. BERTKO: That's what I've heard from some
8 other stuff. I don't know, Arnie, if you'd agree with that
9 or not.

10 Then the second comment is -- well, first of all,
11 let me say I'm extremely appreciative of the amount of work
12 you've done to get to this particular set. It's enormous
13 amounts of data being spun through.

14 And then, unfortunately, I'm going to suggest more
15 work.

16 If I've understood your efficiency one on page
17 nine, your expert panel said to only evaluate docs, group
18 them in episodes, using E&M visits or E&M dollars. And my
19 bias would've been to use all dollars because on behalf of -
20 - I'll call it MedPAC -- it's important for us to look at
21 all dollars.

22 Now the problem with this may be that in infers

1 delivery systems and there might be objections to that.
2 Maybe that's what the panel was objecting to.

3 MR. BRENNAN: I think part of it may also be a
4 technical limitation in that when we use E&M visits or
5 dollars they are, in almost all cases, explicitly linked
6 with a physician UPIN, whereas if you start to pull dollars
7 from other settings, particularly the inpatient setting,
8 there's not necessarily now a UPIN associated with that.
9 Now you could attribute an episodes to a hospital, I guess,
10 or to the physician who sees the patient in the hospital.
11 But the actual inpatient care is not necessarily explicitly
12 linked to a UPIN.

13 MR. BERTKO: No, but it could be explicitly linked
14 through the grouper. I don't know the Medstat one, but the
15 ETG grouper will, in fact, drag in inpatient care. And I
16 guess that's what I'm advocating for is to look at
17 inpatient, outpatient and physician costs as you evaluate
18 how somebody does this.

19 DR. MILLER: Can I clarify something? The episode
20 drags everything in.

21 MR. BRENNAN: Right.

22 DR. MILLER: This question of E&M visit versus

1 dollar is within that episode you have physicians, hospitals
2 and everything. It's how to say which physician was most --

3 MR. BERTKO: So maybe that's my confusion. I
4 should have asked better. If you're strictly using the
5 visits and the dollars to create the attribution but not the
6 efficiency measurement, then I'm --

7 MR. BRENNAN: Absolutely. It's just to assign it
8 to a responsible provider. We will count all the dollars.

9 MR. BERTKO: Okay, then I'm fine on that one.

10 DR. MILLER: I just wanted to avoid the additional
11 work, which is why I was listening very careful to the
12 question.

13 DR. WOLTER: I find this very interesting also and
14 it got me thinking about where we are headed with it and I
15 suppose we'll talk about that in the future in terms of what
16 would we do with this? Would it be linked to some physician
17 incentives at some point in time? Would it be just an
18 information reported back in hopes that that might help
19 change how some practice standards are set?

20 And of course, my bias is that if we could use it
21 to incentive the coordination of care, since if an episode
22 is defined by being 35 percent of E&M visits, by definition

1 two-thirds of the care is somewhere else. And it may well
2 be that if we're thinking about virtual networks and
3 creating incentives around those to form, maybe there's
4 something in that as well, in addition just to staying with
5 the focus on an individual physician.

6 So whether that makes any sense to where this is
7 headed I don't know today, but it got me thinking as you
8 presented the information.

9 MR. HACKBARTH: Just as a reminder, to this point
10 what we've said it is the purpose for developing this tool
11 is confidential feedback to physicians, although we have
12 opened the door to the possibility that based on development
13 and exploration that we ultimately may recommend that it
14 somehow be incorporated in the payment, including pay for
15 performance. But the first step is feedback.

16 DR. MILSTEIN: This report is so good I have no
17 comments on the core of it. My comments are really
18 ancillary and really relate to maybe a parking lot issue as
19 we begin to confront related issues on different topics.

20 That is at the end of the day, as per Nick's
21 comments, we begin to transform this into any kind of policy
22 decisions that are going to make this count in the market,

1 make this matter. The issue of accuracy of attribution is
2 getting to get to be more and more important.

3 We have an opportunity at this point to begin to
4 set in motion collateral changes that would enable much less
5 cloudiness regarding attribution. And what I have in mind
6 specifically is -- and I defer to you, Glenn, as to what we
7 hook this to -- is to begin to move forward with I'll call
8 it the transparency discipline, making sure that at some
9 point in the future when we're paying for a lab test or
10 we're paying for medication we know the provider ID number
11 of the physician ordering such. That's the pathway to
12 having much more confidence in the future about our
13 attribution algorithms.

14 MS. BURKE: I think this really is kind of
15 touching on where Nick started to go. And that is if we
16 look at this chapter and then reflect back on the
17 conversation we just had in terms of coordination of care it
18 seems to me again that our ability to begin to track an
19 individual physician's impact on a particular patient, not
20 only for purposes of feedback in terms of their resource
21 utilization for purposes of comparisons with their
22 colleagues for best practice purposes, it also -- unless I'm

1 sort of not fully appreciating what we're hearing -- I think
2 it underscores once again the impact and the role that an
3 individual physician has in terms of that particular patient
4 and how they're managed.

5 Because again what you see here is in a number of
6 these cases we're picking patients who are chronically ill,
7 who are managed in complex situations over a very long
8 period of time.

9 And so I think it underscores for me again that as
10 we begin to develop more of this understanding, although I
11 think again to the point made, the more we can understand
12 about attribution and the further that goes beyond the sort
13 of direct impact but to the hospitalization and whatever it
14 happens to be, that we have of growing set of tools
15 available to us. Again, the accuracy, as Arnie has
16 suggested, is going to be critical to us.

17 But it seems to underscore once again that there
18 is a way to do this through individual physicians, which has
19 been the stumbling block for a very long time, is that once
20 you get outside of a group setting how do you begin to
21 incentivize individual physicians who are largely
22 entrepreneurial in nature? And I think again this

1 underscores, as I understand it as we gather this
2 information, again our capacity growing to be able to do
3 that.

4 And so again, unless I misunderstand it, I think
5 we are now putting together the tools that will allow us to
6 incentivize in different kinds of ways. So the accuracy,
7 the broader we can get this in terms of capturing
8 attribution, I think will be very important to us.

9 MR. HACKBARTH: How do we evaluate when an
10 attribution rule is good enough and compare them? The
11 approach you used here I found interesting and somewhat
12 comforting that if you vary the threshold you weren't
13 getting dramatically different results when you moved from
14 30 to 50 percent. That was reassuring to me.

15 Do you have other thoughts about how you determine
16 when you're good enough?

17 MS. MILGATE: This is a little off topic on that
18 but what's been interesting to me, in thinking through
19 what's the right threshold, actually is central, is John's
20 point. There's kind of a balance between having it high
21 enough so you really feel comfortable that you've got the
22 right physician who is responsible and having enough sample

1 size.

2 So if we can get a high enough sample size I think
3 John is right, that we would want to ultimately set that as
4 high as we can.

5 And remember those episodes, like the 10 that are
6 not assigned in the first method, and the 25 percent that
7 are not assigned in the 50 percent, would not be assigned.
8 So if you didn't have some sense that you could clearly
9 assign it, then those would just be thrown out so you
10 wouldn't have a concern about those you still had left, I
11 guess is all I'm saying.

12 DR. MILLER: Plus, even within your analysis, I
13 think we also looked at after you made the attribution you
14 looked at the type of physician it ended up getting
15 attributed to for the given condition. And at least there
16 was some face validity and not to push the question off from
17 us.

18 I think part of this is going to be us sitting
19 around looking at it and saying this feels about right.

20 DR. REISCHAUER: My comment was going to be on
21 this point, and I guess I'm much more comfortable with lower
22 numbers than John and Arnie happen to be. For me the

1 question is not just with the threshold is but what's the
2 next largest person you could attribute it to? And judging
3 from the 30 percent threshold versus the 50 and the fact
4 that the episodes go from 90 percent only down to 75, you
5 realize that in a sense the next person is pretty darn small
6 on average. And my guess is it's very small.

7 And so you'll have somebody that you attribute 30
8 percent or more to one person and the next one is 6 percent
9 or below. And so, in a relative sense, you can be pretty
10 comfortable about this.

11 MR. BRENNAN: That's right. Just to add one more
12 data point for you all, when we did test multiple
13 attribution using a 30 percent threshold. We went from --

14 DR. REISCHAUER: In theory, you could have three
15 people with 30 percent. But in fact, you don't. You have
16 one with 47 and another with six.

17 MR. BRENNAN: So of the 90 percent, 78 percent
18 were still only attributed to one doctor and 12 percent were
19 attributed to two or more. So it seems to be -- most care
20 seems to be fairly concentrated around one doctor.

21 MR. HACKBARTH: What you say, Bob, makes sense but
22 in trying to look at this from the perspective of a

1 physician, okay 30 percent of the E&M visits, and now we're
2 saying you're responsible for all this specialty stuff and
3 all this imaging that the specialist may have ordered and
4 the inpatient stay, for a lot of people, for a lot of
5 individual practicing physicians, that may feel like a
6 stretch.

7 DR. REISCHAUER: But remember when we were setting
8 the threshold at 30 percent, still 75 percent are above 50
9 percent. So there will be aggrieved parties but there will
10 be quite few of them.

11 DR. SCANLON: Also, you have that patient at 30
12 but you've got a lot of others at 60 and 70. We're talking
13 about attributing the patient, an individual patient, to a
14 physician. The physician is going to have a distribution.
15 Part of the key here is going to be that there are enough
16 patients that a physician has that there are some risks
17 spread.

18 MR. BERTKO: I just want to add that Mark made a
19 comment, face validity. And I would add transparency to
20 that. So as long as it's not a black box, we've been
21 working on us with the Milwaukee Business Coalition. And
22 with our big brother, 25 or so employers, behind us, the

1 docs have said okay, now that we understand it, it might be
2 good enough. I think I'm putting it in the right
3 paraphrase.

4 MR. HACKBARTH: So in that conversation you do
5 different iterations and let them see how different rules
6 might affect attribution?

7 MR. BERTKO: No. We do it a way that we have
8 found that our Ph.D.'s have said sounds pretty good, and
9 then we explain it to them and go to the medical societies
10 and such. This whole discussion of what these guys did
11 would be, believe me, well beyond what an average county
12 medical society would want to hear.

13 MR. HACKBARTH: Yes, although this one variable,
14 the attribution rule, seems -- these are bright people.
15 That's pretty basic.

16 MR. BERTKO: They may have gotten an A in calculus
17 but not in stat.

18 DR. MILSTEIN: My earlier point about -- and
19 again, as the consequences that pivot on this begin to get
20 more significant, the increasing importance of confidence in
21 the attribution. Earlier I mentioned that the way to
22 remediate this is to make sure the drugs and lab tests, and

1 for that matter imaging tests, are coded as the to the
2 ordering physician. The same certainly applies to physician
3 specialist care that originates in a referral from another
4 physician.

5 If those visits were coded with the identifier of
6 the referring physician, it would also take us a big step
7 towards confidence in attribution algorithms.

8 MR. BRENNAN: The claims data does have
9 information on the referring physician UPIN but it's not
10 very highly regarded at the moment, which ties directly to
11 your point that we should improve coding of it.

12 DR. MILSTEIN: It would get better if there were
13 consequences associated with the attribution.

14 MR. HACKBARTH: Others? Jay, last comment.

15 DR. CROSSON: I know we've decided we're talking
16 about producing this information for comparative, education,
17 and all the rest of that. But we've also had a lot of
18 discussions about impacting the costs. So if you sort of
19 think about the point you brought up which is what about the
20 percentage here which would be a percentage of impact on the
21 attribution which would be viewed let's say by the primary
22 care physician as unfair. So what dynamic would that, in

1 fact, likely create in the fee-for-service community?

2 If you know you're a primary care physician and
3 over time your income is going to be in some way related to
4 what you do but to some portion of those downstream
5 referral-based costs and that you have the ability to direct
6 that and you have some more judicious use of resources
7 available to you than others, you might in fact think that
8 the dynamic they could be created by that same unease that
9 you described might not be a bad one.

10 MR. HACKBARTH: That's where you'd want to go. I
11 guess my point is simply it's a long way from where we are.

12 [Laughter].

13 MR. HACKBARTH: Thank you. Good work and we look
14 forward to the next installment.

15 Next is quality measurement for hospital care.

16 * MS. CHENG: This is actually the second
17 presentation in a series that we started at the end of last
18 year and I was up here with Jack Ashby and Anne Mutti to
19 talk to you about measuring inpatient hospital quality and
20 resource use.

21 What we're after is really trying to make a tool
22 for you. What we'd would like to do is to try to get our

1 hands a little bit closer, if not around, the notion of an
2 efficient provider. We've said now for a while efficiency
3 is a combination of two things, neither of which are
4 particularly easy to measure, one of which is resource use
5 and the other is quality.

6 You've heard a little bit about our work to
7 develop resource use measures. We just talked about
8 physician. That's running in parallel with hospital
9 resource use measurement. And what I'm going to talk with
10 you about this afternoon then is the quality part of the
11 inpatient hospital resource use measure.

12 Obviously, the first step of getting toward a
13 quality measure is choosing the indicators that are going to
14 be a part of this. Because this is a tool that we want to
15 be able to use here on the staff, our first criteria was it
16 had to be run off of data that we could either collect and
17 manipulate ourselves or that we could collect from another
18 source.

19 We set a couple of other criteria to make sure
20 that we had a robust set of indicators. The first one was
21 we wanted to measure an indicator that we had a sufficient
22 sample size for at most hospitals. We're contemplating

1 being able to describe 4000-plus hospitals. So we set an
2 initial threshold. We'd like it to be something that about
3 3000 or more hospitals would have a sufficient sample size
4 so we could get a score for them.

5 Our second idea was we wanted to measure things
6 that occurred with some frequency. This is not a very
7 scientific threshold obviously, but our notion was for a
8 couple of the measures that we could measure with sufficient
9 sample size at more than 3000 hospitals. They were such
10 rare events that they were only occurring at 1000 hospitals
11 or less. So most of the hospitals in our sample had zeros.
12 We thought maybe that wasn't where we wanted to look first.

13 So at least for the time being we've set about
14 three indicators aside because they occurred very, very
15 infrequently.

16 And then our final idea was we wanted to get
17 indicators that had some evidence of variation. To the
18 extent to which we think that quality varies from hospital
19 group to hospital group we wanted to have indicators that
20 gave us some evidence of variation. If all of the scores
21 were really tightly grouped, if there are quality
22 differences they would be harder to see. So we wanted to

1 see some variation.

2 So applying those ideas we looked out across
3 quality measurement for hospitals and, broadly speaking,
4 there are three sets. We have two that were developed by
5 AHRQ and these have been used very widely in the research
6 literature. Those are the mortality indicators and the
7 safety indicators.

8 The third large set we had are the process
9 measures. Now these are the result of the work that CMS has
10 done. They feed directly into the Hospital Compare, and
11 these are the measures that were linked to the voluntary
12 participation. Hospitals voluntarily submitted their scores
13 for these processes and CMS collects it and develops these
14 scores.

15 So when we applied our criteria, we could measure
16 these at a lot of hospitals, they happen with some
17 frequency, and they had some variation behind them. We came
18 up with a set of 37 quality indicators. And I've put them
19 up in this matrix here because I think we can be really
20 satisfied with a set that has a fair bit of breadth and a
21 fair bit of depth. What I've done is I've described them in
22 terms of the mortality, safety and process kinds of quality

1 that we can measure with this set. And then down the other
2 side the kinds of patients that we're going to be able to
3 include.

4 So we've got some focus, an ability to focus on
5 surgical patients. We also have sets that let us look at
6 three different condition-grouped patients types. And we
7 have four adverse events that we can measure on all patients
8 in the hospital.

9 So when you take this set of 37 and you look at
10 them together, I think you've got a pretty nice picture of
11 what's going on in the hospital to the extent that we can
12 measure it today.

13 The good news is we've got a lot of indicators.
14 The bad news is we've got a lot of indicators. So what I'm
15 going to do now is walk you through some of the work that we
16 have done to start to contemplate how we can make some
17 sense. When we start looking at hospital groups and we want
18 to be able to make some comparisons about their comparative
19 quality, I could come back to you with 37 different
20 comparisons of three or four or five hospital groups and I
21 think we'd have a bit of a hard time making sense out of it.

22 So what I'd like to suggest is that we should

1 think about ways to group these indicators together to make
2 some patterns out of them and then, to the extent that we
3 can, maybe start to summarize the scores. So that rather
4 than having 37 comparisons we can break that number down a
5 little bit. We may be driving toward a single measure. We
6 may be driving toward a small set, three or five measures.

7 Let's see what the data looks like and I wanted to
8 get you feedback on where we're going with this and grouping
9 and summarizing the data that we can collect.

10 The next part of my presentation then are going to
11 be some initial work that we've done on not so much testing
12 as illustrating several methods of grouping the indicators
13 together and summarizing the results. One way we could do
14 it would be the weight each indicator in the set the same,
15 just sort of take them as they come.

16 Alternatives to equal weights would be assigning
17 some kind of weight to the scores that would make some
18 contribute more than others to the final score of a
19 hospital. We could do that by some estimate of their
20 relative importance. We could do it perhaps by some
21 estimate of a number of patients or what have you. But
22 there are some ways that we can manipulate the data other

1 than equal weighting.

2 But as I progress through here I'm going to start
3 with more or less taking each one equally.

4 So here are two groups that I thought and that our
5 group thought sort of came out to us as natural ways to
6 group this information. The first one is by the type of
7 indicator. So put all the safety ones together, we've got
8 about a dozen of those, put the mortality together, put the
9 process together. So we've been discussing it by indicator
10 type.

11 The other way that came to us was to look at
12 patient play. So surgical, the three diagnoses and then the
13 all patient.

14 I don't think anybody can read this but that's
15 okay, just hang with me for two seconds. This is just an
16 example. This is less than half of the data that we're
17 going to be able to bring to you.

18 So what I'm going to do is I'm going to grab his
19 first row that we have and I'm going to blow that up. So
20 we're looking at the first row of that illegible table so
21 thanks for hanging with me.

22 What we've got here then are five of the 12 safety

1 measures if we were to group the data in that fashion. Let
2 me help you read this real quick. In the first row, the
3 first column, we took two regions of hospitals. I pulled
4 them out of the hat. I just wanted to show you some data.

5 So we picked hospitals in the South Central region
6 and we're comparing them to hospitals in New England region.
7 So that first number, 28, is the rate of accidental puncture
8 per 10,000 discharges aggregated across hospitals in the
9 South Central region. All of the numbers that we are
10 looking at here are failure rates. I had to do a little bit
11 of a transformation there because of our concepts. We've
12 got safety as a concept, mortality and process. You do want
13 processes to happen. You don't want mortality to happen,
14 you don't want adverse events to happen. But I've
15 translated them all so they're all failures. These are all
16 rate at which things you don't want to have happen happen
17 per 10,000 discharges.

18 The next step then was to compare our two groups.
19 So I've calculated a ratio, and that's just the ratio of the
20 score for the South Central group to the score for the New
21 England group. So on that first indicator your ratio is
22 0.77. That's lower than one. Low is good because these are

1 things you don't want to have happen. So the way you would
2 read that is South Central on that indicator is better than
3 the group to which we are comparing it, hospitals in New
4 England.

5 You could calculate that ratio for each one of the
6 ones on the screen. Just in the ones on the screen you find
7 that for the hospital groups that we've got, in some cases
8 South Central is better. In some, it's worse. We could
9 take this one more step and we could say that the two groups
10 are the same if we couldn't find a statistically significant
11 difference between the two.

12 That's the kind of thing then. We've grouped the
13 data so we've got the concepts the same. We've put them
14 into a group that maybe is going to give us a little bit of
15 information. So our next step is going to be can we make a
16 summary score rather than give you a big column of 37 of
17 these?

18 So I'm going to move to the next slide. I'm
19 seeing heads nodding.

20 This would be one way to summarize the 37
21 indicators after we group them. The first number on this
22 slide, 1.33, is the average of the ratios for these two

1 groups in the safety group. I've taken 12 of the indicators
2 and I've made a single ratio. Remember behind that ratio
3 then South Central does better on some, worse on others.
4 When you take the average then you can say on the whole, for
5 safety, South Central's performance is worse. Do the same
6 thing with mortality and do the same thing with process.

7 If we stopped right here then we could bring you
8 three answers to which group is better.

9 You could take it one more step if you wanted a
10 single score and you could say well all right, what happens
11 if you take safety, mortality and process, given equal
12 weight to each type of indicator, what would you come up
13 with as a summary answer? And here what you see is that you
14 would still come to the conclusion that South Central
15 hospitals' performance was worse on the whole for our
16 quality set. So that's that 1.61.

17 For illustration, if you took each of the 37
18 indicators, you didn't group them by type, you just took
19 each one of the 37, took the average ratio, you get 1.71.
20 This is the punch line that's going to be on the next slide,
21 too. So you come to the same conclusion whether you'd group
22 the data or not in this case.

1 Now if you had different relationships between the
2 two groups of hospitals, that might not be the answer you'd
3 come to but in this case you get the same answer.

4 So what I'm going to show you is one more way to
5 take the same data, regroup it, reweight it, and then see if
6 you come up with the same conclusion.

7 What I've done here is calculate, I've taken those
8 37 indicators, I've put them into groups by patient type
9 now. So within each one of these groups, there's a variety
10 of indicator types. For example, the heart failure group
11 has two mortality measures and then process measures in it.
12 And then I've compare the hospital groups again.

13 I told you the punch line already. You come up
14 with the same answer then when you ask about the comparison
15 between these two groups. But the reason that we're working
16 through this data is that I'm trying to get some input and
17 some feedback about how you feel about some of the ways that
18 we've tried to test, grouping them together, about the
19 summary scores that we're coming up, and give you a sense of
20 where we're going to go from here to bring you this tool and
21 develop it further.

22 So we've got some work to do. One of the

1 questions that I think grouping this data together brings up
2 right away is if we can think of another way to group it
3 would what we get different results when we're comparing
4 hospital groups? And what would that mean if we got
5 different results?

6 How is our answer being driven by the kinds of
7 indicators that we have available? If some of the measures
8 dropped out or some other measures came in, would we be
9 getting different results? A very basic question is
10 grouping and summarizing this kind of data, different
11 indicators, different things going on, is that the right way
12 to go? And then once we start getting toward a final
13 iteration of this tool, what does it tell us about other
14 factors that might relate to hospital quality?

15 Just as we were working through these two regions
16 of hospitals, a lot of questions came right to the fore.
17 Are we really comparing two regions or are we comparing
18 hospital characteristics that are not necessarily randomly
19 sorted into those two regions? So we would start looking at
20 questions like that once we had a little bit of an idea of
21 what this tool is going to look like.

22 That's a lot of data. And we're early in the

1 process. So to the extent that I can, I'll answer questions
2 about what we've done. And please give me some ideas about
3 how you'd like to go forward.

4 MS. BURKE: This is terrific work. I want to make
5 sure I understand where weighting occurs and where it
6 doesn't occur and just ask a question.

7 For example, if you were to go to your blowup
8 slide of the first row, although this, I must say,
9 underscores what I was always told which is if you get sick
10 you go to the airport if you live in Washington, and you fly
11 north. So that's reassuring. Or take a train.

12 If, for example, I were to look at within the
13 safety category among the five areas that you have listed,
14 are there weightings that occur within them? For example,
15 is there a determination made in the calculations that a
16 collapse of your lung is a more serious issue than a
17 decubitus ulcer? Do you weight within the weightings within
18 a category? That's one question.

19 The other question is there is an acknowledgment
20 here, for example, the infection due to care. That's a
21 presumption that that occurs in the context of your current
22 treatment.

1 There's the issue, for example, with a decubitus
2 ulcer which is a presentation question. Is one admitted or
3 does this occur in the course of your treatment?

4 Some of these are things that occur there.
5 Respiratory failure, arguably there. Infection due to the
6 care, presumption it occurs there. The decubitus ulcer
7 could be a presenting issue or it could be one that occurs
8 at the time.

9 But there are clearly variables within these
10 groupings as their relative importance.

11 I mean, if I had to choose, I'd rather get
12 punctured than my lung collapse, depending on whose needle
13 punctured me. It depends on whose needle it is and where
14 the puncture is. And I'd put mortality right at the bottom
15 of my list, but maybe somebody else would vote differently.

16 [Laughter.]

17 MS. BURKE: But I just wondered, as you build them
18 within where the values arise, I can understand the
19 weighting, and I think you're approaching it exactly the
20 right way.

21 There are groupings and there are weightings
22 within but how does that weighting structure work?

1 MS. CHENG: Right now within the groups that I've
2 discussed each measure is weighted equally. So we haven't
3 tried to make what I would suggest is a somewhat more
4 qualitative judgment: punctures really bad, respiratory
5 failures not as bad. So we haven't done that.

6 We could certainly contemplate, if that's the
7 direction we're going, sitting down and putting some
8 qualitative weights. To make that work mathematically, you
9 can't just suggest that infection due to care is really bad.
10 You'd have to be willing to say it's 4.5 times worse than --
11 and so you can see where that impulse would come from but
12 the math could get a little hairy.

13 MS. BURKE: The math could be complicated but I
14 think for credibility purposes, going forward, the more
15 refined this is -- I mean, I think anyone looking at it
16 would suggest that dead was worse than an ulcer. And all
17 things being equal, you really ought not equate one with the
18 other. There ought to be some variation.

19 But you're right, the complication will be how
20 much worse is being dead? Well, it's probably substantially
21 worse. But how you vary within those areas, I think, is a
22 complicated one.

1 It depends on your religion, that's true, whether
2 you're going on to a better world.

3 [Laughter.]

4 MS. BURKE: But I think that that will be a
5 question that -- yes, there are Medicare savings. It's like
6 subsidizing cigarettes in nursing homes. It was always a
7 good idea.

8 [Laughter.]

9 MS. BURKE: But I think that will be something
10 that we'd want to think about, is within those measures.

11 MS. CHENG: We tried looking across other people
12 that have tried scorecards and there's a lot of scorecards
13 that weight them equally because acknowledging that you
14 would like to give them relative weights is difficult. So
15 some scorecard went that direction. Other scorecards have
16 gone the direction of trying to give them relative
17 importance. And one of the first places they go would be to
18 something that you could quantify. So maybe the rate at
19 which these occur would be one way you could -- or the
20 number of patients that are in the denominator or something
21 like that. If there would be a way to assign them a weight
22 like that, that would be another thing we could think about.

1

2 DR. REISCHAUER: There's an assumption that if you
3 weight everything equally you really aren't making a
4 judgment when, in fact, you are making a judgment and you're
5 making one that you know is wrong.

6 DR. MILLER: Let me give you a different way to
7 think about this problem, because if you were to get into
8 the business of let's decide what the weights -- I mean, we
9 could put together experts, ask people to do stuff . We can
10 do that.

11 But another thing is, and I think this is part of
12 what Sharon is trying to illustrate. She organized it once
13 by condition. And within the condition there were measures
14 that were safety. But she also organized it once by the
15 type of measure. And then it might be that you would
16 conclude that -- since I think death is, Sheila thinks it's
17 the most important, you might want to present the
18 information by these categories either to weight them or
19 even not, just to say I think it's important that this be
20 held out separately because this may be intellectually,
21 without assigning a weight, important to know how they
22 performed on this relative to other things. And there was

1 some slide that did that.

2 DR. REISCHAUER: But the consistency of the
3 outcomes here, no matter how we weight it one way the other,
4 is really a function of the fact that on almost all of these
5 individual measures the South Central is worse than New
6 England. So the more difficult thing would be if we were
7 doing New England versus Pacific Coast or wherever there are
8 equivalently good hospitals. And then each one of these
9 would have come out with a different one maybe, a different
10 worse/better.

11 MS. BURKE: I presume. The presumption is this
12 ultimately is not South Central versus New England. It's
13 hospital A versus hospital B. So it's going to get up close
14 and personal real quick. So it isn't going to be California
15 versus the world. It's going to be the MGH versus the
16 Brigham.

17 MS. CHENG: We are trying to crawl before we walk
18 here.

19 MS. BURKE: I understand.

20 MS. CHENG: And you're absolutely right, that's
21 the direction we're going. But boy, I'd like to try to get
22 something that we could use on groups of hospitals and not

1 necessarily hold it to the standard of could we use this A
2 versus B. If we can get it to work on the group level then
3 we'll have something that we can use at these to compare
4 groups of hospitals.

5 MS. DePARLE: I'm trying to think about -- this
6 may not be a fair question given what you just said, but
7 what came to my mind when I was looking at this were the
8 issues surrounding the hospital mortality data that Glenn
9 worked on when he was at HCFA. You sort of raised this,
10 Sheila, when you said do person present with the beginnings
11 of a decubitus ulcer or does it develop at the hospital? So
12 to what extent are these measures or indicators risk
13 adjusted for demographics and for the presentation of the
14 patients?

15 MS. CHENG: One of the cuts that we used, all of
16 the indicators that we put into this set, are ones that at
17 least most of the Commission had a chance to at least think
18 about a couple of years ago when we applied the Commission's
19 criteria for good measures.

20 MR. HACKBARTH: The safety measures that AHRQ
21 developed ones?

22 MS. CHENG: Right. So to the extent that we had

1 to chance to look at them, these are the ones that we said
2 they have risk adjustment behind them. They have evidence
3 that suggests that they're reliable and valid. The safety
4 ones are ones that make people a little less comfortable.
5 They have a lot of exclusions that go in front of them.

6 So just off the top of my head for decubitus
7 ulcer, because we don't know exactly what people present
8 with, a large group of diagnoses that are likely to have
9 come to the hospital, whether we know whether they did or
10 not, with an ulcer are excluded. If you came from a nursing
11 home, if that was a source of admission, you're excluded.
12 So we don't know whether that patient did or not, but we
13 don't even put them in the denominator.

14 So the comparison that I've shown you and the
15 comparisons we'll be able to make with this set are risk
16 adjusted and have exclusions that at least give us some
17 comfort that we're making valid comparisons.

18 MR. MULLER: I commend you for this. I think
19 trying to have this comparative information available is of
20 major gain and import. Obviously, as the comments and
21 questions from Nancy-Ann and Sheila have already said, this
22 gets very juicy when you start getting down to lower levels

1 of comparison such as on the hospital basis. And then, of
2 course, all the usual caveats about risk adjustment become
3 so important. We started that dialogue. For example, in my
4 hospital, one of the other hospitals, all of the deaths
5 occur in our hospital because they transfer right at the
6 time that they're ready to go.

7 MS. DePARLE: Yeah, yeah, yeah.

8 MR. MULLER: That's what they all say, right?

9 [Laughter.]

10 MR. MULLER: But I think the risk adjustment is
11 therefore of critical importance.

12 But I think when you think about -- I've said this
13 in different settings. When you think about it, there's 50
14 years of financial information that are available on
15 hospitals but the measurement of quality in hospitals is
16 still relatively new in the last five or 10 years. It's so
17 much easier for almost all of us to talk about the finances
18 of a hospital than to kind of say here's the quality of
19 care. It's an issue I deal with with my board. You always
20 want to say you have these great doctors in cancer, heart,
21 et cetera, and so forth. But to have these kind of
22 qualitative measurements that can really stand out there in

1 public and be available I think is something that we all
2 have to keep moving towards.

3 And obviously one of the challenges has been, in
4 the last several years there have been so many measures put
5 out there, it's kind of hard to figure out -- you know, with
6 the 57 measures, the 84 measures and so forth, that we've
7 described even in our own work over the course of the last
8 year or two, it's sometimes hard to figure out how to put
9 them all together.

10 So using some of the categories that you've used
11 here to try to group them, I think is a major advantage. So
12 I commend you for that.

13 I think continuing to think in those directions,
14 as to how to group them -- I mean, I could start giving you
15 comments on some of them right now but I'm not going to get
16 into that because some of them are such smaller weight. Not
17 just joking about the mortality one versus smoking
18 cessation, but you want some -- either you need some
19 agreement on weighting, which I think is very difficult to
20 secure, or you need to have some that are close enough that
21 weighting them equally is not as big a random event.

22 So you don't want things that have such major

1 consequence as pneumonia in a hospital and so forth, and
2 smoking cessation, which by and large very few do as well as
3 one should.

4 So I think continuing to go in this direction is a
5 good way to go and I do think keeping it perhaps, obviously
6 from these big regions you really want to start getting it
7 down to county and metropolitan levels. Inexorably you're
8 going to get down to the hospital level because that's where
9 people want to really -- that's where the levers for most
10 places of improvement can in fact be pushed. So I think
11 it's good to go in that way.

12 I think just having the ratios is intuitively
13 ingenious because I think it allows people to come to
14 quicker judgments. One of the real difficulties with the
15 various dashboards and scorecards that are out there right
16 now is most people who aren't in the field have a hard time
17 knowing what's the right number.

18 So therefore, having have this kind of comparator
19 around one I think is a very ingenious and clever way of
20 getting that kind of comparison quickly into that without
21 forcing people to know exactly what the rate might be. So
22 in that sense it could serve considerable public purpose

1 because people do understand ratios of more or less than
2 one. So I commend it.

3 I'm sure you'll get a lot of comments, not just
4 from myself but others, as to which ones should go into it.
5 But I think, especially in the first two categories, those
6 are all, I think, by and large pretty consequential ones
7 that will withstand further scrutiny.

8 MS. CHENG: Just real quickly to one of Ralph's
9 points, because Jack and Anne and the whole team that's been
10 working on this, we've been asking ourselves. The reason we
11 have two mortality measures for most of these events is
12 because we measure it once in the hospital and then once 30-
13 day. We've been wondering if that's double counting or if,
14 as you suggested, there really are differences in hospitals'
15 decisions to retain a patient or to send them home or to
16 another setting that it's fair to use both of those.

17 MR. MULLER: You really need the 30-day.
18 Obviously we've dealt with this in the past in other
19 settings. You start having border issues about what
20 information gets reported by what states. For example,
21 being in a state that's right on a border, many of our
22 patients are from New Jersey and they don't report the 30-

1 day numbers to Pennsylvania. So you have 40 percent of your
2 patient base taken out of the denominator but they're still
3 in the numerator.

4 Those kind of things always make life a little bit
5 more complicated when you start getting --

6 DR. REISCHAUER: The Soprano effect?

7 MR. MULLER: Yes. Roseanne Rosannadanna.

8 [Laughter.]

9 MR. SMITH: Following up a little bit on what
10 Ralph said, I think you're right about the ratios, Ralph.
11 On the other hand it's interesting. If Sheila's right and
12 mortality is 4.5 times worse than any of the safety or
13 process measures, you look at this chart and it really
14 doesn't make much difference whether you stay home or go
15 north. The ratio changes dramatically if you exclude the
16 process and safety measures. So as Ralph said, I think
17 figuring out the weights is terribly important.

18 And if some of these are appropriately weighted
19 significantly higher than the others, then the 1.6/1.7
20 disappears in a flash.

21 You ended, Sharon, by saying what factors. It
22 strikes me we know some of them. Staffing matters, volume

1 matters, hospital type matters. And region may matter.
2 Maybe the region is not a good grouper but it's a good
3 factor and we ought to think about maybe substituting where
4 are you located rather than where are you located as a
5 grouper, but where are you located as a factor along with
6 staffing volume and hospital type as a way to see if we
7 can't come up with something that discriminates more finely.

8 MR. MULLER: You have the Dartmouth 306 groupers
9 and one could go in that direction and some of the RAND
10 people have done work off that, too. So I think once you
11 have the database you can start figuring out -- you can look
12 at states, you can look ta counties, you can look at the 306
13 hospital regions and with computer time you can start seeing
14 which ones make more sense by displaying it that way.

15 DR. MILSTEIN: A couple of comments. Since we're
16 building something now for the future one of the things we
17 may want to think about is integrating into our scorecard
18 that measures flow that we can now count on based on what
19 the Deficit Reduction Act has required. For example, the
20 Deficit Reduction Act requires, I don't know whether it's
21 2008 or 2009, but for hospitals to report their status on
22 three relatively highly important safety, of the NQF safe

1 practices. Are they present or not?

2 So if we're building a scorecard now for something
3 for implementation in the future, we could begin now holding
4 space available for those measures that we know are going to
5 flow based on the Deficit Reduction Act.

6 Let me make another point and then finish with a
7 question. The issue of weighting in the relative disutility
8 or whatever you want to call it, different bad outcomes,
9 there has been a fair amount of work in that area and there
10 is research at Wharton that's already been published on
11 weighting of relative types of complications, including how
12 much you weight death versus a non-serious versus serious
13 complication that's already been published. Robert Kaplan
14 at UCLA, who has been one of the leading thinkers in this
15 so-called Quality Adjusted Life Year, has also done research
16 in the acute area.

17 Let me close with a question and that is if I
18 remember the AHRQ specifications, especially with respect to
19 the safety measures, because those are based on
20 complications and whether or not hospitals are -- hospitals
21 have been shown to vary quite a bit on their inclination to
22 code complications. I remember when AHRQ came out with that

1 list of so-called patient safety indicators. They came with
2 a warning label that basically said in order to be able to
3 use this you have to make sure that a given state's level of
4 discipline and monitoring and management of hospital
5 discharge data reporting is up to a certain level.

6 And so maybe I'm just asking you to elaborate on
7 your earlier comment that these so-called safety measures,
8 which at the end of the day are complication measures, are
9 clean and reliable and we don't have to worry. None of the
10 measures have to be all that good but the basis on which you
11 feel they are good enough. Maybe you could elaborate.

12 MS. CHENG: You're absolutely right and I think
13 that would be something that -- we picked two regions
14 because it seemed like a way to group hospitals that we
15 could sort of get our heads around. And I think that to
16 take AHRQ's caveat, you wouldn't want to have tried to do
17 this with Louisiana versus Massachusetts because you know
18 that there's going to probably be consistent differences in
19 coding between those two states.

20 I blew it up to a region, there may very well be
21 regional differences as well but I was hoping at least by
22 putting several states together you might want to look

1 behind this and see the comparative rate of coded
2 complications versus the known health of the population or
3 something like that to get a feel for whether you're
4 measuring coding differences here or complication
5 differences.

6 DR. MILLER: To get more comfortable with it, as
7 you churn through looking at these things if you're finding
8 that specific measures or collections of measures, the
9 safety category, just seems to move all over the place each
10 time you move to a different level of aggregation. That
11 might tell you maybe that one's not a good one to work with
12 or to put very much weight on it or something like that. I
13 think some of that can fall out from the data analysis. You
14 put the categories together, you can look at how it runs
15 across the data. If you're getting very different result it
16 may tell you that.

17 DR. SCANLON: This, in some ways, is reminiscent
18 of the development of DRGs. When we were developing DRGs
19 the goal was to explain something, the costs per admission.
20 And statistics were applied but they were done in a
21 constraint way. It had to be done with an outcome that was
22 going to be understandable to clinicians and that there was

1 kind of agreement that this made sense. You had to be able
2 to sell it.

3 This is similar in that statistics might help you.
4 It's handicapped because there is no dependent variable.
5 You don't have costs. Well, we want to measure quality.
6 There is no single quality metric. We're actually looking
7 for something that's akin to that.

8 But we may think about going through the same
9 process, which would be to think about statistical methods
10 that might help us summarize the variation that we see in
11 these 34 variables. Or let's say that we get better
12 measures and we have 64 variables.

13 There's a question of how many of those variables
14 are redundant? When you're talking about differences in
15 hospitals that certain things just move together and that
16 you really only need to focus on a core set of five or 10.
17 That will give you sort of a much more manageable problem
18 because it won't solve the weighting problem for you because
19 the weighting problem which involves values is something
20 that you're going to have to confront. But it's a whole lot
21 easier to think about that if you're dealing with this
22 relatively small set than if you are with the 34 you've got

1 today or the much bigger number you're going to have
2 tomorrow.

3 And that's going to, I think, help increase your
4 confidence about applying this at the individual hospital
5 level when you can talk about -- you can understand the
6 relationships among these things and you can see that things
7 move together and that there's no need to measure all of
8 them, you only need to measure a certain number of them.

9 MR. HACKBARTH: Has there been any research on the
10 correlation among the quality measures? I think I heard
11 something about that.

12 DR. MILSTEIN: There is research that's relevant
13 but it suggests that intrahospital correlation of quality
14 measures is not a good validator because the overwhelming
15 evidence is that hospital performance varies substantially
16 by service line. can be some service lines in a hospital
17 that are excellent and others that are quite subpar.

18 DR. SCANLON: But it may be that you can get to a
19 more parsimonious set than the 64 or whatever we're going to
20 ultimately end up with.

21 DR. WOLTER: As I looked at this there's very few
22 institutions in the country that would have 10,000

1 discharges and if we're looking at failures per 10,000
2 discharges, what really struck me about this would be the
3 importance of linking the process measures that we require
4 for hospitals with this kind of information because to me
5 the idea would be if more hospitals get to 100 percent in
6 terms of implementing evidence-based protocols that deliver
7 those process measures over time we ought to see in these
8 rolled up measures here improvements on a regional basis.

9 And so I think there could be important linkages
10 of this to the individual institutional process measure
11 reporting. But it's going to be hard to take this down to
12 the individual institutional level. If you only have 300
13 discharges for bypass surgery, one or two cases just changes
14 everything.

15 So I think it's going to be important to think
16 about the linkages between what we require at the individual
17 institutional level and data like this.

18 And then I always keep wondering when we have
19 these reports to look at where are we headed in terms of the
20 overall coordination of what is decided should be looked at
21 for hospitals or physicians or whatever? And what should be
22 requested of them? IOM, I know, Alan, you and Bob are on

1 committees looking at reporting. Were looking at report.
2 And I haven't yet got in my mind the picture of how this is
3 unfolding so that at some point in time we have some sense
4 of who's going to coordinate this and make it a little
5 clearer to providers how the decisions will be made and how
6 the adjustments will be made as the evidence changes, et
7 cetera.

8 I don't know if that's an issue for us or not.

9 MR. HACKBARTH: It is an issue that we have
10 flagged at various times in our chapters on pay for
11 performance. We've said that we think that the process
12 needs to be, among other things, streamlined and providers
13 need to get some consistency in the measures used so that
14 they are not overly burdened, and so that we have the
15 maximum impact on their behavior. If their efforts are
16 being diffused in all different directions we're less likely
17 to get the sort of progress that we would like.

18 The IOM, in the first of their reports, has made
19 some pretty specific proposals about how we might achieve
20 some of those goals. When we come back to P4P in the
21 future, I would be open to looking at those recommendations
22 and seeing if we want to explicitly add our support to that

1 approach. I think it's a critical issue for the future of
2 pay for performance.

3 MR. MULLER: I echo Bill's comments about these
4 measures really have to be salient in terms of really
5 describing the differences in these places. A lot of them,
6 as you say, are correlated so they really don't make much
7 difference. That's point one.

8 Secondly, there's obviously a great temptation to
9 use measures that one can get off the claims database
10 because we have it. Some of the ones that Arnie mentioned
11 are not available in the claims database, so they're very
12 hard to get it. They have a lot of persuasive power but
13 there's no way of getting them into your analysis in any
14 kind of comprehensive way.

15 So I think one of the things that we may want to
16 speak to and that we've spoken to earlier in the day is to
17 what extent are we willing to go with measures that aren't
18 as good as possible because you can get them off of the
19 claims database. And this argument about administrative
20 claims database has been going on for 30 or 40 years, so
21 it's not so they we're talking about just today. But
22 there's a reason why people keep going back to those

1 databases, because you can get them.

2 At the same time, if you start making profound
3 judgments about the quality of care in a hospital and a
4 doctor's office based on them, understanding they may only
5 get you 60 percent of the way there, then people are going
6 to have real problems with it. So I think making judgments,
7 you can get good descriptive data on physician practices and
8 hospitals, maybe not at the division of a small grouping by
9 the claims database. You can get even better information
10 from medical records and other kinds of case descriptive
11 information but you can't update it and get it in any kind
12 of consistent way.

13 So I think speaking to that over the course of our
14 work would be -- is claims database good enough in terms of
15 what we're trying to get it? And also the question of
16 saliency, I think, is a very important one as well.

17 And also Nick, I would say in terms of the volume
18 I hope we don't get immediately into kind of measuring this
19 year by year in a kind of a payment system and so forth,
20 because obviously things don't change in most of these
21 settings that quickly. So one can aggregate over a longer
22 period of time and obviously have bigger samples by looking

1 at this two or three years at a time. Very few things
2 change that quickly. So one can get a three-year rolling
3 average of some of this data and that perhaps get your
4 sample size up a little bit more.

5 But those are the kind of things I think we can
6 keep going, but I think basically trying to put this into
7 categories that allow this discussion to go forth in a way
8 that we can get more agreement, because I do agree that
9 there's just too many measures out there, it's too
10 confusing, and we are not advancing as quickly as I thought
11 we would in terms of agreeing on what are the measures that
12 really make a difference in terms of the quality of outcome.

13 DR. KANE: I was just going to mention that
14 financial data is produced like this all of the time and we
15 might learn a few things from it. One thing that helps when
16 you're looking at financial data, financial ratios, et
17 cetera. One is to say how many hospitals are contributing
18 to that measure. For instance, you say South Central, but
19 if there's only five hospitals that are producing that
20 measure it would be helpful to know that.

21 Also it would be helpful to the distribution
22 overall of the ratios across the region. So you're showing

1 the average but are they skewed? How skewed is the
2 distribution of values?

3 I guess the other thing in financial measures
4 that's really useful for a benchmark is to show not
5 necessarily one region next to the other, but to maybe take
6 the best quartile and show everybody next to the best
7 quartile for a benchmark. So that ratio isn't Massachusetts
8 to Louisiana or New England to South Central, but it is
9 everybody else to the best quartile. Or if you eventually
10 are going to get down to the hospital level, that hospital
11 up against the best quartile.

12 And then finally, for how to weight these, I agree
13 with Arnie that I think there are ways that you can weight
14 these that relate somewhat to the amount of damage they
15 actually do either in QALYs or death being obviously the
16 worst.

17 But another one is the likelihood that it will
18 occur. Because some of these have a 0.00001 percent
19 likelihood of occurring, and others have much higher
20 likelihood of occurring. And maybe the ones that are more
21 likely to occur are the ones we'd rather -- once you get
22 past death, which is obviously not a great one to have occur

1 -- would be the ones you'd want to focus on.

2 I would agree that we should definitely look into
3 weighting them in some way other than just smoking cessation
4 is the same thing as a puncture of your lung.

5 MS. CHENG: We certainly can try that. Right off
6 the top of our heads we didn't go to incidents. We can only
7 see the full-size numbers on safety. But keep in mind the
8 ones that are going to happen the most often are the process
9 measures. And so you'd be giving a great deal of weight to
10 aspirin and very little weight to mortality.

11 DR. KANE: I'm inclined to keep those three
12 categories overall separate anyway, and then go into the
13 frequency with which they occur because I think you really
14 are mixing apples and oranges. That's like trying to mix a
15 profitability index with a solvency -- I think you just get
16 garbage.

17 Even Bill Cleverly stopped trying to do that after
18 a while.

19 MS. HANSEN: Actually, just to think about adding
20 -- it's not probably appropriate but I'll bring it up
21 because Dave, I'll tag onto a comment you made about
22 staffing, whether there's a structural measure here about

1 what the stabbing is like, what its retention is, what its
2 perhaps potential use of temporary types of staff. That
3 component.

4 I know in some states the whole ratio of staffing
5 has become a factor of safety.

6 And then going back to safety, and it may be that
7 these are some of the areas that Ralph had said are tough to
8 measure because we don't have them. The frequency issued
9 that, Nancy, you just brought up about medication errors
10 that lead to untoward events like death or falls that lead
11 to hip fractures or death or failure to rescue. These are
12 some areas that seem to be pretty significant in terms of
13 the safety aspects of hospitals right now.

14 So again, it doesn't help because I'm offering
15 some other ways to think about it, but eventually how to
16 ferret down to the most salient elements, including the
17 structural components of the hospital.

18 MS. CHENG: Just by the way, failure to rescue is
19 actually in the set. And we tried hip fracture, and we can
20 put that back in, but that was one of the measures we could
21 get a sufficient sample size. But the good news is it
22 happens so infrequently that it's even a smaller rate per

1 10,000 discharges. If that's an important one, we can put
2 it back in.

3 MS. HANSEN: No, I would value your analysis on it
4 if it is that infrequent.

5 MR. HACKBARTH: Okay, when you're finished
6 writing, Sharon, you can put on your home health hat and
7 proceed with home health measures.

8 * MS. CHENG: This afternoon Sarah Friedman and I
9 are going to launch a new topic for you, and these are
10 process measures for care delivered in home health.

11 We don't anticipate doing a presentation in front
12 of you again on this topic before we write this chapter for
13 the June report. So that's a little bit of a heads up. We
14 would like to get your comments on this material now so that
15 we can incorporate that in the draft of the material that's
16 going into the June report.

17 In this presentation, what we're going to do
18 together here is discuss the need to evolve the quality
19 measure set for home health. We're going to talk to you
20 about the first step that we've taken on that path, which
21 was our work to gather best practices in two areas of home
22 health.

1 And then finally we're going to talk about the
2 next step in moving from best practice as a concept to
3 process measurement.

4 The focused our work on two areas, fall prevention
5 practices and wound care practices. We did that for about
6 three reasons. We looked at the expert consensus in the
7 literature on home health and there was a lot of a sense
8 behind the importance of both of these practices in home
9 health among the experts.

10 We also found that there was a consensus that this
11 is a pretty important part of the home health as a benefit,
12 keeping patients safety at home is really central to the
13 mission and what we're trying to achieve with home health.

14 And finally, they have the advantage of being
15 applicable to pretty much every patient that's being cared
16 for in the home health sending. That gives them an
17 advantage over the measures that we have now. I'm going to
18 go this in a second, but in five seconds, the measures we
19 have now only apply to patients who have a potential for
20 functional improvement. And that's a subset, and it leaves
21 out a chronic care population, people who are trying to be
22 maintained at home so they can avoid a nursing home or

1 another care institution. And we had a sense early on in
2 this process, we wanted to get some measures that reflected
3 the quality of care for those folks, and they were by and
4 large being left out by the outcome measure sets that we
5 had.

6 So why add process measures? We've said a couple
7 of times, in fact we just hit on this a moment ago, quality
8 measurement should not be a static thing. It should evolve
9 as more measures become available, as we can reach for
10 different concepts. So this has been a goal that we've had
11 as we started off measuring quality in home health.

12 The Commission established an agenda to do so in
13 2003 and we were starting to contemplate pay for performance
14 across the Medicare program. And then in 2005 we said
15 specifically that home health was a setting where we thought
16 we were ready to start thinking about implementing pay for
17 performance.

18 We made that decision based on our assessment of
19 the starter set that was available in 2005. It's still
20 available now. And those were largely outcome measures. We
21 said at the time that we had a goal to evolve the set, had a
22 good place to start, but let's see what else we can reach

1 for. And process measures were one of the areas that we
2 identified now a year or so ago as someplace that we wanted
3 to go with this setting.

4 So process measures would allow us to hit a couple
5 of these goals. First off, it would allow us to broaden the
6 quality of measurement. We'd be able to add patients that
7 are getting care that is not likely to lead to their
8 functional improvement but could reflect the quality of the
9 home health efforts to keep them safely at home and to care
10 for wounds that they might have.

11 We and the NQF, at looking at the outcome
12 measurement sets, said that we would like to evolve the set
13 to measures that applied to more patients. We also wanted
14 to be able to move from the concept of clinical
15 effectiveness, which is really where our outcomes were
16 geared toward, and see if we couldn't reach into safety,
17 which is another important kind of quality that's been
18 identified by the IOM as one of the six types of quality.
19 So we wanted to see if we could broaden into another type of
20 quality in our next generation.

21 There's another sort of intuitive appeal. Process
22 measures are a very distinct, very practical tool that says

1 to get a better outcome for the patients that you care
2 about, that you are caring for, here's a really great
3 evidence-based thing to do. So the outcome measures have
4 the benefit of setting a goal. We would like to see more
5 people have less limitations due to shortness of breath and
6 a process measure can say to all the providers in the
7 Medicare program here's a tool, here's a clinical practice
8 that we think will get you closer to that goal. So they
9 have an intuitive appeal as well.

10 By developing process measures, you're encouraging
11 the diffusion of evidence-based practice. One of the issues
12 that we've talked about a number of times for home health is
13 that there's a wide variation in the practice of home
14 health. One of the members of our panel said quite
15 pointedly she's in a national Organization and she routinely
16 sees the same kind of patient in different parts of the
17 country getting very different care. So to the extent that
18 you could develop process measures and you could say this is
19 a good clinical practice, what it might have the benefit of
20 doing is pulling together some of that variation that is the
21 result of deviation from evidence-based practice. I think
22 that would be a good step forward in home health.

1 And finally, this is a broader goal that we have
2 for quality measurement, but it is a tool to encourage
3 better information systems. The Commission has identified
4 quality reporting and attaching it to a pay for performance
5 system as a way to incentive the development of better
6 information tools. Collecting, managing and reporting on
7 the content of home health visits, which might be one of the
8 steps towards getting process measures, would require a
9 higher level of information, technology information system,
10 than most agencies are currently operating.

11 So by contemplating process measures in a pay for
12 performance system what you're talking about is putting an
13 incentive behind information innovations like putting point
14 of care computers in the hands of nurses. You're
15 contemplating having a system that takes evidence-based
16 pathways and embedding it right in there in the assessment
17 activity that the nurse is doing for each one of these
18 patients. You're talking about putting an incentive behind
19 maybe using telemonitoring to automate the regular
20 collection of vital signs.

21 So all of those together I think make an argument
22 for why we think it would be a good idea to reach for

1 process measures for home health as a setting.

2 So to start us on that path what we've done is
3 convene a home health best practices panel. It had two
4 parts. One was a group of people that met here in D.C.
5 around a table and gave us their input. We also had a
6 review group of a similar set of experts that helped us get
7 more out of the results of our panel discussion group.

8 Both of these groups included nurses, academics
9 and many people that have a long experience with home
10 health. We had representatives of both for-profit and not-
11 for-profit home health providers. And we had voices of both
12 large and small agencies to give us input about these
13 practices. The quality measurement experts included a
14 member of a national measurement group, a representative of
15 CMS, and a representative of a national quality
16 accreditation organization.

17 So we got a good group of people together and we
18 put several questions in front of them. On the screen is a
19 list of the questions that they answered for us. First off
20 we wanted to know what's the evidence behind the best
21 practices that we were asking them to describe? We were
22 after two things here. One, very technically, what is the

1 evidence base that links doing this practice to a measurable
2 improvement in outcomes? And the second one was we wanted
3 to at least hear some stories about a successful
4 implementation of this practice in the field, that agencies
5 that were maybe a little ahead of the curve have tried this
6 and it's worked for them in their agencies and they've seen
7 measurable improvements in their outcomes.

8 Second, we asked them about the impact of the
9 diffusion. He wanted to make sure we were focused on high
10 impact practices.

11 And the last one was to get a sense from them
12 about what kind of data would be needed. We weren't at the
13 data point yet but we wanted to see if we could sort of
14 steer them towards things that could be collected without an
15 undue data burden.

16 So the panelists in the first area of focus shared
17 with us these fall prevention practices. One that they were
18 very passionate about was the use of a standard multifactor
19 fall risk assessment tool. It should include things like
20 the patient's detailed fall history, which is a very good
21 predictor of their ability to remain safely at home without
22 a fall and a medication inventory because they could look at

1 medications that are known to increase the likelihood of a
2 patient falling at home.

3 The second one that they discussed was the use of
4 validated techniques to measure that patient's fall risk.
5 Panelists felt that some of the assessments that were going
6 on today had kind of devolved into a bit of a check box
7 exercise and they felt that there were validated strong
8 evidence-based tools that you could use so that you got a
9 really good sense of this particular patient's risk of fall.

10 One that was measuring postural hypotension. The
11 idea here is that you measure somebody's blood pressure and
12 you see if it changes significantly when they're standing.
13 It's a very good predictor of their risk of falling.

14 Another one was to ask patients who are able to
15 stand on one foot for 10 seconds. This did two things.
16 One, it allowed the nurse in the home to directly observe
17 the patient's balance or any balance deficits. And the
18 panelists also told us that this had a very good halo effect
19 that it allowed the patient to really understand what their
20 balance deficit was and to understand the importance of
21 trying to work to alleviate that to the extent possible. So
22 it got some good patient engagement and buy-in in the

1 process.

2 The final one was to link the assessment tool to
3 appropriate follow-up, to put that appropriate follow-up
4 right in with the same activity when the nurse is assessing
5 that fall risk. That practice was based on a national study
6 group convened gold star agencies and was talking to them.
7 What makes your outcomes consistently beat the national
8 average? And they found consistently that those gold star
9 agencies were embedding the practices right in their
10 assessments.

11 As we alluded to earlier, we asked them to look at
12 fall prevention and they conceded that this is a very
13 important area for improvement. This is a place where we
14 could do a lot better for many patients at many agencies.
15 Falls are a common cause of re-hospitalization among home
16 health beneficiaries and some research suggests that falls
17 not only can lead directly to an injury that's caused by the
18 patient falling but they can also be the trigger for a
19 really detrimental cascade when the patient decides that
20 they're going to self-limit activity and then they might be
21 exacerbating underlying chronic conditions.

22 And so it's a place where we felt that we needed

1 to look and the panel felt that way as well.

2 The panel's practices that they brought to us we
3 found to be consistent with a comprehensive meta-analysis
4 that included 62 different clinical trials, randomized
5 controlled trials, of these practices and involved over
6 21,000 elderly adults. Many panelists also reported that
7 they had had success with implementing these practices in
8 the field. And some of our panelists felt that a prevention
9 process measure would be better than an outcome measure.

10 The reasons that they gave to us on the panel was
11 that measuring falls as an outcome relies a great deal on
12 patient self-report which might not be reliably calibrated.
13 And also, it was difficult for some agencies to really
14 concede that a fall that happened on a Wednesday when their
15 nurse hadn't been there all week could really be directly
16 attributed to the quality of their fall prevention
17 practices. So they wanted to reach to these fall prevention
18 practices maybe as a better way to get at this concept.

19 With that, that's on our fall prevention. I'm now
20 going to switch to Sarah Friedman and she's going to share
21 with you our panel's results on wound care.

22 MS. FRIEDMAN: Here the panel has identified

1 several areas of practices where wound care can be improved.
2 First, panel participants stressed the need for standardized
3 wound assessment. This includes a regular head to toe
4 assessment where nurses identify, count and state venous and
5 pressure wounds. Surgical wounds should also be monitored
6 regularly.

7 Panelists also recommended keeping updated images
8 of wounds in the patient's record to supplement the medical
9 record. The agencies represented on the panel use a variety
10 of assessment tools and agree that a comprehensive tool
11 should investigate the location, size, drainage, and margin
12 of the wound, as well as inspect for signs of wound
13 infection.

14 The next practices are ones that are triggered by
15 the presence of wounds identified in the assessment. If a
16 patient has a pressure wound, the following steps may be
17 appropriate. Offload the wounded to relieve pressure from
18 the wound area, turn the patient and instruct the regular
19 caregivers to turn the patient on a turning schedule.

20 If a patient has any kind of wound, the nurse
21 should implement an appropriate infection control strategy
22 as well as educate the regular caregivers about infection

1 control. If a patient's wound requires treating the wound
2 bed, the nurse should use a standardized wound bed
3 preparation technique.

4 Finally, the panelists discussed the need for
5 protocols on physician communication. If the wound does not
6 respond within two weeks or shows signs of infection, the
7 home health nurse should contact the patient's physician.

8 The next slide will explain how process measures
9 based on these practices achieve the goals for process
10 measures presented earlier in the presentation.

11 Measuring these processes would broaden the scope
12 of current quality measure sets. Because the wounds
13 compromise the safety of all home health patients, the
14 panelists believe that regular head to toe assessments would
15 benefit all patients, regardless of their diagnosis or
16 potential for functional improvement. This is the rationale
17 given by the panelists for giving all home health patients
18 an initial wound assessment to be followed by the
19 appropriate link to care.

20 As discussed earlier, another goal of process
21 measures is to measure an action over which the provider has
22 direct control. These actions should be specific tools that

1 home health agencies can use to improve outcomes. The fact
2 that all of the practices discussed above are currently in
3 use at home health agencies represented on the panel
4 suggests that these are such tools.

5 Panelists indicated that measuring use of
6 standardized protocols for wound care treatment would reduce
7 the variation in care provided by home health agencies.
8 Analysts believe that one reason for current high variation
9 is that some doctors routinely prescribed outdated wound
10 care treatment rather than treatment based on current
11 evidence. One example familiar to panelists is preparation
12 of the wound bed. The use of a wet-to-dry wound dressing
13 technique is frequently prescribed by doctors even though
14 evidence and nurses' experience suggests that in some cases
15 it is preferable to keep the wound bed moist.

16 Measuring home health agencies use of evidence-
17 based treatment protocols should reduce the variation that
18 this causes as well as encourage the agencies to engage
19 physicians in a broader examination of best practices.

20 Sharon will now continue the discussion of next
21 steps for turning these practices into process measures.

22 MS. CHENG: There's yet one more step that you

1 have to take in getting from what is a best practice to what
2 can be applied as a process measure. You have to define
3 specifically the patient population to which this practice
4 applies. You have to describe very precisely what time and
5 how often it should occur, a very specific definition of the
6 practice itself and if there are any exemptions for patients
7 who should not receive this care.

8 The process measure, as you put it together then,
9 could be tested against the Commission's criteria for good
10 measures. Is it reliably specified? Is it a valid
11 indicator of good practice? And would it require unduly
12 burdensome data collection?

13 CMS right now is in the midst of a contract to do
14 some similar work and they are developing condition-specific
15 process measures. They have a contract with the University
16 of Colorado and what they're doing is looking at best
17 practices and process measures for practices that are
18 related to such things as a care for a diabetic patient or
19 the care for a patient with chronic obstructive pulmonary
20 disease.

21 The next steps that we see would be to look at the
22 feasibility of taking some of the best practices that our

1 panelists identified and translating them into process
2 measures.

3 With that, we'd like your input on the process
4 that we are under and this as a potential chapter for the
5 June report.

6 DR. NELSON: I really don't want to sound like a
7 wet blanket, and I'm aware of the fact that we asked for
8 this, but in my five-and-a-half year experience with MedPAC,
9 we haven't gotten into the business of developing process
10 measures or practice guidelines. And it's the kind of thing
11 that I'd like to see AHRQ do, or CMS do, or the home health
12 community themselves do it.

13 It seems to me that what we would want to focus on
14 is the application of performance measures when they were
15 developed by somebody else with respect to how are the data
16 collected? What is the burden in terms of documenting all
17 of this? And what is the linkage with payment policy?

18 So I think what you've done is great. I
19 personally think they're great measures. But I'm timid
20 about adding, about publishing something that lays an
21 additional documentation burden on the folks that are
22 already coping with OASIS when I'm not so sure that it's

1 been validated or pilot tested or going through the other
2 kinds of things that the National Quality Forum and others
3 do before they put their stamp of approval on it.

4 DR. SCANLON: I could respond to Alan by saying
5 that you can take it in the context that the chapter, as
6 written, identifies the need for going beyond the measures
7 that represent improvement, recovery, et cetera, because
8 there are other types of home health patients. It was an
9 outside process. Maybe it's a recommendation in the text,
10 and not a bold-faced one, is that some other group continue
11 to look at process measures because they recognize that
12 there is variation in terms of home health patients.

13 I'm disappointed, though, from a different context
14 which is the perspective of our discussions when we talk
15 about the adequacy of payment and we look at the
16 distribution of margins and we see they go from zero to 40
17 or 50 percent, I say we don't understand the home health
18 benefit. And this panel, though that wasn't their charge,
19 they could have come back with information in terms of a
20 richness of process measures, a richness of quality measures
21 that would have told us a lot about the home health benefit,
22 but they didn't.

1 I come away from this still concerned that it's
2 about the recovery, the rehabilitation patient. It's about
3 skilled services. The role of the aide is still a complete
4 back black box and certainly part of the margin variation is
5 the fact that the aides have really diminished in terms of
6 the frequency of their services. And probably there's great
7 variation across agencies in terms of their services.

8 So I'm concerned that while we talk about pay for
9 performance at the margin, we've got this fundamental
10 problem about the base payment that we don't understand what
11 we're buying. And when there's a 40 percent margin I don't
12 think of it as all efficiency. I think that we have to ask
13 ourselves what did we get? And should we be doing a whole
14 lot better in terms of describing what we want and then
15 being able to measure whether we got it?

16 MS. CHENG: I think this is a critical part for
17 the tone of this work. We didn't ask the panelists to tell
18 us all of the practices that were going on in home health
19 and we specifically asked them about falls and about wounds.
20 So this is not the universe of good practice and of benefit
21 that the home health service can deliver.

22 This was done against two backdrops. We do have

1 outcomes that are looking at functional improvement, which
2 is also an important part of the benefit. We were aware of
3 work that CMS was doing about the care of diabetics, about
4 the care of patients with COPD, and my sense was the best
5 way to use our resources was to not duplicate that work.

6 So this is really important for tone and I really
7 don't want to put these out suggesting that this is what we
8 think is the breadth of the scope of what the home health
9 benefit is about. It's just two places that are important
10 that we found best practices in.

11 And so I'll make sure that's a critical part of
12 the chapter.

13 DR. MILLER: I just want to reinforce that because
14 if you're upset about that -- not upset, wrong word -- we
15 have to take responsibility for that because we directed and
16 tried to focus the group.

17 But that's not to dispute your point. Your point
18 is well taken. There is still a broad misunderstanding of
19 what's going on in the product. So I don't want to miss the
20 point for the tone issue.

21 I also want to say, on Alan's point, just so
22 everybody tracks on how we could proceed here as a

1 commission, one way to look it what Sharon has done so far
2 is to say look, we've pulled these experts together, we've
3 looked at these two areas, they agreed they were important,
4 they helped us talk about how to specify. And we've
5 actually taken this a certain distance and could say this is
6 important for someone else to go and now make the linkage
7 between practices to process and then, depending on that
8 outcome, we could come back in behind it and say yes, now
9 make this part of the pay for performance or not if it
10 doesn't happen.

11 I think the question on the table, and you've been
12 very clear on your opinion of it, is -- because I don't
13 think Sharon is saying she would put these measures,
14 recommend using these as they stand. These have to go to a
15 process like an NQF-type of process. It's whether someone
16 else does it or would we, as a commission, contract and take
17 it through that process. I think that was the question on
18 the table.

19 And I think I hear your answer to that. That's
20 not our business. We should kick that to someone else.

21 MR. HACKBARTH: Others?

22 Good job, Sarah, Sharon.

1 Last for today, certainly not least, is clinical
2 lab services.

3 * MS. KELLEY: In previous sessions Ariel and I have
4 discussed concerns that Medicare is not paying accurately
5 for clinical lab services. When we talk about inaccuracy
6 here, we mean with regard to relative prices. Medicare's
7 payment rates were initially set separately in each of 56
8 carrier markets based on what local labs charged in 1983.

9 It was thought at the time that charges were
10 substantially higher than costs, so the fee schedule rate
11 for each carrier was set at 62 percent of prevailing charges
12 for hospital-based labs and 60 percent of charges for
13 independent and physician office labs. 20 years later it
14 would be surprising if relative payments were accurate.

15 This is especially true given that the method for
16 determining payments for new services is likely to generate
17 inaccurate rates.

18 Improving Medicare's payment methodology is
19 important because uses of services is growing. The clinical
20 lab benefit has grown an average of 9 percent per year since
21 1999, reaching almost \$6 billion in 2004. This is despite
22 the fact that payments have been updated only once during

1 that time period.

2 We can expect the rise in volume and complexity to
3 continue in future years as the range of lab tests expands
4 and as innovations and equipment and techniques make some
5 testing more efficient and automated. The growing
6 prevalence of clinical practice guidelines and advances in
7 medical knowledge will also boost the use of screening and
8 monitoring tests, as will the implementation of pay for
9 performance programs.

10 The challenge for Medicare will be to improve its
11 payments without cost data. CMS has had some success in
12 overcoming that obstacle in developing payment systems for
13 other providers, namely the RBRVS for physicians and
14 competitive bidding for durable medical equipment suppliers.
15 Both methods could be considered for lab services.

16 But encouraging efficient use of tests through
17 payment mechanisms will be more difficult. Many lab tests
18 that are important for preventing and treating disease are
19 underused. But at the same time there's evidence that
20 greater use of tests does not lead to improved outcomes at
21 the population level. This lack of relationship raises
22 questions about whether every lab test is of value to

1 Medicare beneficiaries and to the program. Ariel will talk
2 more about that in a moment. But one thing to consider as
3 we think about improving the payment system for lab services
4 is that tests are ordered by physicians. So labs themselves
5 can do little to control volume.

6 Bundling certain physician or hospital outpatient
7 services with associated lab tests could help control the
8 volume of some tests but this approach may not be broadly
9 applicable. And at any rate, limiting growth across the
10 board in the use of lab services would not be desirable,
11 given the fact, as I said, that experts believe many
12 screening and monitoring tests are underused.

13 A final issue is the fact that no coinsurance is
14 required for lab services.

15 So Ariel and I are going to briefly review
16 information about labs and the services they provided and
17 then we'll discuss some options for improving the accuracy
18 of Medicare's payments.

19 You've seen part of this slide before. Lab
20 services are furnished, as you know, by labs in hospitals
21 and physician offices, as well as independent labs. And
22 then there are institutions such as nursing facilities,

1 dialysis facilities, that also have labs and they're
2 included in that other category.

3 Frequently those services are covered under other
4 Medicare benefits. As of August 2005, there were more than
5 192,000 labs in the U.S. and that number has grown on
6 average about 2 percent per year over the last decade.

7 As you can see here, physician office labs account
8 for about half of all labs but they furnish a much smaller
9 proportion of ambulatory lab services paid under the lab fee
10 schedule, about 17 percent. By comparison, hospital-based
11 labs furnish about half of all ambulatory lab tests and
12 independent labs furnish about 31 percent.

13 It's important to note that relatively few labs,
14 even in hospitals, perform all types of tests. Most labs
15 conduct some subset of test in-house and send out other
16 tests to labs called reference labs, which provide a broader
17 range of tests.

18 Although there are over 1000 items on Medicare's
19 lab fee schedule, the volume of tests is fairly concentrated
20 with the top 10 tests accounting for 38 percent of total
21 volume and 45 percent of total payments. Venipuncture
22 accounts for an additional 18 percent of volume under the

1 fee schedule and an additional 6 percent of payments. So 11
2 tests and services account for about half of all payments.

3 The tests on this slide with asterisks grew more
4 than 10 percent between 2001 and 2003, with complete blood
5 count growing at a rate of about 25 percent per year.

6 MR. WINTER: As we noted in December, many of the
7 rapidly growing lab tests are recommended by clinical
8 guidelines. For example, complete blood count tests and
9 potassium tests are recommended at certain intervals for
10 patients with congestive heart failure.

11 A study by researchers at RAND which was published
12 in the New England Journal of Medicine a few years ago found
13 that many recommended tests are underused. For example,
14 only 34 percent of patients newly diagnosed with heart
15 failure received a CBC test within the recommended time
16 frame and only 24 percent of diabetics received hemoglobin
17 tests as recommended.

18 On the other hand, there's evidence which we'll
19 discuss on the next slide that regions that provide more lab
20 tests do not have better outcomes. There's a tension
21 between these two findings that may merit further
22 exploration.

1 Researchers at Dartmouth Medical School co-
2 authored a study three years ago that found that geographic
3 regions that provide more health services overall do not
4 provide better quality care or have better outcomes. At our
5 request, two of the researchers, Eliot Fisher and Daniel
6 Gottlieb, modified their analysis to look at whether areas
7 providing more lab tests in general have improved outcomes.
8 They used the same data and methodology as the original
9 study.

10 First they ranked over 300 hospital referral
11 regions by their intensity of outpatient lab testing, and
12 intensity is based on per capita Medicare spending on
13 outpatient tests standardized for geographic differences in
14 payment rates. Their models adjusted for differences in
15 demographic characteristics, patient comorbidities and other
16 factors.

17 First, they looked at whether areas that provide
18 more tests have greater long-term survival and fewer
19 hospital readmissions for three cohorts of beneficiaries:
20 patients with heart attacks, colon cancer and hip fracture.
21 They included all lab tests, not just those that are used
22 for these conditions. They found that areas with more tests

1 per capita do not have higher survival rates for
2 beneficiaries with one of these conditions.

3 In addition, greater use of tests was not
4 associated with lower rates of readmission after 90 days.
5 In fact, high use areas had higher readmission rates.

6 Second, they examined whether high use areas had
7 lower rates of hospital admissions for a representative
8 sample of beneficiaries from the Medicare Current
9 Beneficiary Survey. They found that patients in those
10 regions were actually more likely to have at least one
11 hospital admission in a one or two-year period.

12 What could explain the findings that regions using
13 many tests had more hospital stays is that both lab tests
14 and hospital admissions could be proxies for underlying
15 practice patterns. Regions with more intensive practice
16 patterns are likely to have both more tests and more
17 hospital stays. Collectively, these findings raise
18 questions about the marginal value of additional lab tests.

19 If many tests are underused, why don't areas that
20 provide a lot of tests achieve better outcomes? One
21 possible explanation is that regions providing more tests in
22 general may not necessarily provide more clinically

1 recommended tests. The original Dartmouth study published
2 three years ago suggests that regions that deliver more
3 health services overall have a mixed record when it comes to
4 providing clinically recommended tests. Patients in the
5 high health care spending areas were less likely to receive
6 Pap smear tests than patients in lower spending areas. On
7 the other hand, higher spending regions provided more PSA
8 tests, which are used to screen for prostate cancer, and
9 more lipid panel tests for diabetics.

10 Another possible explanation is that in high use
11 regions tests are being done more frequently than
12 recommended by clinical guidelines. Finally, the frequency
13 of testing is not the only thing that determines outcomes of
14 care. How physicians interpret clinical information and
15 manage their patients may be more important factors.

16 As part of our work on physician resource use,
17 which Niall and Karen discussed earlier, we'd like to
18 examine variations in the use of lab tests by physicians for
19 similar episodes. This may help shed more light on the
20 relationship between the use of tests and quality of care.

21 We could also look at whether physicians who order
22 more tests use fewer of other services. And we might

1 examine whether an episode-based payment might create
2 incentives for more efficient use of services.

3 A final thought here is that a pay for performance
4 system could reward the greater use of clinically
5 recommended tests.

6 Now we'll go back to Dana.

7 MS. KELLEY: Turning now to how to improve
8 Medicare's payment system.

9 As I mentioned before, a stumbling block to
10 setting accurate payments is the absence of provider cost
11 data and that Medicare has had some success in overcoming
12 that in some other areas, namely physician payment and
13 durable medical equipment. Using technical expertise from
14 the private sector, Medicare has established resource-based
15 relative values for physician services and relying on
16 supplier bids to approximate costs Medicare used competitive
17 pricing to set payments for durable medical equipment.

18 A regulatory approach to laboratory services would
19 involve the development of a new fee schedule based on
20 recent data on the resources needed to furnish lab tests.
21 This approach could improve Medicare's payment system by
22 better aligning payments with the resources required to

1 furnish tests. A method for establishing relative values
2 for existing and new tests and for reviewing the relative
3 values over time would need to be developed. Establishing a
4 resource-based payment system for lab services would, in
5 some ways, be far simpler than developing the physician fee
6 schedule was. Most importantly, there are about one-sixth
7 as many codes for lab services as for physician services.

8 But as you know, developing and maintaining a
9 system such as that is time consuming and costly. Indeed,
10 to keep the RBRVS up to date, CMS has had to rely heavily on
11 the American Medical Association and physician specialty
12 societies and it's not known whether the various clinical
13 lab associations would be able to undertake such a role.

14 Competitive bidding may be a more viable option.
15 This market approach is based on the theory that competition
16 among labs will result in a price for tests that more
17 closely reflects their costs than other pricing methods. To
18 implement such a program policymakers must design market and
19 bidding incentives to achieve a balance among Medicare goals
20 of access, quality, choice, equity and efficiency. A
21 bidding process that focuses solely on price, for example,
22 might compromise access and quality.

1 The MMA mandated that CMS conduct a competitive
2 bidding demonstration for lab services and CMS is now in the
3 design phase of the process.

4 The lab industry has been opposed to competitive
5 bidding. Industry organizations argue that clinical lab
6 services are complex medical services requiring significant
7 training, expertise and supervision, as compared to health
8 care equipment and supplies which are usually standard and
9 interchangeable.

10 Both the American Clinical Laboratory Association
11 and the College of American Pathologists maintain that
12 competitive bidding will compromise the quality of lab
13 services.

14 The competitive bidding design currently under
15 consideration would include all tests and services paid
16 under the clinical lab fee schedule with the exception of
17 Pap smears and colorectal cancer screening tests, which
18 Congress specifically excluded. All labs with \$100,000 or
19 more in annual Medicare lab payments in the demonstration
20 area would be required to bid. This amount would be
21 calculated for the lab company, including all affiliates.
22 This requirement would exclude most physician-owned labs

1 from mandatory participation. The demonstration will run
2 for three years in two sites, which have not yet been
3 selected.

4 The bidding process under consideration is very
5 similar to the one used for the DME demonstration. One
6 important difference is that bidders would be required to
7 bid for all services with the exception of Pap smears and
8 colorectal screening tests. By comparison, the DME demo
9 allowed bidders to bid only on selected categories of
10 products, such as enteral nutrition or urological supplies.

11 CMS considered a design that would have included
12 only the top 100 tests in the demo, but the industry was
13 opposed to that plan. Many labs feared that larger
14 reference labs would be able to underbid smaller labs by
15 offering high volume tests at cut rates, subsidizing any
16 losses with relatively high payments for more rare tests.

17 Requiring all bidders to bid on all services,
18 however, may not eliminate this potential problem. Many
19 labs will have to bid on a substantial number of services
20 that they do not provide in-house. Some labs fear that
21 reference labs still may undermine smaller labs by setting
22 high prices for smaller labs that contract with them for

1 services.

2 For the purposes of bidding, small labs could ban
3 together to create bidding consortiums, subject to review by
4 the FTC, which could allow labs to extend their test menus,
5 capacity and geographic coverage.

6 There's a lot of information on this slide. I'll
7 just hit a few highlights.

8 After suppliers submit bids, the draft design plan
9 would use a multi-step process to select the winners in each
10 area. CMS would calculate a single composite bid for each
11 lab, which would be a weighted average of a lab's prices for
12 all tests using weights based on each tests share of totally
13 expected demonstration volume. This would have the effect
14 of weighting a composite bid more favorably if the bidder
15 lowered prices for items that Medicare purchases frequently
16 rather than discounting more rare tests.

17 CMS would use the composite bids to rank each lab
18 from highest to lowest and then identify a cut-off composite
19 bid price which must be lower than the composite bid that
20 would result from current fee schedule prices. The cut-off
21 price would be determined using criteria such as capacity,
22 geographic coverage, quality, the number of winners and the

1 distribution of composite bids.

2 Bidders with composite bids less than or equal to
3 the cut-off price would be winners. Losers would receive no
4 reimbursement for Medicare tests under the demonstration.
5 Required labs that chose not to bid would also be unable to
6 receive Medicare reimbursement for lab tests.

7 CMS would then calculate a payment rate for each
8 test. Winning labs would be paid the same price for each
9 test, regardless of what they bid. Medicare's prices would
10 be set to provide winners with total revenues for all labs
11 services that were the same or greater than the revenues
12 implied by their composite bid, assuming the lab furnishes
13 the typical mix of lab services.

14 The demonstration would include structures and
15 processes to monitor quality and access. Winning labs would
16 be required to report data on six different measures of
17 turnaround time and would also be monitored on the results
18 of proficiency testing, survey inspections, log-in error
19 rates and physician satisfaction surveys.

20 CMS would also monitor five different rates of lab
21 tests per beneficiary, including monitoring specific lab
22 tests to ensure that diabetics and other patients were

1 receiving tests as recommended by clinical guidelines.

2 The last issue we want to talk about today is that
3 of beneficiary coinsurance. As you know, there is no
4 coinsurance for lab services.

5 The Congress has, at times, considered applying a
6 20 percent coinsurance which would equalize cost-sharing
7 between clinical lab and most other Part B services. In its
8 June 2002 report, MedPAC estimated that such a change would
9 reduce Medicare spending by \$1.5 billion in 2002. At that
10 time, the Commission concluded that, because beneficiaries
11 do not initiate their use of lab services, adding
12 coinsurance would probably not encourage more efficient use
13 of care and might pose a financial barrier to low income
14 beneficiaries who lack supplemental coverage.

15 In addition, the cost of billing and collecting
16 coinsurance might exceed the coinsurance amount for low
17 payment tests.

18 So to summarize, we're concerned that we're not
19 paying accurately for lab services, especially at a time
20 when use of tests has been growing and is likely to continue
21 to do so. The absence of cost data poses a pricing problem
22 for Medicare and Congress has asked CMS to explore whether

1 competitive bidding would help solve this problem.

2 I've taken you through some of the highlights of
3 the proposed design for the competitive bidding
4 demonstration and more detailed information is in your
5 written materials.

6 One thing to think about is whether MedPAC wants
7 to comment on any aspects of the proposed design and whether
8 there are other payment methods that should be examined.
9 Another issue you may want to explore is how to encourage
10 more efficient use of lab tests.

11 And finally, you may wish to consider whether, for
12 the sake of equity, coinsurance should be required for lab
13 services, as it is for most other Part B services.

14 We look forward to your comments.

15 DR. SCANLON: We seem to go quickly to the
16 competitive bidding option and I'd like to express some
17 caution, because the one thing that was remarkable about the
18 DME competitive bidding demos was, in some respects, the
19 tender loving care that CMS gave to those demos. And care
20 to the extent that they couldn't replicate it on a national
21 basis. They invested a lot to make it work.

22 And now we're faced with under the MMA there's the

1 provision that in metropolitan areas we're going to have
2 competitive bidding for DME. And my sense is they're going
3 to have to do it differently, and there's the potential that
4 we get somewhat different results. And so that's something
5 we don't have the experience with yet to know whether that's
6 going to happen.

7 The second thing about competitive bidding for DME
8 was that they selected the items, too, that they were
9 willing to put out for bid. So it wasn't a complete DME
10 schedule that resulted. It was savings on particular items.

11 If we're thinking about the way this lab demo
12 seems to be set up, you bid on all of the services. But I
13 wonder what that does in terms of the competition among
14 labs. How many labs are going to be disqualified because
15 they're not going to be in a position to bid on everything
16 that's required?

17 One of the things about competitive bidding that
18 one has to worry about is maintaining your bidders over
19 time. Because yes, you can maybe get savings in the first
20 round but if you don't have a healthy market where there are
21 people that are going to come in and challenge the former
22 winners, and that you can have former winners become losers

1 in future years, that starts to deteriorate.

2 So those are all things I think that we need to be
3 concerned about. I'd be more cautious about waiting for the
4 experience of the demo is an important aspect of this. But
5 then also the experience of the demo, it shouldn't be
6 assumed that it can be duplicated nationwide. One needs to
7 think about how it has to be adapted in order to do it
8 nationwide.

9 The other fundamental challenge, and I don't have
10 an answer to this at all, is the issue of volume growth and
11 how does one address that? I'm not sure that the
12 coinsurance is necessarily going to be the effective way to
13 do it. It's a troubling aspect, but I don't have a policy
14 answer for you.

15 MR. HACKBARTH: Bill, go back to the first issue
16 for a second, how we price accurately. You expressed
17 reservations about competitive bidding. How do you size up
18 the alternatives?

19 DR. SCANLON: Well, I think that the alternative,
20 in terms of trying to do something that's similar to the fee
21 schedule, the one disadvantage that we pointed out is that
22 it's somewhat expensive.

1 MR. HACKBARTH: Talk about tender loving care.

2 DR. SCANLON: But you do it once and you
3 potentially can cover the universe. You do it once for --
4 we probably have more stability in this area than we do in
5 physician services in terms of the kinds of things that we
6 talk about the RUC dealing with. I think we would have a
7 lesser challenge over time in terms of trying to maintain
8 this schedule than we do with physician services. And that
9 would be my not well informed judgment.

10 But it seems that that was our principal objection
11 to that, was that it was going to be costly to do this.

12 I guess I'm saying I don't want us to
13 underestimate the cost of competitive bidding, that we'd
14 need to look at the cost of both very carefully first before
15 we say that we want to make a choice based on the cost of
16 implementation.

17 DR. KANE: I'm just reporting a little bit about
18 what goes on in our marketplace in Boston, but we've got two
19 or three integrated delivery systems, one of which is this
20 Partners Health Care System that's kind of made all the
21 hospitals and doctors send their lab tests into the mother
22 hospital as part of their integrated delivery system. And

1 then you can get access to those lab tests wherever you are
2 out there in the doctor's office as a part of the system.

3 What would happen if Partners lost the bid? I'm
4 just trying to understand what that would do to the
5 integrated delivery systems and electronic records where
6 they have the lab tied in to the system, if you had places
7 lose bids?

8 I just think it's kind of contrary to the notion
9 that we're trying to foster systems of care.

10 DR. WOLTER: That was one of my concerns, as well,
11 as I was kind of thinking about the clinical implications of
12 this. First of all, from the provider standpoint, most
13 hospitals are going to have to provide lab services of some
14 kind for intensive care and emergency room and stats. Even
15 in clinics, our oncologists wouldn't stand for not having
16 same-day lab results prior to infusion therapy, for example.

17 So the implications of trying to maintain a
18 smaller base of lab services, if you lost a contract, would
19 be significant for the clinical delivery of care.

20 And that, as far as labs go, they are a little
21 different I think that a DME commodity in that they are an
22 integral part of the overall clinical care of the patient.

1 And so if you looked at the more advanced electronic medical
2 records that are coming along, lab is a key part of that.
3 It's right there. The physicians can look at that, then
4 they can jump to imaging reports, they can jump to
5 transcription, et cetera. And if your labs are off in
6 somebody else's system, integrating those results with the
7 other clinical care items in the patient's history is going
8 to be much more difficult and I think much less effective.

9 Even patient access to their own labs is something
10 that is now starting to happen. If they have access to
11 their record, including their laboratory, and it's there in
12 an integrated way I think that has value.

13 And then some of the new decision-support tools
14 that are being embedded in the new electronic medical record
15 allow you to look at lab result trends compared to when
16 medications were started and stopped and some things like
17 that that will be lost, I think, if we fragment where that
18 care is provided.

19 So I guess I worry about all of those things and
20 is competitive bidding he better approach, as opposed to
21 some administrative pricing approach if we think we have an
22 issue?

1 The last point, which I have made before, in the
2 hospital world I think there are five or six service lines
3 where there is profit: lab, imaging, certain surgical
4 procedures. Much of the rest of it is neutral or negative.
5 And so if we can't price right across the whole range of
6 services and we just pick on ones where there may be more
7 profitability, we're going to have some problems eventually.

8 And so that's why I think over time, not just
9 where we think we have to price down but in outpatient
10 surgery and some of those other areas where we're seeing
11 negative margins, I think we have to address it as a package
12 or we're going to run into trouble eventually.

13 MS. KELLEY: Can I address those comments? This
14 would only be for lab services that are paid under the fee
15 schedule. So hospital inpatient labs would be completely
16 separate and continue to be paid under the hospital PPS.
17 CMS has also been concerned about this. Congress
18 specifically excluded from the demonstration labs that are
19 the result of a face-to-face -- labs that are connected to a
20 face-to-face encounter, which CMS has taken to be physician
21 office labs. So if you see your doctor and then walk down
22 the hall to his or her lab and have the blood drawn there

1 that's considered a face-to-face encounter and that would be
2 excluded from the demonstration.

3 But CMS has also expanded that now to include
4 hospital outpatient labs, as well. So hospital outpatient
5 labs would continue to be paid under the current fee
6 schedule.

7 What would not be paid under the current fee
8 schedule are what they're calling hospital non-patients. So
9 if you go to the hospital to get your blood drawn because
10 the physician sent you there, then that would be paid under
11 the demonstration.

12 DR. WOLTER: That would mitigate some of my
13 concerns. However, if you have a patient that you're
14 checking some lab on at two or three month intervals, not
15 necessarily seeing them that day, or if you're an
16 independent physician office and happen to use the hospital
17 for those lab services, there could be instances where that
18 volume change really is quite significant.

19 I think the integration into the electronic
20 medical record, of course, is an issue that really isn't
21 addressed very well by all of this. And I think there's a
22 significant issue.

1 MR. HACKBARTH: Dana, before we leave that, do you
2 rough numbers on what percentage of lab services would be
3 subject to the demo versus the exclusions? The exclusions
4 sound very, very large.

5 MR. WINTER: Hospital outpatient labs account for
6 about half of volume and just under half of spending as a
7 share of all lab services paid under the lab fee schedule,
8 if you go back to that slide. So if you assume that all
9 outpatient labs are excluded, then it's about half that --

10 MR. HACKBARTH: What about the exception for the
11 face-to-face?

12 MS. DePARLE: What's in? What's left?

13 MR. HACKBARTH: So 34 percent. These don't
14 exactly match up with the --

15 MS. KELLEY: We have not been able to sort out the
16 number in the hospital-based row. Hospital-based labs
17 account for half of all services paid under the clinical fee
18 schedule. But some large proportion of that number, of the
19 49 percent, is going to be outpatient. What we don't know,
20 what we haven't been able sort out from the claims is what
21 proportion of that it is.

22 MR. HACKBARTH: She said if you go to the doctor's

1 office and the doctor says you need to go to the hospital
2 and get your blood drawn and these tests done, that's
3 included under the demo.

4 MS. KELLEY: That would be included.

5 MR. HACKBARTH: If it's a hospital outpatient
6 department, it's not.

7 MS. KELLEY: Right. So when you go to the doctor
8 and the doctor says you need these test drawn, and here's a
9 list of labs you could go to, Quest, LabCorp, the hospital
10 down the street, then that would be something covered under
11 the demonstration. But if you go as an outpatient to the
12 hospital to receive some medical care and get labs
13 associated with that care face-to-face in the hospital, then
14 that would continue to be covered under the fee schedule and
15 not in the demonstration.

16 MS. BURKE: And the labs that are drawn but sent
17 out in a docs' office?

18 MS. KELLEY: If it's drawn in the doctor's office
19 that's considered part of the face-to-face encounter, even
20 though it's sent to the hospital or Quest or wherever.

21 The independent line, everything provided by
22 independent labs is included unless it's sent to them by a

1 hospital or a physician office lab.

2 But keep in mind that labs have direct billing.

3 So for the most part these are services provided, the
4 independent category are services that are from when you
5 show up at a lab facility that just draws your blood because
6 labs have direct billing. So a physician office, even if
7 they send it out to an independent lab, the physician office
8 generally -- not always but generally bills for it.

9 DR. REISCHAUER: Can I ask how does Aetna and
10 BlueCross BlueShield determine how much they pay for these
11 tests?

12 MR. WINTER: We have not looked at this ourselves
13 but the Institute of Medicine did in its report from 2000.
14 They hired a consultant to look at and compare Medicare
15 rates to private payer rates and look at how private payers
16 set their rates for lab tests. The private plans generally,
17 by and large, base their fee schedules on the Medicare fee
18 schedule although they adjusted it.

19 DR. REISCHAUER: So we should then do ours on
20 theirs.

21 [Laughter].

22 MR. WINTER: There were some wrinkles so in some

1 cases they would pay a capitated rate to a lab to do all the
2 tests for their enrollees. In some cases they would pay a
3 hospital more than a physician-base lab, in some cases they
4 would pay a physician lab more than an independent lab, so
5 there are definitely variations.

6 For the most part, the private plans paid more
7 than the Medicare rate, and this again is six years ago. We
8 haven't updated this. The one exception where private HMOs
9 were paid a little bit less, 2 percent less for 22 tests
10 that they looked at, and Medicaid HMOs were even lower than
11 that relative to Medicare.

12 DR. CROSSON: Getting back to the concerns that
13 Nancy and Nick raised, I don't quite get the value in this
14 model of forcing out the so-called loser bidders. What
15 value does that create, other than terrifying the people who
16 are making the bids? Because if you just pay them the demo
17 rate you end up with the same outlay; right?

18 DR. REISCHAUER: Bid high? What's the incentive?

19 DR. CROSSON: All right, because there's no way to
20 direct the business.

21 DR. REISCHAUER: You could pay them 2 percent less
22 than the demo rate or something like that, but let them stay

1 in, sort of a penalty.

2 MS. BURKE: I'd like to get back to a point that
3 Bill raised earlier on and get away from the payment piece
4 of this, and that is to the more fundamental question of the
5 volume issue. Essentially, what the chapter focuses on
6 largely, and what we've talked about today, is how one sets
7 up a method of payment for a fraction of the total test.
8 One wonders at some point the value of doing this, if
9 essentially you're excluding 70 percent of the tests from
10 the demonstration, which at least in terms of the payments
11 is what it looks like.

12 But setting that aside for a moment, I think there
13 is also a critical question which is how are we going to
14 essentially begin to influence people's use of tests in an
15 appropriate way? I was troubled that we have this strange
16 extreme where there is overuse but apparently underuse of
17 what ought to appropriately be done and overuse of things
18 that ought not. So it's not like they're just trying to get
19 more because they're not getting more where they could in
20 fact get more appropriately. They're getting more and not
21 doing what they ought to do where they ought to do it.

22 So one of the things I'd like us to begin to think

1 about and figure out how we want to opine on is the question
2 of how we also begin to encourage and influence behavior
3 that is appropriate use of lab tests that are linked to
4 quality and to outcomes. And I think whether we want to
5 deal with that separately, whether we want to reference that
6 point, but I think this has to be linked as well to
7 incentivizing good behavior which is how all of our --

8 DR. REISCHAUER: But that might have nothing to do
9 with what we pay labs.

10 MS. BURKE: I understand and appreciate that.

11 MR. HACKBARTH: In fact, one place that it might
12 lead back to is physician resource measurement, and this is
13 one of a number of --

14 MS. BURKE: That's exactly right. But I would
15 hesitate, and Bob's exactly right. How we pay a lab,
16 particularly since you're excluding all these other labs,
17 won't impact what people order. That's an independent
18 decision. But I would hate to have us talk about and get
19 involved in the payment without mentioning that we are
20 equally as concerned about the appropriateness of the test
21 and the volume and that that's something we need to focus on
22 as well, even though this won't influence it directly

1 because the labs are doing with the labs get, but they're
2 not ordering it.

3 MR. HACKBARTH: Others?

4 DR. REISCHAUER: Should we have any kind of
5 discussion on of coinsurance and how much appetite there is
6 for coinsurance?

7 MR. HACKBARTH: Sure. Go ahead.

8 DR. REISCHAUER: Not much.

9 [Laughter.]

10 MR. HACKBARTH: For the same reasons as were
11 covered in 2002.

12 Just for my education, can I just ask Ralph and
13 Jay and Nick a question? You all have labs onsite and you
14 do some of the work onsite. Do you also take some of it and
15 ship it off to a reference lab?

16 MR. MULLER: We don't because we're so big but
17 part of -- no. And obviously the hospital-based stuff, the
18 volume is so high that really the marginal cost is
19 incredibly low. But it's all the new tests that are being
20 developed right now in and the next years that are going to
21 get very expensive. The very specific, these genetic tests
22 and all of the new drugs that are coming down that are much

1 more individually specified and so forth are much more
2 complicated tests. They're not likely to be that Quests and
3 LabCorps are not likely to get in that business because it's
4 not the kind of volume stuff. They do very well on the high
5 volume stuff, where again the marginal cost is basically
6 zero when you look at it.

7 So I think, in terms of the discussion we're
8 having, it would be interesting -- I would like to see this
9 broken out a little bit more. While these volumes one here
10 on the complete blood counts and stuff like that, you get up
11 to 44 percent here. But I would hypothesize that a lot of
12 these tests that are pretty small in number are going to get
13 fairly big in terms of payment because these tests can be
14 \$1,000 tests in true costs to run, as opposed to fees and so
15 forth.

16 So a place like us, the big places tend to have
17 their own labs. But doctor's offices, by and large, send
18 them out to the Quests and LabCorps and so forth. Smaller
19 hospitals send them out to the Quests. That's the business
20 that the Quests and LabCorps are in.

21 MR. HACKBARTH: I'm trying to get a sense of the
22 cost curve here. When you say that you are large enough to

1 do it in-house and your marginal costs are low, they're
2 competitive with Quest or one of the big reference labs?

3 MR. MULLER: Yes.

4 MR. HACKBARTH: So the level of scale required is
5 not -- you're a big institution.

6 MR. MULLER: But then, we're one of the 10 or 20
7 biggest places in the country in terms of that kind of
8 scale. But the community hospitals in the area, and others
9 can speak to this, they tend to send a lot of theirs out, on
10 the more routine stuff to the national competitors and on
11 the stuff that's less used to places like us or Hopkins or
12 Duke, et cetera. We are reference labs for regional places.

13 MR. HACKBARTH: So the community hospitals, I
14 guess they're choosing between Quest and the other one or
15 two competitors based on price?

16 MR. MULLER: They'll generally go to the Quests
17 and so forth of the world because they're just more price
18 competitive and they want that kind of business.

19 MR. HACKBARTH: So they're able to parcel out
20 their business and say part of it we need to have integrated
21 into our practice but another piece we can send outside for
22 a good price? And so why can't Medicare do that?

1 MR. MULLER: As Nick said, some stuff you need
2 right there in your emergency room, your ICUs and so forth.
3 So you have some minimal capacity. But by and large,
4 they're not going to make these -- these lab systems, I mean
5 they're \$10 million, \$20 million investments. So the really
6 big places can do that. The 50-bed hospital is not going to
7 be able to afford that and so forth. So they keep a pretty
8 much more modest thing.

9 So the Quests and LabCorps really, whatever the
10 5000 hospitals in the U.S., an awful lot of them send things
11 out but I would think top 500 or 600, in terms of scale keep
12 most of it in. They may still send something out at the
13 margin, but the really big places hardly send anything out.

14 DR. CROSSON: It's essentially the same answer.
15 We have three large reference labs, two very large ones in
16 California and one in Oregon. And we don't send anything
17 out. We do send tests from some of our other areas to those
18 labs, but we essentially have internalized everything.

19 DR. WOLTER: We partner with the Mayo Clinic to
20 provide reference lab services in our region and then we
21 ourselves provide lab services, for example, to a number of
22 the critical access hospitals that we support.

1 DR. MILLER: Just to say a few things about these
2 comments and where to go, as we looked at this we're pretty
3 convinced that the current pricing structure and how we've
4 arrived at all of this and how we're maintaining it
5 currently doesn't make a lot of sense. And you have this
6 inherent tension of lots of volume but not so clear that
7 it's the right volume. So that's what brought us to this
8 topic.

9 Then leaning towards the competitive bidding I
10 would say it just a little bit different. The Congress has
11 kind of pushed people down this road, which is why we paid
12 some attention to it. And one way to think about what's
13 happened here is some of these questions about why is the
14 demo being designed that way. Or how does the demo address
15 this issue? These are things we could ask to be addressed
16 if we think that there are anomalies or problems with the
17 demo.

18 I'm not trying to push you into the demo. But by
19 law they're going to do it. So we might want to say if
20 you're going to do it this would be a better or worse way to
21 design it.

22 So one way to think of all these comments is maybe

1 we should think through this and make some recommendations
2 or some suggestions on how to run the demo to deal with
3 these kinds of issues, although I think I heard pretty
4 clearly not a lot of enthusiasm for competitive bidding, at
5 least as it stands.

6 My last point was going to be a point that was
7 just made, so I hate to be redundant. The volume issue we
8 are at least so far thinking of that in the context of the
9 physician episodes and looking at it through the measurement
10 of physician resource. And that's sort of the way we were
11 figuring we would chase that. And we'll be sure that these
12 two things refer to each other.

13 MR. MULLER: I would also urge us, just like 10 or
14 12 years ago one could have anticipated that the devices
15 would explode in the sense of use and forth. These new
16 tests are going to do the same thing in the next five to 10
17 years. So the big money is not going to be in blood counts.
18 It's going to be in these very specified, highly specific
19 tests that give you a lot of advance in terms of therapy and
20 treatment. They're going to be very highly valued by the
21 patient and the doctors because they can tell you how to
22 proceed with therapy.

1 And one could arguably then make cost arguments
2 that by targeting therapy much more precisely they will save
3 a lot of money for the system. That by and large most
4 things we add to the system head on all fronts. But by and
5 large, at least conceptually, these tests should save quite
6 a bit of money in terms of diagnosis and treatment because
7 they're just much more powerful and profound.

8 But these things are not a dollar test. They're
9 the big ones. I'd keep my eye on them over the next five or
10 10 years because there's a lot of competition coming and a
11 lot of venture money coming, which is always a good sign, a
12 lot of venture money coming to this field.

13 DR. MILLER: Ralph, one more iteration on this,
14 and I know we've got to stop. But one of the things I think
15 that really scares us about this is it is like devices and
16 things like that, these will come on the market, an
17 administered price system will have no way of pricing it,
18 and the information imbalance will be entirely held by
19 whoever manufactured the test. And the system, like
20 technology, they will be able to extract very large payments
21 out of the administered price system.

22 So I think that's some of what makes us nervous

1 here is we don't have a good way of capturing that
2 phenomenon.

3 MR. MULLER: I'd just say I'd spend more time then
4 in trying to figure out how to price blood counts.

5 DR. SCANLON: I agree with you that the
6 administrative pricing system is going to be challenged at
7 that point but potentially competitive bidding is also going
8 to have challenges. it's going to depend upon how the
9 suppliers in that market develop. There is the potential
10 that we would ultimately decide that we want to deal with
11 these really small things where the marginal costs are very,
12 very low versus these rarer things where it's very high in
13 different systems.

14 And I agree with your point about the demo is
15 going to happen. We should be positioning ourselves to
16 learn the most we can from it.

17 MR. HACKBARTH: Okay, anybody else?

18 Okay, thank you very much.

19 We are now to the public comment period. We'll
20 have a brief public comment period.

21 * MR. DOUGHERTY: Hi, I'm Bob Dougherty from the
22 American College of Physicians. I will keep my comments

1 brief because I see everybody is about to head out.

2 I wanted to comment on the care coordination
3 presentation earlier today and the discussion, which I
4 thought was excellent. A lot of the concepts that were
5 presented in terms of the physician role in care
6 coordination, integrating that better with the disease
7 management companies are things that the American College of
8 Physicians have been talking about in our advanced medical
9 home paper.

10 A few observations, though. The two options you
11 put forward, the staff put forward, one was the more
12 integrated large group. And the other was the care
13 management organization plus the small physician practice.

14 The other way of looking at it is to create a
15 model that works with the small physician practice
16 epicenter, and that practice then may have arrangements with
17 disease management companies and others to provide the full
18 spectrum of services needed.

19 The concept we're looking at is the process where
20 practices would qualify and be recognized as advanced
21 medical homes and they would take on responsibility for full
22 care coordination, not just kind of having that kind of

1 disease management function in place either internally or
2 through an arrangement with one but, they would be
3 responsible for the resources used. There would have
4 patient-centric services like ease of access scheduling.
5 They would use health information technology to measure and
6 report quality. And they'd be accountable for the quality
7 that they provide, the total cost of care they provide, and
8 patient experience measures.

9 It's a different way of trying to transform small
10 practices by using care coordination to get and provide the
11 kind of care that we think patients want and will
12 particularly be useful for patients with multiple chronic
13 diseases, although it may work very well for patients with
14 acute illnesses, as well.

15 So my suggestion is if you think of the continuum
16 from the large integrated group to a model that puts the
17 resources on the care management company and says plus the
18 physician, that you think of a model where you can really
19 change the reimbursement structure to enable practices to
20 use technology and office redesign to coordinate and manage
21 and arrange for the care of their patients where the
22 physician has that responsibility.

1 And in terms of control over resources, the
2 physician has control over a lot more resources, that was
3 discussed earlier, than disease management companies have.

4 So again, it's a suggestion and it's something
5 we'd like to talk further with you about.

6 MR. WATERS: Good afternoon. My name is Bob
7 Waters. I have actually spoken to you previously on behalf
8 of the American Association of Bioanalysts.

9 This afternoon I'm here on behalf of the Clinical
10 Laboratory Coalition. The Coalition is comprised of
11 laboratory groups that represent the full spectrum of health
12 professionals and laboratory facilities that are involved
13 with the nation's Medicare population. It includes the
14 American Association of Bioanalysts, the American
15 Association of Clinical Chemists, the American Clinical
16 Laboratory Association, American Medical Technologists, the
17 American Society for Clinical Laboratory Science, the
18 American Society for Clinical Pathology, American Society
19 for Microbiology, AVAMED, Clinical Laboratory Management
20 Association and the College of American Pathologists.

21 We don't agree on a lot of things. But we do
22 agree on several of the key issues that you actually, I

1 think, are going to have a major impact in terms of where
2 Congress heads in this direction.

3 First of all, we believe it's important that
4 MedPAC places this issue in its proper context. Laboratory
5 tests, I think, are conceded by almost every medical
6 professional I know as being a critical component for not
7 only diagnosing and treating the patient. But they've been
8 recognized as an important part of clinical practice
9 guidelines. Laboratory services are also very cost-
10 effective and provide enormous value to patient care.

11 In recent years Congress and health quality
12 organizations have recognized the value of laboratory tests.
13 In fact, 80 percent of the clinical evidence- based
14 guidelines for the most costly disease conditions specified
15 the necessity of ordering clinical laboratory testing.

16 Congress in a recent years has also taken some
17 action to actually increase laboratory testing through
18 expanded screening services such as a PSA, diabetes,
19 colorectal cancer and cardiovascular health. Many of these
20 were mandated as recently as the MMA, which was just passed.

21 It's actually in the public interest for Congress
22 to provide more rather than less of these valuable

1 preventive screening tests.

2 Now as far as the issues you're considering, a
3 couple issues that come at hand. One is what happens, why
4 is the aggregate number -- what drives costs in the
5 laboratory area?

6 Congress and the executive branch have done a very
7 good job controlling price in the laboratory field.
8 Unfortunately for us, laboratory payments have not remotely
9 kept pace with inflation. Overall, Medicare fees for
10 laboratory services have been reduced by 40 percent in real
11 terms between 1984 and 2004. Our statutorily mandated
12 inflation updates, we have not received them in 11 of the
13 last 15 years. The national limitation amount that controls
14 laboratory tests has actually been ratcheted it down.

15 So this is a reduction in real terms. This is not
16 an anticipated growth or an increase that we thought we
17 might have got that we would like to have. It's been an
18 actual reduction in the amount we get.

19 We have succeeded in controlling the price for
20 laboratory tests.

21 There are a few provider groups who have been
22 asked to repeatedly absorb similar real reductions and we

1 appreciate that MedPAC has recognized that fact, and I think
2 it's been pointed out in some of the briefing materials
3 pretty well.

4 As you look at solutions to what should be done in
5 the laboratory area, we would urge you to be wary of
6 precipitously moving to any type of one-size-fits-all or
7 type of solution that sounds good, is a nice sound bite, but
8 has never really been tested.

9 This model is actually a radical departure,
10 competitive bidding, from the current system. And it's a
11 model that has not yet even been designed, much less tested.
12 To move to the implementation phase, which is actually
13 suggested in the President's budget this year, without
14 designing it, testing it, could have serious and irrevocable
15 consequences to this segment of the market.

16 Clinical laboratory services are just that. They
17 are a test. They are a service. They are not a commodity.
18 They are not a crutch tip. You can't measure them as they
19 come across the assembly line to make sure they're all
20 uniform and done in the same manner. These complex services
21 require significant training and expertise to perform and
22 interpret accurately. And the end goal of positively

1 affecting patient outcomes could be seriously jeopardized if
2 the system is not designed correctly.

3 The Clinical Laboratory Coalition has grappled for
4 a number of years with the issue of competitive bidding and
5 we've become increasingly convinced there has not yet been
6 designed a bidding model that could accurately take into
7 account a number of the objectives that need to be dealt
8 with. And that includes ensuring that the laboratory
9 services are fees below the current reimbursement rate while
10 simultaneously maintaining quality and access of care and
11 keeping pace with improvements in diagnostic technology, and
12 ensuring that all geographic settings and service delivery
13 settings such as nursing homes continue to receive the range
14 of highly qualified testing that's essential to caring for
15 those patients.

16 In summary, laboratory testing plays an absolutely
17 essential part in the delivery of health care quality.
18 Laboratory tests provide physicians with objective data that
19 they absolutely need to properly diagnose patients and by
20 equipping physicians with critical information, laboratory
21 tests ultimately will lives and reduce overall health care
22 costs.

1 I'd like to thank you for the opportunity to speak
2 on behalf of the Clinical Laboratory Coalition and I would
3 like to add just a couple of comments with my AAB hat on, if
4 I could, in response to some of the points that were
5 recently raised.

6 I actually agree with some alarm the possibility
7 that people might move down this path toward competitive
8 bidding. And I would urge you that if you were speaking to
9 or going to provide a report to the Administration in terms
10 of things that they ought to look at, in terms of designing
11 any model in this area, you ask them about five critical
12 questions.

13 One, who's going to determine market share? What
14 part of the government is going to decide how much my
15 community laboratory gets? How much a large national
16 laboratory gets? How much goes to the hospital? That has
17 never been answered in 20 years of trying to design
18 competitive bidding in this area.

19 Secondly, who's going to ensure that nursing homes
20 get service? That they're not redlined, that they're too
21 hard to serve and they're too costly.

22 Third, who's going to protect against low-

1 balling? Some people have deeper pockets than other and
2 they can come into a market for three or four years and give
3 you a low ball price just to clean out the competition.

4 Fourth, what will the new market look like when
5 you're done? You may find out that the market looks
6 radically different. What you've got is you've got only one
7 or two labs to choose from. You still have to have a
8 regulated price because now you've winnowed the competition.

9 And finally, please, please don't move
10 precipitously to implementation in this area before you know
11 what you're doing.

12 We appreciate your thoughtful consideration and
13 your indulgence with my long comments.

14 Thank you very much.

15 MR. HACKBARTH: Okay, we reconvene at 9:00 a.m.

16 [Whereupon, at 5:12 p.m., the meeting was
17 recessed, to reconvene at 9:00 a.m. on Friday, March 10,
18 2006.]

19
20
21
22

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, March 10, 2006
9:05 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
JOHN M. BERTKO
SHEILA P. BURKE
FRANCIS J. CROSSON, M.D.
NANCY-ANN DePARLE
JENNIE CHIN HANSEN
NANCY KANE, D.B.A.
ARNOLD MILSTEIN, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
WILLIAM J. SCANLON, Ph.D.
DAVID A. SMITH
NICHOLAS J. WOLTER, M.D.

AGENDA

PAGE

Cost effectiveness

3

-- Nancy Ray

-- Peter Neumann and Josh Cohen, Tufts University
School of Medicine

Hospice

55

--Kathryn Linehan

--Melinda Beeuwkes Buntin, RAND

Physician practice expense

91

-- Nancy Ray, Ariel Winter

P R O C E E D I N G S

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22

MR. HACKBARTH: Good morning, everybody. We have three sessions today, one on cost effectiveness, and then two about trying to get prices more accurate for hospice and physicians, respectively.

Nancy, will you do introductions? Thank you.

* MS. RAY: Good morning. I'd like to welcome Dr. Neumann and Dr. Cohen. The three of us are going to be talking to you about cost effectiveness this morning.

Recall last spring we had an expert panel that included Dr. Neumann which discussed the use of cost effectiveness by Medicare. One of the issues that was raised was the lack of standardization of the methods and assumptions of cost-effectiveness studies, so we asked Dr. Neumann to look at the methods and assumptions of cost-effectiveness studies for two Medicare coverage services. They are going to go ahead and present their analysis and results. Following their presentation I'm just going to give you a couple of additional ideas for you to discuss.

Peter Neumann and Josh Cohen are with the Tufts University School of Medicine's new Center for the Evaluation of Value and Risk in Health. Dr. Neumann is the

1 director of the center.

2 DR. NEUMANN: Thank you very much, Nancy. Good
3 morning, Mr. Chairman, and members of the Commission. As
4 Nancy mentioned, my name is Peter Neumann from Tufts
5 University New England Medical Center and I'm here with my
6 colleague Dr. Josh Cohen, also of Tufts. We're pleased to
7 be here today to talk to you about cost-effective analysis
8 and the Medicare program.

9 As many of you may recall and as Nancy mentioned I
10 was here about a year ago to talk about the challenges and
11 opportunities in using cost effectiveness on a panel with
12 Dr. David Eddy, and how cost-effectiveness analysis might be
13 used to inform coverage and reimbursement decisions for the
14 Medicare program.

15 As we highlighted last year, cost-effectiveness
16 analysis offers a potentially valuable tool to help target
17 resources more efficiently and to avoid paying for health
18 care that offers little or no benefit for the dollars
19 expended. Medicare has chosen not to use this tool in the
20 past for possible reasons we discussed last year; namely,
21 that it is perceived as a tool for rationing health care in
22 ways that may be politically unacceptable, but also because

1 of ongoing concerns about the methodology and the
2 feasibility of using the approach.

3 One of the key challenges that Dr. Eddy and I
4 discussed and that was mentioned by the commissioners last
5 year pertained to the quality of the methodology of cost-
6 effectiveness analysis and whether existing studies are
7 robust enough to rely on for Medicare decisionmaking.
8 Subsequent to that discussion, my colleagues and I were
9 asked by MedPAC staff to review and analyze cost-effective
10 analysis for selected Medicare services.

11 What we'd like to do this morning is discuss our
12 methodology, our findings on the cost-effectiveness of two
13 selected services, colorectal cancer screening and
14 implantable cardioverter defibrillators, and then offer some
15 concluding observations. We look forward to your feedback
16 and questions.

17 Our objective was to evaluate the potential for
18 use of cost-effectiveness analysis in the peer reviewed
19 literature to characterize the cost-effectiveness of major
20 services covered by Medicare. Our specific research
21 questions were as follows. What methodologies and
22 assumptions are used? To what extent is there concordance

1 of assumptions, methodologies, and results across studies?
2 And three, can influential study assumptions be identified?

3 We emphasize at the outset that our purpose was
4 not to delve into technical aspects of colorectal cancer
5 screening or implantable defibrillators, per se, but rather
6 to discuss more broadly what these case studies tell us
7 about the cost-effectiveness methodology and how it might
8 help Medicare decisionmaking in general.

9 Per the scope of work agreed upon with MedPAC
10 staff we first identified four candidate Medicare-covered
11 services for evaluation. Our intention was to identify
12 examples that included pharmaceuticals, medical devices,
13 surgical procedures, diagnostic procedures, and cognitive
14 services covered by Medicare. The aim was to explore the
15 completeness of the cost-effectiveness literature for these
16 four services and then to select two for further
17 exploration. In conjunction with staff we selected four:
18 colorectal cancer screening, implantable cardioverter
19 defibrillators, positron emission tomography, PET
20 Alzheimer's disease, and erythropoietin for cancer patients
21 undergoing chemotherapy.

22 Just to orient you a little bit to the cost-

1 effective analysis and the cost-effectiveness ratio, cost
2 effectiveness is a word that's sometimes used loosely and
3 generally. We'll use it specifically in this presentation.
4 The cost-effectiveness ratio as we define it has, in the
5 numerator, the incremental costs associated with a new
6 technology versus existing technology or services, and in
7 the denominator, life years gained or quality adjusted life
8 years gained. There are other ways to measure cost
9 effectiveness but we used this kind of standardized ratio in
10 this talk today.

11 This slide summarizes the results of a Medline
12 search for cost-effectiveness analyses that report cost for
13 life year, or cost per QALY, quality adjusted life year, for
14 these four services. It shows you something about the
15 availability of studies and the completeness of the
16 literature for these four services.

17 As the table shows, we found 26 cost-effectiveness
18 analysis for colorectal cancer screening, 14 for implantable
19 cardioverter defibrillators, four for PET for Alzheimer's
20 disease, and five for erythropoietin in cancer patients.
21 Based on this information we selected colorectal cancer
22 screening and implantable defibrillators as the two services

1 we would examine in detail.

2 We then examined key methodologies and assumptions
3 used in each study to get a sense of the quality and
4 completeness of this literature. Let me to briefly review
5 each of these categories. The funding source. Most studies
6 explicitly report the funding source with government funding
7 the most common source. The type of model used in the
8 analysis. For colorectal cancer, screening a type of model
9 called Markov modeling was typically used. For implantable
10 defibrillators, statistical comparisons were used.

11 In terms of identifying the software, typically
12 software was specified for the type of simulations
13 conducted, though this was less so for other types of
14 models.

15 The perspective or viewpoint of the analysis.
16 Almost all studies used a health care perspective focusing
17 on the health care costs in the studies, although this is
18 not always reported, and some investigators report a
19 societal perspective in which total societal costs and
20 benefits are noted. In terms of the costs used, almost all
21 studies included only health care costs, excluding non-
22 health care costs. In terms of discounting future events,

1 most studies discount future costs and benefits at a 3
2 percent discount rate.

3 In terms of the clinical outcomes, most studies
4 measure outcomes in terms of net life years rather than net
5 QALYs gained. In terms of uncertainty or sensitivity
6 analysis, most studies include univariate analysis whereby
7 one variable at a time is varied. Probabilistic methods
8 whereby many variables are varied simultaneously are
9 generally not used.

10 Finally, we examined the extent to which analyses
11 reflected recommendations of the U.S. Panel on Cost
12 Effectiveness in Health and Medicine. As the slide shows,
13 most studies discounted costs and benefits. Most studies
14 use life years rather than QALYs, as recommended by the
15 panel, and most studies used the health care payer
16 perspective rather than a societal perspective as
17 recommended by the panel.

18 DR. COHEN: I'm going to step you through some of
19 the findings that we had. First on the concordance of the
20 methods used across studies, first for colorectal screening,
21 we found that discounting approaches tended to be similar,
22 the perspective was also similar. The health care payer was

1 typically used. And even if they used the term societal,
2 usually the way we read it, the study, they were using the
3 health care payer.

4 In terms of model structure, 11 of the studies
5 that we looked at in colorectal cancer screening used Markov
6 modeling, and that's a type of simulation that can be to
7 extrapolate beyond empirical measure of results, such as in
8 a randomized controlled trial. Fifteen others used other
9 types of modeling, including statistical comparisons, which
10 would be essentially more directly taking the results from
11 the empirical studies.

12 Comparisons across studies were complicated by
13 differences in the interventions, comparators, and
14 populations analyzed, and the united used to quantify
15 benefits. To compare different values from different
16 studies you'd have to really match on all of those things
17 and there's a lot of different combinations for colorectal
18 cancer screening.

19 So there's two slides now which you can look at
20 simultaneously in your handout and I'll talk a little bit
21 about them. This slide shows results for the CRC screening.
22 There are lots of different interventions evaluated, as I

1 said. Our analysis in terms of comparing the values from
2 different studies, we limited that to those that compared
3 screening to a no-screening alternative, just so we could
4 get some numbers to compare. Without this constraint it's
5 difficult to find multiple estimates that match both the
6 intervention technology and the frequency, and the
7 comparator technology and the frequency.

8 On this particular slide you can see that the
9 alternatives examined, including colonoscopy, CAT scan
10 colonoscopy, DCBE, FOBT, sigmoidoscopy, and combination
11 therapies. The slide shows that the variation in frequency
12 of screening examined and the variation in the results from
13 \$3,000 for some options to \$26,000 in others.

14 This slide shows the concordance across studies.
15 In the right column what you have there is a statistic
16 called the coefficient of variation. All that is is the
17 standard deviation of the values in that particular set
18 divided by the mean. It gives you an idea of how much
19 variation there is. The values you see there are relatively
20 small given that you're taking these values, these cost-
21 effectiveness ratios from different studies.

22 Even more importantly we think is that if you look

1 at the values qualitatively the concordance is pretty good.
2 The values fall below typical benchmarks, even \$50,000 per
3 quality adjusted life year. They fall into that category.
4 So if you look at them collectively, even though the numbers
5 they may vary, they give you the same sort of policy result.

6 Which of the assumptions were most influential to
7 the results? We found that studies tended to evaluate
8 varying set of assumptions in the sensitivity analysis. Now
9 that's not necessarily an indication of how much the
10 methodology of the studies varied. But when they went and
11 looked at how different assumptions influence the results it
12 was more difficult to compare their sensitivity analyses.

13 Certain assumptions were evaluated in a relatively
14 large number of studies and the general implication
15 therefore is that they are important. For example, polyp
16 dwell time and the diagnostic test sensitivity and
17 specificity. Even reading the studies you can pick that up
18 from the text even if it doesn't come out directly from the
19 numbers.

20 Now turning to ICDs, we examined concordance in a
21 similar fashion as we did for CRC screening and we found
22 that discounting approaches were similar across studies.

1 Moreover, the perspective taken was similar, usually the
2 health care payer. There was some variation in model
3 structure. Five studies used Markov modeling and eight used
4 statistical comparisons, and that was somewhat flipped from
5 what we saw in the CRC screening. Here was there was more
6 use of statistical comparisons and that's because there was
7 a richer set of randomized controlled trials to draw on so
8 it was easier to use the directly available effectiveness
9 information.

10 This study summarizes some of the results. In the
11 case of ICDs there were many fewer types of comparisons. So
12 on this slide generally you had three types of comparisons,
13 ICDs versus pharmaceuticals, ICDs versus no therapy, or
14 pharmaceuticals versus no therapy. So you had a larger
15 number of data points to directly compare.

16 Now the concordance here is somewhat less
17 impressive than in the case of CRC screening. Note that the
18 standard deviation in the first row is greater than the
19 mean. However, when we look more closely at the values, if
20 you look at the report that we submitted you'll see that
21 that is driven in particular by a couple of data points. I
22 seem to remember one was around \$200,000 per quality

1 adjusted life year and another was on the order of \$600,000.

2 If you even look more closely at what's driving
3 these differences, it's really differences in the assumed
4 effectiveness of the device. There was a recent paper by
5 Sanders in 2005 that provides some indication of what gives
6 rise to differences in ICD effectiveness estimates. Of the
7 eight RCTs in the Sanders paper, six translated into cost-
8 effectiveness ratios of \$34,000 to \$70,000 per quality
9 adjusted life year, indicating reasonable value for the
10 money. Two of them, on the other hand, the other two
11 randomized controlled trials are associated with increased
12 mortality risk and hence led hands led to the finding that
13 ICDs were dominated by the control group.

14 Now those two particular randomized controlled
15 trials, there are different interpretations as to why they
16 gave such different results. The CABG trial, patients had
17 undergone revascularization before implantation of the ICD
18 and it's thought that that procedure may have achieved the
19 available benefit to this population leaving no incremental
20 benefit to the ICDs. The DINAMIT trial, the second one that
21 yielded this increased mortality risk for ICDs, the
22 implantation was done relatively soon after the event,

1 compared to other trials and for whatever reason, for
2 example, the heart may not been sufficiently strong for the
3 procedure, that timing may have affected the benefit.

4 The bottom line here is that just as in -- the
5 cost-effectiveness numbers can vary a lot but that's because
6 underlying those cost-effectiveness numbers, especially in
7 the case of ICDs, are big differences in the effectiveness
8 estimates. So of course we're all familiar with how hard it
9 is to deal with that and that translates into this arena as
10 well.

11 In terms of the influential assumptions, several
12 assumptions were influential. Most of the variation is due
13 to the assumed effect, just as I said, and because that's
14 part of your cost-effectiveness ratio it translates into
15 differences in the cost-effectiveness number that you get.

16 DR. NEUMANN: So we'd like to end with some
17 observations and general conclusions about these particular
18 services, but also more generally about the prospect for
19 using cost-effectiveness analysis in the Medicare program.
20 These kinds of analyses we believe show both opportunities
21 and challenges in using cost effectiveness in Medicare.

22 On the one hand, it shows that for high profile

1 and potentially high cost Medicare reimbursed procedures
2 there are numerous cost-effectiveness analyses in the
3 literature and these studies provide a ballpark estimate of
4 the costs and clinical consequences of using these services.
5 The information could be used to help inform Medicare
6 coverage and payment decisions. Other public payers,
7 internationally certainly, have incorporated such
8 information into their decisions.

9 The studies also reveal challenges in using the
10 information. There's variation in the methods used, for
11 example, in the costs considered. There's also variation in
12 the populations, the comparators, and the clinical data
13 underlying the analyses.

14 Despite this variation, the literature does
15 provide a useful range of estimates. Also we believe that
16 it's important to recognize that even clinical studies, even
17 rigorously done randomized controlled trials of a particular
18 technology or service often suffer from these same problems,
19 that is, variation in the design, different populations
20 studied, different comparator interventions and so forth.

21 Finally, for decision-making purposes, CMS,
22 Medicare may want to undertake its own synthesis and review

1 of existing literature and its own analysis of that
2 literature on a case-by-case basis. That is to say, simply
3 taking numbers from the literature is likely not going to be
4 enough.

5 Thank you very much. We look forward to your
6 questions.

7 MS. DePARLE: Thanks, Peter and Joshua, for
8 another really interesting presentation.

9 One thing that occurred to me given your last
10 point, Peter, about CMS may want to do its own analysis is,
11 at least for ICDs and maybe for the other things that you
12 studied here, weren't they already covered by Medicare
13 before the analysis was done? So I'm getting deep into
14 operations here before we've figured out how to do this, but
15 how would CMS -- it sort of a chicken and egg thing. Most
16 manufacturers would argue, we've met the FDA standards,
17 we've shown this is safe and effective. You need to let it
18 be diffused now so we can see what it does with other
19 populations. So how would you then go back and make these
20 kind of analyses and change it?

21 DR. NEUMANN: It's a very good question and I
22 think not only for ICDs but other technologies this often

1 happens, that a technology is approved for the marketplace
2 by the FDA. The question then becomes for Medicare, how do
3 cover it? In which populations do you cover it? How do you
4 pay for it?

5 With ICDs the case was, it was covered but then
6 additional clinical trials were done raising the possibility
7 of covering this technology in expanded populations; namely,
8 prophylactically for people in primary prevention. A series
9 of clinical trials were done in 2000, 2001 and 2002 and then
10 Medicare made a decision and decided to expand the
11 indication, expand the populations for ICDs. They went back
12 again after an additional trial was done in 2003 and 2004
13 and in January of 2005 expanded yet again.

14 I think it indicates that simply having the FDA
15 approval is not enough for the specific Medicare decision in
16 terms of populations, and also perhaps in terms of exactly
17 how you cover it. Colorectal cancer screening is covered
18 differently depending on the risk group, for example.

19 MS. DePARLE: I guess I'm a more raising a -- I
20 agree and I assume you agree that the process they followed
21 on ICDs was appropriate, the looking at the evidence. But
22 what if they did the kind of analysis you're suggesting and

1 it turned out that something didn't meet the standard?
2 Would you suggest then they should go back and withdraw
3 coverage or change the -- because then you have doctors
4 using it, people believing in it. To some extent, lung
5 volume reduction surgery is an example of that, which you
6 didn't look at.

7 DR. NEUMANN: Right, we didn't look at but we have
8 looked at it in other studies. I think it raises all kinds
9 of challenges for Medicare. What do they do? They could do
10 coverage with evidence development as they're trying to
11 think through now. They could try to go back and look ask
12 for another clinical trial or have a clinical trial done as
13 they did with lung volume reduction surgery.

14 That's an expensive proposition and a long term in
15 terms of time decision, and one that may not be practical
16 for a device like ICDs which is already out. But you're
17 right, in terms of the physicians starting to use it and how
18 Medicare makes decisions and tries to limit coverage or
19 expand coverage I think is just an ongoing challenge that
20 they need to decide on a case-by-case basis.

21 DR. MILLER: Can I also just add one thing to
22 that? I just want to remind the commissioners that the other

1 thing we've said about this whole line of discussion is it
2 doesn't have to always be about coverage. It could be about
3 whether your payments are set differently.

4 Also Glenn has made the point in previous
5 conversations that depending on research, let's say after
6 it's been disseminated you get results that suggest it's not
7 as effective, you could use that information for pay-for-
8 performance purposes and pay differentially on who does and
9 who doesn't use these types of things.

10 MS. DePARLE: I remember this and we had a
11 discussion. I've often thought we spend a lot of energy now
12 I think on new technologies. We spend very little on some
13 of the things we're spending hundreds of millions of dollars
14 on every day that we don't know if it works or perhaps we
15 could know that it doesn't work that well. So payment would
16 be a good way to influence that.

17 MR. HACKBARTH: Nancy, I apologize. I forgot that
18 you had some additional comments, so let me go back to
19 Nancy.

20 MS. RAY: That's okay. I just wanted to pick up
21 on Peters's last point about CMS undertaking its own
22 synthesis. As everyone is well aware, CMS does consider

1 clinical information when making national coverage decisions
2 and the agency is increasingly linking those decisions to
3 collecting clinical data in registries, for example. The
4 agency does not explicitly consider cost information or
5 cost-effectiveness analysis, and Peter and Josh's analysis I
6 think raise some issues about the consistency of methods and
7 assumptions across studies.

8 Peter also referred to the Panel on Cost
9 Effectiveness in Health and Medicine. They made a series of
10 recommendations back in 1993. It was a panel convened by
11 the U.S. Public Health Service and I think there was 13 non-
12 government scientists on the panel, and they made a
13 recommendation about the use of a reference case, which is a
14 set of standard assumptions and methodologies that studies
15 should use. And they did so in order to improve the
16 comparability of analyses.

17 Revisiting these standards by some public groups,
18 including Medicare as well as private groups, is one option
19 here to think about. Doing so might lead to even more
20 improvements in the consistency of methods and assumptions
21 across studies.

22 Your briefing paper also raises some issues to

1 think about if Medicare were to try to develop the
2 infrastructure to consider both clinical and cost
3 effectiveness. Considering effectiveness information could
4 mean reviewing the information just like what Peter and Josh
5 have done for us. It could also mean conducting a cost-
6 effectiveness study when the literature does not provide a
7 clear indication of the effectiveness of the service.

8 Your briefing material raises three issues to
9 think about. There are clearly more to think about if
10 Medicare were to move forward and develop the
11 infrastructure. The first question would be who would
12 sponsor the research? It could be Medicare or it could be
13 Medicare with other public payers like the VA, as well as
14 private groups, private employers, private purchasers,
15 private payers.

16 Who would conduct the research? CMS is one
17 possibility. They have some capability, but they do ask for
18 assistance from AHRQ and from their coverage advisory
19 committee when making national coverage decisions. AHRQ has
20 developed some infrastructure. They have set up 13
21 evidence-based practice centers that they use when they are
22 conducting their comparative effectiveness research under

1 the MMA 1013 program as well as their technology
2 assessments.

3 A third option -- of course there's more here --
4 would be one or more independent groups to conduct the
5 research.

6 The last issue that's raised in your briefing
7 material is who would fund the research. Discretionary
8 federal or private funding might be vulnerable to
9 uncertainty. One researcher suggested a method that is not
10 linked to either annual federal appropriations or
11 discretionary private funding.

12 So that concludes my other additional topics you
13 may want to discuss.

14 DR. REISCHAUER: Thank you for the paper. I
15 thought it was really excellent and the presentation was a
16 very way of concise way of summarizing what took a lot
17 longer to read.

18 The question that I had when I was reading this
19 last night was one of age. Are these studies all done of
20 people who are 65 and older or not? For a lot of this type
21 of analysis, these ratios, I would think would change
22 dramatically as one aged. That's question number one.

1 Question number two is, would I be wrong in
2 assuming that the failure to use social cost is less of a
3 problem when we're talking about Medicare than if we were
4 talking about the working age population, simply because the
5 major component that's left out is foregone income and out-
6 of-pocket spending, which is also probably less for the
7 Medicare folks than for others.

8 DR. COHEN: In terms of your first question on the
9 age and whether we limited somehow the inclusion criteria
10 for studies, we did not. For ICDs, that really wasn't even
11 a criterion that was specified in studies. For colorectal
12 cancer screening it's a bigger deal.

13 There were some studies, not a huge number, that
14 looked at how differing the age affected the cost-
15 effectiveness ratio. So there wasn't a lot of information
16 where you could say, all right, here's five different ratios
17 that compare starting screening at age 60 versus age 50. So
18 that did not show up as something that we were able to tease
19 out and do some sort of analysis on.

20 In terms of the social costs, your second
21 question, I thought about that myself. I guess, not that
22 I'm someone who knows a lot about these conditions. The one

1 place where I think that including social costs could make a
2 difference is if you do have an appreciable number of people
3 who have heart attacks before they retire there could be a
4 productivity loss that does affect the answer in some
5 appreciable way. I don't know whether that's with really
6 true. I was just guessing about it in my mind. It's
7 something that would have to be resolved by analysis.

8 DR. NEUMANN: I would just add one thing because I
9 think your observation that perhaps because it's an elderly
10 population foregone income is not important is a good one.
11 We can speculate that that may be a lot more important in
12 younger populations.

13 This issue of societal versus health care costs
14 comes up a lot and sometimes it's argued that for the
15 Medicare program, funded by general revenues as well as
16 other sources and it's a large social programs, should take
17 a societal perspective. Even if we don't include the
18 foregone income there could be other costs that are not
19 included in the analysis that might make a difference for an
20 elderly population.

21 For example, do you include nursing home costs and
22 custodial care and such as an issue? It could make a

1 difference whether you're taking a societal perspective and
2 health care perspective.

3 DR. REISCHAUER: Just as a practical observation,
4 even if you found that age was terribly important I can't
5 imagine the political circumstances that would allow us to
6 say, implantable defibrillator if you're under 64 but not if
7 you're above. So it's interesting for analysts but does not
8 have any practical policy ramifications.

9 DR. MILSTEIN: I have a couple of questions.
10 First, there are many people who have expressed skepticism
11 as to whether or not there is the funding availability or
12 political will to force the kind of degree and granularity
13 of randomized controlled studies that you'd need to begin to
14 really map all of the -- even a fair percentage of the
15 treatment-treatment indication diads for which one would
16 want information if I were putting together a careful
17 policy.

18 In response to that some have said, can we take
19 advantage of the fact that in America there is such wide
20 variation in the rate of uptake of new treatments, new
21 technologies and use the Medicare database, perhaps with
22 some expansions, as our pretty good database for purposes of

1 conducting non-randomized control studies? I wonder what
2 your thoughts are about that? Specifically, has anybody
3 given any thought as to the incremental data elements one
4 would have to routinely collect as part of the Medicare
5 billing data set in order to give us a pretty good start on
6 that kind of a course?

7 I'll hold my second question because my first
8 question is complicated enough.

9 DR. NEUMANN: There is a lot of discussion about
10 the fact that you don't have the kind of treatment-treatment
11 randomized trials that you would ideally like to make
12 decisions and what do you do about it? Whether existing
13 Medicare databases are sufficient is a big question but I
14 think certainly it's true that there's a lot of activity
15 that's going on to try to tease out of all kinds of non-
16 randomized data evidence, treatment effects out of
17 observational databases and so forth.

18 There is an effort that is the drug effectiveness
19 review product that's an alliance of 16 states, mostly
20 Medicaid programs, and a couple of non-profit organizations
21 that have banded together and are looking very hard at this
22 science of reviewing the totality of evidence including

1 randomized controlled trials and all their non-randomized
2 evidence and trying to put a lot more rigor behind it. So I
3 think that activity and others like it are certainly
4 shedding light on areas where you don't and probably won't
5 ever have head-to-head comparisons. Some of the Section
6 1013 work that Nancy mentioned is also getting at non-
7 randomized evidence.

8 It's certainly an area that needs a lot more
9 activity and I think Medicare databases are great resources
10 to try to exploit for those kinds of analyses with all of
11 their limitations and selection effects of everything else.

12 DR. COHEN: I'll just add one thing to that and
13 that is that you can get some information just from
14 modeling, extrapolating, simulation to extrapolate beyond
15 trial results. Now obviously you'd much rather have
16 empirical information, but sometimes you can do modeling and
17 if you do your uncertainty or sensitivity analysis correctly
18 you can establish that even though you don't have the
19 empirical information you can be pretty sure that the result
20 is in some range that is either this is a no-go or it's
21 really good value for the money. So you can qualitatively
22 get your answer even if you haven't been able to measure it

1 directly.

2 DR. MILSTEIN: I'd like to follow up on -- it's
3 actually a combination of both Bob and Mark's comments,
4 appreciating the fact that, particularly in view of the
5 politics and the information imperfection it might be
6 difficult to move ahead with cover/non-cover. I wondered if
7 you could comment on the option that Mark touched on, which
8 is to vary the amount paid either for the technology or the
9 professional services associated with service types that are
10 more rather than less cost effective or vice versa? Are you
11 aware of other countries that have successfully faced the
12 political challenges associated with that kind of a policy?

13 DR. NEUMANN: I think you're right in the sense
14 that the cost-effectiveness analysis is often framed as a
15 tool to say we cover or we don't cover, when in fact I think
16 the way it's been used is much more nuanced. It's a tool to
17 figure out where to cover. So we cover this technology and
18 we use the cost-effectiveness analysis to figure out that
19 the really good value for money or the cost effectiveness is
20 in this population, defined by clinical characteristics or
21 age or even other dimensions.

22 I think that's been the case, for example, in the

1 U.K. with NIHCE, National Institute of Health and Clinical
2 Excellence. Even in the U.S. I think there's some emerging
3 evidence that cost-effectiveness information and related
4 information is being used in terms of informing formulary
5 placement decisions. So we cover this drug but we put it on
6 this tier, or we cover this drug but only as second and
7 third line therapy and after you use the cheaper job drug
8 first.

9 It could be used, as you said and Dr. Miller said,
10 to inform payment policy, either which DRG it goes into or
11 perhaps whether it warrants add-on payments and a number of
12 other options.

13 MR. BERTKO: Just a quick to follow up to Arnie's
14 first question, actually two parts. But the first is, I
15 noted that you chose for AHRQ, the work here for MedPAC, to
16 pick two of the four study procedures because they had more
17 studies. The question is, how many are good enough? Would
18 one really big study be sufficient or would you want to have
19 multiple studies? Any thoughts about what's the threshold
20 for that?

21 DR. COHEN: I think it really has to be looked at
22 on a case-by-case basis. If there is an important decision

1 that has to be made, and say there's one study and it's
2 really good. I think you have to look at it and you have to
3 say, is this really answering the question that we want
4 answered? Is it using the assumptions that we think are
5 valid assumptions? Can we even tell what it's doing?
6 That's an important thing.

7 If you don't have that then you have to think
8 about what is needed next. So there isn't a hard threshold,
9 of course. I think it's just a number of considerations
10 that you have to think about.

11 MR. BERTKO: The second, to more directly connect
12 with Arnie's first question is, the Medicare database is
13 very rich in claims data. It allows you to identify
14 diagnoses, multiple comorbidities, but not medical records.
15 I know that people like RAND have gone back and done medical
16 record review, which is very expensive, but given the
17 difficulties of finding randomized controlled trials that
18 expense might be minor compared to the time and effort going
19 forward. I just wondered if you had any thoughts about that
20 idea.

21 DR. NEUMANN: I think you're right. Claims data
22 have a lot of advantages. One of the limitations is they

1 tend not to have rich descriptive clinical information that
2 you can get out of a medical record. So certainly there are
3 advantages to going to records and it is costly, to be sure.

4 But again, I think to get back to the comment
5 earlier, we need to push on the science of assembling non-
6 randomized information, and our databases are getting better
7 and better, and our ability to link claims data to clinical
8 data is getting better and better. So I think those
9 approaches are very valuable and will be even more so in the
10 future.

11 DR. KANE: I have two questions that are totally
12 unrelated but I'll ask them both at the same time. One is,
13 do you expand the group of clinical trials that you look at
14 and cost-benefit analyses you look at to international
15 settings? If you do, do they give you roughly the same
16 types of answers or greatly different, and would you have
17 any notion of why? That's question one.

18 The other question is, apart from using this for
19 coverage decisions or payment decisions, can you see it
20 having any use in influencing consumer choices?

21 DR. NEUMANN: First to the international question.
22 The convention is internationally patients' biology doesn't

1 change but health systems do. So the clinical trials might
2 be relevant. There may be exceptions in certain populations
3 even on clinical data but by and large clinical data, if the
4 trials are well done, and randomized, are generalizable.

5 Health systems often are not, so that a hospital
6 length of stay might be much longer in Japan or Germany. To
7 use the economic data from an international trial, from an
8 international cost-effectiveness analysis, may not be as
9 generalizable. But again I think you need to look at that
10 on a case-by-case basis. Even though the study is done in
11 Sweden it still may yield some important information in
12 terms of the cost-effectiveness analysis.

13 If, as does Josh was saying earlier, if it's very,
14 very clear that it's cost effective and you can see why in
15 Sweden it may well be that you for comfortable enough that
16 conditions are generally holding elsewhere in the U.S.

17 DR. KANE: That suggests that how the practice
18 around that technology is delivered as a big effect on your
19 result. So if you're in Sweden you may have a very cost-
20 effective treatment but in the U.S. you may not because of
21 the differences in practice.

22 DR. NEUMANN: It's certainly possible.

1 DR. MILLER: Consumer choice?

2 DR. NEUMANN: How the cost-effectiveness
3 information is dealt with for consumers and some of the
4 consumer issues is a question people debate. Often these
5 studies are targeted at managers and policymakers and they
6 are done for people who are thinking about broader societal
7 resource allocation decisions. To try to interpret a cost
8 per QALY ratio as a consumer is difficult.

9 Nonetheless, I think there is an attempt to try to
10 in some way marry cost-effectiveness information with the
11 kind of burgeoning consumer movement. Maybe it means using
12 the cost-effectiveness information to influence what tier or
13 how the cost sharing is done. So the idea is to try to
14 match value with giving incentives for consumers to do good
15 things.

16 So even if an expensive new technology in terms of
17 its price shows to be very good value for money from a
18 longer-term perspective, you don't want the patient have
19 high cost sharing on that because you don't want to offer a
20 disincentive for the consumer to use that.

21 MR. HACKBARTH: Can I just follow up on that,
22 Peter? For patients, even if, because of insurance

1 coverage, cost-effectiveness research has less significance
2 for them personally, certainly risk benefit analysis can be
3 very important. There are those who feel that that's a
4 major opportunity for us to improve the health care system
5 systematically, in a user-friendly way provide information
6 to patients about risks and benefits of alternative
7 therapies.

8 To what extent does the database necessary to feed
9 the cost-effectiveness research for payers also support risk
10 benefit information for patients?

11 DR. NEUMANN: In the cost-effectiveness framework
12 we're dealing with cost per unit of health, cost per life
13 or cost per QALY. The QALY has some strong assumptions
14 attached to it which may or may not incorporate some of the
15 risk benefit information that you've like to convey to the
16 patients. It may well be that technologies are associated
17 with risk trade-offs, in fact they undoubtedly are
18 associated with risk benefit trade-offs that you'd like to
19 convey to patients and have them much better informed about
20 the risks and the benefits that they themselves face.

21 It may be that the cost-effectiveness ratio, some
22 of the ones we presented here, obscure or mask some of those

1 risk benefit trade-offs and it may be you need to do a
2 separate analysis or present both of those pieces of
3 information to the decision-makers. It could be that you
4 provide it to the payer, the physician and the patient and
5 they use all of that information in making their decision.

6 MS. RAY: Can I just point out, I think on
7 everybody's chairs there was an article, I think it was from
8 the New York Times. I think it showed a really good example
9 of how the risk benefit information trickled down to
10 physicians for lung reduction surgery and that in turn help
11 physicians talk to patients about going ahead with the
12 surgery, or at least the indication of the article suggests
13 not going ahead with the surgery. I think that's one
14 example to follow up on your point where this information
15 has been put together and used.

16 MR. MULLER: Just a technical question. One of
17 the new biologic drugs is likely to be very effective for
18 colon cancer for a certain subset of the population but not
19 for another subset based on genetics. How does the ratio
20 change? If you pick the population which we can test now
21 where it's likely not to be effective versus the one -- how
22 does the calculation change? If it's, current evidence,

1 clearly ineffective versus highly effective.

2 DR. COHEN: It depends on some of the specifics of
3 the drug. For example, -- I don't know anything about this,
4 but if this is the type of drug that is effective if you can
5 catch the disease before it manifests itself in an obvious
6 way then clearly that's going to make screening more cost
7 effective because it means that when you catch something
8 early you're going to get a greater benefit. If this were
9 some sort of drug that we're able to knock out the cancer
10 later on in the process than the incremental benefit of
11 catching it really is not going to be as great.

12 Then there is the issue of whether you can
13 identify this specific population for which the drug is
14 beneficial. If it's 5 percent of the population but you
15 need some sort of expensive test to identify who that 5
16 percent is, then it sort of becomes a moot point. You may
17 as well just go on with your general screening.

18 MR. MULLER: But does the calculation, would it
19 also take into account the treatments you could avoid by
20 identifying the set of the population for whom the therapy
21 would not be effective? Does that go into the calculation
22 as well? Almost like a cost avoidance type, is that --

1 DR. COHEN: Sure, in principal.

2 MR. MULLER: I think in many ways right now many
3 of the cancer drugs are, as you know, applied to whole
4 populations. Part of the promise of the new biologics is
5 that they could be used for the 30 or 50 percent of the
6 population for which they're most effective. In that sense,
7 cancer therapy can be quite expensive, \$50,000 or \$100,000,
8 et cetera. So to the extent to which one can cost avoid, if
9 that's a verb, that \$50,000 or \$100,000 treatment, in that
10 sense the test I would think becomes very cost effective.
11 I'm just wondering whether the calculations take those kind
12 of considerations into account.

13 DR. NEUMANN: It should. The methodology is
14 certainly flexible enough to accommodate assumptions. To
15 the extent you have clinical information it should be in
16 there.

17 MR. MULLER: That obviously is -- we had part of
18 this discussion yesterday but there's a lot of cost
19 avoidance by targeting these drugs much more effectively and
20 avoiding \$50,000, \$100,000 therapies where they're not
21 effective and targeting them on the people where they are.

22 DR. CROSSON: Thank you. One of the questions I

1 think for the Commission to consider is the cost
2 effectiveness of recommending that CMS think about using
3 cost effectiveness in anything, coverage or payment
4 determinations. So as we think about that I'm thinking that
5 a lot of this, particularly if we're going to be looking at
6 payment mechanisms, we're really talking about using cost-
7 effectiveness analysis in a comparative effectiveness way
8 because most of the time -- not always but most of the time
9 you're talking about doing this versus doing this other
10 thing which is standard practice.

11 It seems to me if that's the case most of the time
12 then you have sort of a two-by-two table in your head where
13 over here you've got small or large differences in quality
14 and here small or large differences in cost. Then if you
15 apply that two-by-two to Nancy's universe of not just what's
16 new but what Medicare is paying for you've got four
17 different cells. And the cell that seems to be the most
18 attractive is the cell that has small or no differences in
19 quality but large differences in cost. That's the cell --
20 just to say, the cell that has big differences in quality
21 and small differences of cost, that's kind of a slam dunk.

22 If there are big differences in quality and

1 doesn't cost much then you expect that things are going to
2 go in that direction. If you've got big differences in
3 quality and big differences in costs then that takes us into
4 the hard analysis like the British are doing because you end
5 up basically saying yes or no to something which does make a
6 difference but it costs a lot. That's the political
7 minefield, I think. If you've got small differences in
8 quality and small differences in cost, who cares?

9 So the box we're really talking about is the box
10 theoretically where there are small or no differences in
11 quality but big differences in cost.

12 So the question is, do you have any intuitive
13 sense of whether that in fact is a big box or a little box?

14 [Laughter.]

15 DR. NEUMANN: There's an awful lot of new drugs,
16 technologies, procedures out there that are expensive and
17 probably have positive benefit. So the box is probably
18 pretty large.

19 There also, as Nancy-Ann was saying earlier, a lot
20 of existing things that we do you that really haven't been
21 subject to some of the scrutiny that also may well have
22 positive benefit but also positive cost. These are

1 empirical questions. But there's an awful lot that one
2 might look at.

3 One of the challenges is to figure how to
4 prioritize the big-ticket items. Often they're the ones
5 with the biggest budget impact. That I think is a key
6 question.

7 MS. BURKE: I wonder if I could ask just a follow-
8 up question for either Nancy or for either of you. That is,
9 in looking at Great Britain's process and the NIHCE process
10 I wonder -- there's a brief description in the materials but
11 I wonder as to how they make the decision as to the
12 procedures they refer to the advisory process. There's a
13 reference to a base amount in terms of cost. But I wonder
14 if you could give us just a two-minute -- to your point,
15 Peter, which is, there is an enormous universe out there and
16 query, given limited resources how best to target your
17 resources were you to begin to get into this business.

18 Can you give me just a couple of minutes so I
19 fully understand how they go about making that decision?
20 Have they gone backwards or are they only going forwards in
21 terms of new applications as compared to existing? And how
22 are they discriminating among all the things that come on

1 the market as to which of them they will refer to the
2 advisory process?

3 DR. NEUMANN: I'll try to take a stab at it. I
4 must say I know something about the NIHCE system but there
5 are people who know a lot more about it than I do. But I
6 think they have tried to think hard about how to identify
7 those procedures to look at in the first place. They have
8 what I think they call a horizon scanning group and process
9 where they have people who are looking for things coming,
10 and also existing, that are costing a lot of money, that are
11 areas of uncertainty, that are areas of perhaps some
12 clinical controversy, and certainly good candidates for
13 scrutiny of clinical and cost-effectiveness evidence.

14 There are also people who -- and I think in the
15 U.K. and at NIHCE as well in particular perhaps, who are
16 trying to develop some formal methodology for doing this
17 with value of information analysis, where they're trying to
18 actually formally estimate the costs and the benefits of
19 collecting information in the first place. It's a
20 methodology that's fraught with its own challenges and
21 uncertainties but I think that's how they do it.

22 I don't know if I answered all of your questions.

1 MS. BURKE: That's certainly helpful. I think,
2 Glenn, one of the issues for us as we go forward and as we
3 begin to think -- I think Nancy's done a nice job of
4 identifying three of the key issues. I would add to that
5 issue not only these sort of functional questions of who
6 sponsors it, who conducts it and who funds it, but also the
7 fundamental question is how one makes a decision as to where
8 one prioritizes one's efforts. To the extent that we go in
9 this direction, the universe -- the box, to answer the
10 question that was asked, the box is potentially quite large
11 or not.

12 It was interesting to watch the British decision
13 on the Alzheimer drugs which has met with some anxiety, not
14 surprisingly.

15 But again, I think one of our questions, were we
16 to go forward and I think it's something that the Commission
17 would need to look at it is, all things being equal how
18 would you even begin to approach the process? How would you
19 begin to set priorities? Because that issue -- I mean, I
20 think back to some of the OTA issues and I think back to
21 some of the AHRQ problems that arose, it was about what you
22 chose to do, what was the reason. Was it solely based on a

1 set of criteria that were clearly established, that had to
2 do with either clinical effectiveness or controversy over
3 its use or its cost? I think clearly delineated that and
4 creating a transparency will be critical to making this a
5 process that people are comfortable putting into play.

6 MS. HANSEN: Actually I'd like to follow up with
7 what Sheila just brought up about the decision-making
8 process. I know that AHRQ in its process now of looking at
9 comparative effectiveness is making this a very public,
10 transparent process where it's on a web site. They have
11 stakeholder groups that really talk about this, and they are
12 actually trying to, from an AHRQ perspective, choose
13 different methods and have the criteria definitely
14 transparent.

15 I think they were really stung by the previous
16 process of just all the different special interests. But
17 now it is publicly there on a web site and available out
18 publicly.

19 MS. BURKE: That's probably, Nancy, worth our
20 getting a hold of. As I recall the last big issue for them
21 was back surgery, was it not, orthopedic stuff? But if
22 they've moved in this direction it would be interesting

1 going forward for us to understand and to get further
2 information on NIHCE. But also if AHRQ is going in this
3 direction it would be nice to how are they in fact
4 establishing their criteria and what's the basis.

5 MS. HANSEN: They've chosen two topics that are
6 public right now. One is GERD, the gastroesophageal reflux
7 disease as well as positive mammograms and what are some of
8 the follow-ups. But separately, this segues to a question
9 or comment that I don't know whether that was an
10 underpinning of Ralph's comment about effectiveness for
11 certain groups.

12 My question is relatively broader and that is, in
13 terms of looking at all of these studies whether or not in
14 terms of coverage decisions or preventive, kind of
15 encouragement of taking on services, whether considerations
16 are differentially done for populations that may be racial
17 groups that are more predisposed as well as people who might
18 be predisposed say for breast cancer. Are there ways to
19 take a look at some of these studies with any kind of volume
20 that looks at populations a little bit more differentially
21 for this?

22 DR. NEUMANN: Many of the studies do stratify on

1 lots of risk factors. It's all a matter of what the
2 particular investigators happen to do, but they often will
3 take into account family history, perhaps race or ethnicity,
4 certainly clinical risk factors. One can certainly do
5 analysis, clinical analysis, cost-effectiveness analysis, on
6 those dimensions. Then whether or not you want to make
7 actual coverage decisions on those dimensions that's a
8 question for the decision-makers.

9 MR. HACKBARTH: Between this session and the one a
10 year ago we've heard that there are a series of challenges
11 that must be addressed to expand use of cost-effectiveness
12 analysis. We need better funding for clinical studies so we
13 have a better idea of what works and what doesn't. The
14 number and quality of the studies themselves varies. We
15 need standards on cost-effectiveness analysis. There's a
16 rationing reticence, shall we say, both in the public and
17 private sectors. So there are a lot of fronts where we need
18 to do work.

19 What I wonder is whether this is an area uniquely
20 or almost uniquely calling for public/private collaboration
21 if we're going to make headway in addressing these multiple
22 challenges.

1 I think, focusing on the rationing reticence for a
2 second, I think there's a dynamic whereby Medicare is
3 reluctant to be seen as more restrictive than private
4 payers, that's a politically untenable position. And
5 private payers are often looking to Medicare for leadership
6 for a variety of reasons. And so everybody is saying, you
7 go first and we're not going anywhere as a result.

8 In some ways this seems analogous to me to maybe
9 the pay for performance area where if the public and private
10 sectors together come to build infrastructure and invest in
11 research and development of standards, that both would be
12 significantly better off and we'd have a much greater
13 likelihood of advancing the cause.

14 Any thoughts either from the panel or
15 commissioners about that?

16 DR. REISCHAUER: The problem is this is a public
17 good. It's really an international public good so there's
18 no incentive for the private sector to invest in it. It's
19 the kind of thing that even if you do produce the public
20 good, politically you can't do it unless everybody else does
21 it, in which case whatever benefit you might have has
22 disappeared completely.

1 I'm an advocate of this being a public/private,
2 not voluntary kind of thing, because I think you have to
3 coerce the private sector into contributing.

4 MS. BURKE: Bob, I'm not sure I would agree
5 necessarily that it's not in their interests. They,
6 arguably have, certainly with the bigger plans, with United
7 or Wellpoint or Aetna, they've got 15 million, 20 million
8 lives on the line as well. So the value, if you assume that
9 there's a quantitative value in not doing things that aren't
10 cost effective, would be to their advantage as well I would
11 think. It's not just a public good.

12 DR. REISCHAUER: But they can't capture the
13 benefits from it.

14 MS. BURKE: You mean for certain age cohorts or
15 generally?

16 DR. REISCHAUER: Just in general. They discover
17 treatment A is not cost effective. Let's say it's in
18 existence already and everybody is providing it and they're
19 going to clamp down on it. They're going to get into some
20 political problems just as Medicare has --

21 MS. BURKE: But they don't seem to be reluctant --

22 DR. REISCHAUER: -- in denying it to their people.

1 If they've done all the research and it comes out and they
2 can impose it, then Humana can glom onto that knowledge for
3 free, and these things are not cheap to do.

4 MS. BURKE: I would think it would depend on the
5 makeup of their population. All things being equal you're
6 right, anything they do that gains knowledge advantages
7 everybody. But I've got to believe there's some advantage
8 to them.

9 MR. BERTKO: Bob, some of these are clear-cut and
10 easy, others are much more difficult. I'll give you one
11 example that's simplistic.

12 There is apparent, in some places, overuse of
13 human growth hormone off label. It's an approved drug.
14 It's useful for certain people, and some of us have seen
15 some spikes that are clearly inappropriate so, ping, it goes
16 away. It's to our benefit, it's to our customers' benefit,
17 the large employers, and in fact arguably it's a good idea
18 for our members because it was a bad idea to treat just
19 short but normal kids with human growth hormone.

20 DR. REISCHAUER: So everybody does the same thing
21 you do but you've done the research to show --

22 MR. BERTKO: But it was sequential. One company

1 found it, other companies heard about it. Horizon scanning
2 is an appropriate term here. We didn't even know it was
3 happening until we heard via, I'll call it the industry
4 gossip line, rumor that it was happening and then we found
5 some happening in some geographic locations.

6 DR. NEUMANN: I guess I would just say, I do think
7 there's a process here. Maybe it should indeed involve
8 public and private groups. But I think there's a process
9 that has gone on in other places that have used it, in the
10 U.K. for example, that involves input from all kinds of
11 stakeholders, and the public, and feedback and so forth.

12 I think part of the answer may lie in how this is
13 done, not only in terms of the process but in terms of how
14 it's framed. That is, I think cost-effectiveness analysis
15 is often framed as a tool, as we discussed earlier, to deny
16 coverage, to ration, when indeed it should be seen as a tool
17 to improve the value of the care delivered and to try to
18 inform the types of coverage and payment decisions that are
19 made. I've argued in the past, perhaps the term itself,
20 cost effectiveness, has become a kind of pejorative because
21 it sounds like it's about cost containment. So maybe we
22 need a new term as well.

1 But regardless of what term we use I think we do
2 need to frame it in the right way for people.

3 DR. MILSTEIN: Reflecting on Glenn's question, it
4 seems to me than Congress has in some ways already taken the
5 first step forward with respect to implementation of what
6 could be framed loosely as cost-effectiveness analysis, both
7 in MMA and the Deficit Reduction Act. In MMA they basically
8 said, we want payment levels to providers geared to what
9 efficient providers need. They didn't tie the definition of
10 efficiency to cost effectiveness. Then in the Deficit
11 Reduction Act they signaled an interest in provider pay for
12 performance to take into account both effectiveness as well
13 as efficiency. And I think efficiency translates into
14 resource use, and the ratio between resource use in an
15 administered-price environment, resource use and
16 effectiveness becomes a proxy.

17 What is left a little vague is the time frame of
18 reference. Cost effectiveness is a lifetime assessment,
19 whereas some of the other time units on which efficiency and
20 effectiveness can be calculated are much shorter than that.
21 But that really remains an unspecified aspect of the policy
22 that's already been laid out.

1 So essentially we already have a signal from
2 Congress that with respect to both effectiveness and
3 efficiency we should move forward in our payment system to
4 gear it to both of those characteristics.

5 I want to go back to Mark's question and ask
6 whether there are any countries globally that have taken
7 into account cost effectiveness, efficiency, effectiveness,
8 any of the above, in setting the service payments levels? I
9 think, for example, in the last Commission meeting or the
10 one before, the CDC when they rank preventive interventions
11 smoking cessation counseling keeps coming out number one off
12 the charts in terms of not only cost effectiveness but it's
13 actually a cost savings intervention. Yet there's been no
14 effort in the Medicare program or many other programs to
15 more favorably reimburse that very high yield service.

16 Have any countries moved forward on, I'll call it
17 pay for performance but in which the unit of analysis is the
18 service rather than the providers' practice writ large?

19 DR. NEUMANN: There are many countries I think
20 that are trying to use cost-effectiveness information,
21 sometimes an indirect ways perhaps, to negotiate prices
22 down. Now for example, your drug is very expensive, it does

1 offer some benefits but at the price you're offering it it's
2 not cost effective. It becomes cost effective at a much
3 lower price. Now sometimes the rules don't allow them to do
4 that explicitly but that seems to be the outcome of the
5 process.

6 The other part, there's experimentation in trying
7 to use cost-effectiveness analysis in doing risk sharing
8 arrangements. The famous example is the MS drugs in the
9 U.K. There was a lot of uncertainty about whether they were
10 cost effective or not. It depended on whether you believed
11 assumptions about long-term effective based on short-term
12 trials. The decision that was made was, we'll cover your
13 drugs and we'll actually see. We'll look and see if they
14 work overtime. If it turns out that they do, we'll give you
15 the higher price. If they don't then you get a lower price,
16 so you have to pay us back, in that sense.

17 DR. MILSTEIN: First of all, that was very
18 informative. My question pertained to the level of
19 professional payment. In other words, are there any
20 countries that are moving ahead, for example, with paying
21 for smoking cessation at a substantially higher -- or
22 beginning to vary that based on demonstrated high levels of

1 cost effectiveness? It's taking the other, in some ways the
2 less politically challenging cell of Jay's four cells, which
3 is the services that are off the charts in terms of
4 favorable cost-effectiveness rating and pay them more
5 generously. In an overall constrained environment it has
6 the effect of paying less generously those things that
7 aren't in that favored cell.

8 DR. NEUMANN: I get it. So to use the information
9 to give incentives to do good things, and maybe pay people
10 more. I can't think of any offhand. Maybe there are. It
11 certainly seems reasonable to do and I've certainly heard
12 people mention, for example, tying it to pay for performance
13 in a way that you suggest. But I don't know of any actual
14 cases.

15 MS. RAY: But that is an issue that in the future
16 we could explore it. We could look and see what's going on
17 in Canada and the U.K. and Germany and Australia and New
18 Zealand, for example, to see if there are any cases That
19 could be on our future work agenda certainly.

20 MR. HACKBARTH: Unfortunately, we're going to have
21 to bring this to a conclusion and move on. Thank you very
22 much. Very well done, Peter and Josh.

1 Okay, next up is payment for hospice services.

2 * MS. LINEHAN: Good morning. This session is about
3 Medicare's hospice benefit. The hospice payment rates were
4 developed 25 years ago and since then the use of hospice has
5 grown and the provision of hospice has changed. These
6 changes to the use and provision of hospice care that I'm
7 going to review motivated us to assess whether payment could
8 be adjusted using patient characteristics to improve the
9 accuracy of the payment system.

10 I'm going to present some background and that is
11 going to set the stage for why we contracted with Dr.
12 Melinda Beeuwkes Buntin at RAND and her colleagues to
13 undertake an analysis of possible payment system
14 refinements. Melinda is a health economist and co-director
15 of the Center for Health Care Organization, Economics and
16 Finance at RAND. After I review the background she's going
17 to discuss their results based on an analysis of data from
18 one large hospice chain provider.

19 The CMS office of the Actuary estimates that
20 Medicare spending on hospice will be \$9.8 billion in 2006.
21 Spending on hospice services is projected to increase at an
22 average rate of 9 percent per year from 2004 to 2015. This

1 growth rate is more than the rate for hospitals, physicians,
2 SNFs and home health services. Medicare is by far the
3 dominant payer of hospice care. The National Hospice and
4 Palliative Care Organization reports that Medicare paid for
5 88 percent of total days in 2004 in the every facility.

6 Hospice was added as a Medicare benefit in 1983.
7 The benefit covers palliative and support services for
8 beneficiaries who have a life expectancy of six months or
9 less and who agree to forgo Medicare coverage of curative
10 treatment for their terminal condition. Covered services
11 under the benefit include skilled nursing care, drugs and
12 biologicals for pain control and symptom management,
13 physical, occupational and speech therapies, counseling,
14 home health aide and homemaker services, short-term
15 inpatient care and other services necessary for the
16 palliation and management of the terminal condition.

17 Hospice care is and always has been carved out of
18 Medicare's managed care benefit. Beneficiaries do not have
19 to disenroll from their MA plan but they may choose to do
20 so.

21 The payment methodology and Medicare's four daily
22 payment rates were developed using cost data from 26

1 hospices providing care to Medicare patients with terminal
2 cancer under a HCFA demonstration project between 1980 and
3 1982. The base rates have been updated for inflation but
4 the payment methodology and the base rates haven't been
5 changed since the initiation of the benefit.

6 The four categories of care that are shown on the
7 screen are distinguished by where they are provided and the
8 intensity of the service, and the dollar amount following
9 the names of the days of care are the 2006 daily rates. The
10 vast majority of hospice days are routine home care days,
11 that first category listed. In 2003 they were 93 percent of
12 days billed. Routine home care is the default payment
13 category that hospices are paid if one of the other types of
14 care aren't provided.

15 There's another feature of this payment system
16 that bears noting. There are two types of caps. There is a
17 cap that 20 percent of the total agency's days can't be, or
18 no more than 20 percent of days can be for inpatient types
19 of care. The other type of cap is an aggregate annual
20 spending cap. In 2005 it was around \$19,000. That amount
21 is multiplied by the number of Medicare patients seen by the
22 agency. If total payments to the agency exceed that amount,

1 they have to pay that amount back to the program.

2 Hospice services are characterized by growth.
3 Hospice has become much more widely used as the visibility
4 and acceptance of hospice care has increased. This share of
5 Medicare fee-for-service decedents electing hospice grew
6 from 22 percent in 2000 to 31 percent in 2004. Between 2000
7 and 2004 the number of Medicare hospice users increased
8 almost 50 percent, the days of care doubled, and payments
9 increased 130 percent. As this shows, the number of days
10 increased more than the number of users. When we look at
11 data on changes in the length of enrollment we see that
12 between 2000 and 2004 the median length of enrollment
13 remained at about two weeks but the mean length of
14 enrollment for a beneficiary in hospice increased from 51 to
15 67 days.

16 The mean length of enrollment was driven up by the
17 upper end of the distribution having increasingly longer
18 lengths of stay before they died. 25 percent of
19 beneficiaries dying in hospice were enrolled for less than a
20 week and that persisted over time. That might be suboptimal
21 because the patient and family may have benefitted from a
22 longer hospice enrollment.

1 This distribution likely reflects several factors
2 related to the structure of the benefit: the difficulty of
3 estimating the amount of time a patient has to live, and the
4 election of hospice only when death appears imminent. It
5 also reflects that the benefit has expanded beyond cancer
6 patients to patients with other terminal conditions such as
7 neurodegenerative conditions and cardiovascular disease. In
8 2003 more than half of all Medicare hospice patients had a
9 non-cancer terminal diagnosis. On average non-cancer
10 patients tend to have longer lengths of enrollment.

11 Another change since the implementation of the
12 hospice benefit, and even in the past five years, is in the
13 composition of hospice provider types. As you can see in
14 this chart, between 2001 and 2006 the number of hospices
15 increased and that increase is attributable to the growth in
16 freestanding, here labeled non-provider affiliated to make
17 the point that they're not necessarily a freestanding
18 building somewhere out there but they're not affiliated with
19 a home health agency or hospital or a SNF.

20 Not shown on this chart but noted in your paper is
21 that new hospices are nearly all for-profit. As of February
22 2006 47 percent of hospices were for-profit and that's

1 compared to 31 percent in 2001.

2 MedPAC has not done a formal payment adequacy
3 analysis of the hospice sector, including look at hospice
4 agency margins, like we do with other providers. There is,
5 however, some information on agency margins from other
6 sources. But these are not necessarily representative of
7 the entire industry and given the recent changes may not
8 even reflect the current state of the sector.

9 GAO found that freestanding hospices had Medicare
10 margins of over 10 percent in 2001, but margins vary by the
11 type of day of care, suggesting that the relative values of
12 Medicare rates for different payment categories may need to
13 be recalibrated. They also found that smaller hospices had
14 higher costs. NHPCO, the National Hospice and Palliative
15 Care Organization data on margins from 2004 showed margins
16 of 11 to 19 percent, again varying by the size of the
17 agency. These were voluntarily reported and not necessarily
18 representative of the entire industry.

19 An analysis of margins using freestanding Medicare
20 cost reports that was published in the Journal of Palliative
21 Medicine found margins varied by the size and for-
22 profit/non-profit status with the median for a large for-

1 profit agency at 18 percent but the median for a large non-
2 profit at just 2 percent. In addition, SEC filings from
3 publicly-traded hospices report that they are acquiring and
4 opening new hospices and have growing average daily censuses
5 which is consistent with the increasing use.

6 I'm going to turn now to Melinda and she's going
7 to discuss the results from their analysis of patient level
8 costs using one chain provider's data.

9 DR. BUNTIN: Thank you, Kathryn, and thanks to the
10 Commission for having me. It's always a privilege to be
11 here. Kathryn has really summed up the motivation for my
12 empirical work that I'm going to be presenting; namely, that
13 we have a per diem system currently that's based on four
14 categories, but that it was implemented about 25 years ago
15 and since then there's been a large change in both the types
16 of patients seen by hospices and the providers serving them.

17 This led us to three specific questions we wanted
18 to investigate. First, how well does the current per diem
19 system reflect current hospice costs? Second, should case
20 mix adjustment be considered, specifically case mix
21 adjustment using, for example, patient diagnoses as has been
22 done with other prospective payment systems? And third, are

1 the beginnings and ends of hospice stays more intensive?
2 These are all questions that have been raised in prior
3 literature by the GAO reports and in the Commission's June
4 2004 report.

5 In order to address this we needed to have data in
6 addition to Medicare claims data which are very limited in
7 the hospice area. So as Kathryn said, we arranged to obtain
8 data from a large for-profit hospice chain. These data
9 contained information on the frequency, timing and duration
10 of visits to hospice patients and on the type of staff
11 providing those visits. It also contained rich patient
12 level data on things, for example, like marital status,
13 nursing home residence, and discharge status.

14 That probably requires little explanation. Most
15 patients, 90 percent or so, die while in hospice, but there
16 are some who are discharged either to move to another area,
17 to go to another hospice because their prognosis is extended
18 or because they decide to see curative treatment and that
19 affects their costs of the pattern of care they receive.

20 There were, however, a number of limitations to
21 using these data. First, it only covered about 6 percent of
22 the hospice population and during the time period we

1 examined only encompassed one chain provider and about two
2 dozen sites.

3 This provider saw a slightly different patient mix
4 than the Medicare hospice population as a whole,
5 particularly it saw a little less lung cancer and debility
6 patients, more of the chronic diseases like cardiovascular,
7 cerebrovascular, neurodegenerative disorders, and had more
8 patients who were in the oldest age category. The hospice
9 also had slightly different practice patterns. It used
10 inpatient care to a greater degree, it did not use respite
11 care and it had very favorable negotiated pharmacy and
12 supply rates. I should also note that they had higher mean
13 but lower median lengths of stay than the industry average.

14 So even though we had these very rich data we also
15 still had to impute costs for direct patient care. We did
16 this using the information I describe on the visits and BLS
17 wage data on relative wages and different labor categories.
18 So again just to reemphasize this, we're not including in
19 here drug costs, supplies, overhead, things like that.
20 We're just looking at the direct costs of patient care
21 visits.

22 When we did this, however, in response to our

1 first question we did find that the per diem system is
2 reflected very well in current visit and visit cost
3 patterns. This bar chart shows R-squared so the proportion
4 of variation explained simply by using the number and type
5 of visits that a patient received. In other words, the
6 variation in cost was really explained by the patient's
7 variation in length of stay or days of care.

8 Now there are two possible reasons for this. One
9 is that this provider may have responded extremely well to
10 the current payment system. The other is that the needs of
11 dying patients could be relatively, clinically similar.

12 When we spoke to the clinical advisors on our project they
13 were actually not terribly surprised to see this. They did
14 feel like on a daily basis the needs of dying patients were
15 relatively similar.

16 We did, however, go ahead and look at whether
17 additional variance could be explained using this rich set
18 of demographic and diagnostic information. The green bars
19 on this chart are the same as you saw on the prior chart.
20 The much smaller blue bars are the portion of variation that
21 we're able to explain using that rich set, again, of
22 demographics and diagnoses. When we combine all three

1 categories of information into a model we're able to
2 actually, in a statistical sense, explain a little less of
3 the variation given that we're adding so many co-variates to
4 the model. So really the per diem system does seem to be
5 reflecting costs well.

6 Another way to look at this is shown on the next
7 chart where you can compare the predicted total visit cost
8 using just the days of care model versus the model that
9 includes the types of days of care, demographics and
10 diagnoses. The takeaway point here is that these bars are
11 very similar.

12 Finally, we did find some evidence that more
13 intensive care is delivered at the beginning and end of
14 hospice stays. Here the green bar shows the average visit
15 labor cost or number of visits across an entire stay. The
16 red bar shows the average in the first three days, the pink
17 in the days that are neither the first or the last three
18 days of a stay, and the blue, the last three days of a
19 hospice stay. You can see that in particular resource use
20 is more intensive during those last three days of a
21 patient's stay in hospice when they're actively dying and
22 need a lot of services.

1 So to conclude, the current per diem system
2 reflects resource utilization in this particular hospice
3 chain well. Again, perhaps because the chain has adapted
4 its practices to the payment system parameters or perhaps
5 because the clinical needs of these patients are relatively
6 similar on a daily basis. Potential case mix adjusters
7 really added little explanatory power conditional on days of
8 care.

9 I'm going to pause here and anticipate a question
10 about selection that the Commission may have. Similar to
11 what I said about adapting to practice patterns, we are
12 looking at the data for the patients who are actually
13 enrolled in this hospice. So if it's the case that patients
14 are adversely selected against, for example, certain
15 category of very expensive cardiovascular patient just isn't
16 admitted to hospice, then it won't be reflected in our data.
17 That said, there is evidence in the literature that these
18 large chain hospices don't have the type of explicit
19 admission criteria that some of the smaller hospices say
20 that they're forced to.

21 Again, in response to our third question we did
22 find that greater compensation for the first and last days

1 of hospice care could be warranted. But I would caution
2 that these results should be validated with a more
3 representative dataset and with complete patient level
4 costs.

5 I think Kathryn is going to wrap up with some
6 implications.

7 MS. LINEHAN: I'm just going to review some
8 possible directions for analysis in the hospice sector.
9 There's something that we could clearly do here which is to
10 analyze payments and costs at the facility level like we do
11 for other types of providers. Based on the evidence
12 available payment levels are generally favorable, but a
13 deeper exploration could show whether there's variation in
14 costs and financial performance by agency size, geography
15 and other characteristics of the facility. This could help
16 us assess the adequacy of the base rates.

17 The second thing that we could think about,
18 although it would require CMS or someone collecting
19 additional data, we undertook the case mix analysis with the
20 proprietary data to determine whether it would suggest the
21 viability of adding case mix adjusters to the payment
22 system. The results, as Melinda said, of RAND's analysis

1 don't make a compelling case that case mix adjusters based
2 on patient characteristics would improve the accuracy of the
3 payment system. However, depending on how you feel about
4 the limitations of the data, doing an additional analysis on
5 a more representative population with a more fully defined
6 dependent variable could lead to different results. But
7 like I said, the data don't currently exist to do this kind
8 of analysis.

9 Also suggested by RAND's work, that redistributing
10 payments from the middle days to the first and especially
11 last days of the stay would more accurately reflect the
12 costs incurred at these stages of the hospice stay. There's
13 evidence of two distinct populations of patients in hospice,
14 a persistent share of patients with short stays and those
15 with increasingly long stays at the upper end of the
16 distribution. Paying more at the beginning and end of the
17 stay would raise the average payment per day over the entire
18 stay for shorter stays but lower the average payment per day
19 for longer stays. But again, testing on a larger population
20 would still be required to know whether we'd see these same
21 patterns in a more representative sample of hospice
22 agencies.

1 Finally, we could consider other policy issues
2 such as whether, in the interest of coordinating care for
3 Medicare beneficiaries, that hospice should, like other
4 Medicare covered services, be included in the managed care
5 benefit given that hospice is no longer a new benefit and is
6 covered by commercial insurers for non-Medicare populations.

7 Now I'm done and I'll take any questions, and
8 Melinda as well.

9 DR. REISCHAUER: I found this stuff really
10 interesting and I want to ask Melinda some questions. I
11 guess, as you suggested, it's not surprising that when you
12 give somebody \$500 they spend \$500. The real question is,
13 is this the optimal or best level of care? And how do we
14 tease that out? You've gone through different types of
15 people and shown that the costs are close to what they're
16 paid in those situations. But I wondered. can you break it
17 between for-profit and non-profit and see if there's any
18 variation that way?

19 And then the other way of trying to answer a
20 question like this would be to say, what kind of services
21 for similar types of people are provided in hospices in
22 other countries where maybe the levels of payment are

1 different from ours?

2 DR. BUNTIN: Unfortunately, we only have patient
3 level data from one hospice chain which is a for-profit
4 chain so I can't compare the practice patterns in a for-
5 profit versus a not-for-profit, but I do think that that
6 would be interesting, in particular because there are
7 reports about different margin levels across the two types
8 of providers. So that would be interesting to do but I'm
9 sorry I can't answer that question.

10 MR. HACKBARTH: The for-profit would presumably be
11 less likely to spend \$500 because they have \$500.

12 DR. REISCHAUER: They didn't. They spent 75
13 percent of \$500, right? There was a margin there.

14 DR. BUNTIN: Actually, I would like to clarify.
15 What we looked at here was the variation in days of care,
16 explained variation in these visit costs, not that they
17 spent the entire \$500. So we didn't look at that payment
18 adequacy issue. But given what Kathryn said, given what
19 this provider publishes in its industry reports it is clear
20 that they are making overall a healthy profit margin.

21 DR. SCANLON: When you say days of care. is this
22 days in the episode or days that they actually received a

1 service in the episode?

2 DR. BUNTIN: This is days in the episode.
3 Remember, there's a default category here so if you don't
4 receive any -- you only receive the inpatient respite or
5 continuous care rate if you're getting one of those three
6 types of services. Otherwise the default category is that
7 you receive the routine home care rate.

8 MS. LINEHAN: You did look though, I think, at the
9 number of days in the episode and the number of days that
10 they actually had a visit and didn't you find an average
11 rate of --

12 DR. BUNTIN: There's an average of about 1.5
13 visits per day. So people actually get services from a
14 variety of different disciplines. That doesn't mean that
15 everybody is getting a service on every day. We didn't
16 actually look at it that way. We could. But people are
17 often getting a visit from a home health aide and a nurse,
18 or a therapist and a daily home health aide, for example.

19 DR. REISCHAUER: Do you have any way of saying if
20 a mix of folks is different between for-profit and not-for-
21 profit?

22 MS. LINEHAN: We could look at some

1 characteristics using claims but we could know their
2 diagnosis, we could know their age. We couldn't know things
3 very easily like whether they were in a nursing home. And
4 we don't know whether patients actually got a service on any
5 given day using the Medicare claims data.

6 DR. MILLER: Let me just ask one other way of
7 asking that question. So there's four different payments
8 that a person can get. From the claims data can you say
9 between for-profit and non-profit, tell the mix of that?
10 Which I know is pretty gross but still it's --

11 MS. LINEHAN: Yes, you could.

12 DR. BUNTIN: Yes, and we compared this hospice
13 chain to all freestanding hospices and to the Medicare
14 hospice population as a whole. We didn't break it down for-
15 profit versus not-for-profit, but we could do that given the
16 information we have.

17 MR. SMITH: On that point, do we know anything
18 about patient characteristics and point of service? Is
19 there something that explains at the patient level when
20 they're in a hospital. when they're in respite care, when
21 they're at home? Is that likely to be situational? Is it
22 likely to be patient characteristics? Is it associated when

1 in the episode -- are you more likely in a hospital at the
2 end of the episode or more likely to be at home?

3 MS. LINEHAN: We didn't look at that. I don't
4 think you looked at that either, Melinda. This particular
5 chain didn't have any days of inpatient respite care. They
6 would have the other inpatient category. We could look at
7 where in the episode they used different types of days of
8 care, and we could look by patient characteristics whether
9 that varied. But the vast majority of days are the routine
10 home care days, like 95 percent of the days. So just at the
11 median patients don't have any other types of days.

12 Sorry that was unclear. They don't have use of
13 any other types of days except routine home care days.

14 MS. BURKE: This was really quite helpful. I am,
15 again, at the risk of asking to have more work done, I'm not
16 pushing that but I am actually interested in some of the
17 statements that were made and some of the points that were
18 made. And that is understanding -- I mean, I remember only
19 too well why we created this benefit and how we structured
20 it at that time.

21 I am interested in understanding the comment that
22 to a certain extent the nature of the patient has changed.

1 I noticed in the materials that the greatest lengths of stay
2 tended to be around patients who had neurological
3 conditions; not terribly surprising, largely I suspect
4 Alzheimer's patients. Interesting. It is a good thing that
5 people are beginning to use this benefit with somewhat
6 different diagnosis than what we originally expected, which
7 were largely cancer patients. But it would be interesting
8 to understand how in fact the benefit has changed and the
9 nature of the patient. The distribution across diagnoses.
10 Who's now using it.

11 I was also struck -- and there is, as I recall
12 from the materials the average was about 50 days for that
13 particular population. We were constrained at the time of
14 the creation by the fear that people -- one, the requirement
15 that people chose between essentially curative services and
16 palliative services was a conscious one because we wanted to
17 be sure that people were making an actual decision. So it
18 is interesting that you are now seeing more people make
19 those decisions.

20 But I would be interested in understanding whether
21 because of that the nature of the benefit has also begun to
22 change. For example, your comment that you didn't provide -

1 - we didn't ask you to but there's no understanding as a
2 result of this work as to what has occurred with respect to
3 the use of pharmaceuticals. That, of course, was one of the
4 fundamental issues at the time was the flexibility in the
5 use of pharmaceuticals that was not prevalent in the more
6 curative services; that there was more freedom. It would be
7 interesting to understand whether that's still very much a
8 part of what that occurs and whether that has changed.

9 There's also the reference to the fact that this
10 particular chain had no respite, I found stunning, since
11 that is a fundamental piece of the presumption that people
12 in fact are staying in a home-based setting and then
13 essentially you're relieving -- so I'm interested that they
14 had a greater inpatient use, is what I understand, but no
15 inpatient respite use.

16 There was also a desire to essentially keep people
17 out of institutional settings. So if we're suddenly moving
18 to more inpatient use I'm interested in understanding
19 whether that's stabilizing someone, whether that's
20 determining whether their pharmaceutical needs have changed
21 and they have to alter it. What exactly is leading to that?

22 Again, some fundamental understanding of how this

1 benefit has in fact changed over time, and how the patient
2 has chosen. And our capacity to manage these patients has
3 also changed. We can now manage people in a home-based
4 setting that I couldn't have cared for in an acute care unit
5 in 1922 when I was trained.

6 [Laughter.]

7 MS. BURKE: But it would be interesting to
8 understand whether this benefit has fundamentally begun to
9 change. And if so, what is it, in addition to the payment
10 system, do we need to think differently about the patients
11 that are being seen, why they're being seen, how they're
12 being cared for, and by whom? There's just interesting
13 little facts that came out of this that lead me to wonder
14 what in fact is going on here is.

15 MS. LINEHAN: I can answer some of that. With
16 respect to the use of no respite care, we asked about that
17 and heard that -- we asked two things. One, why people
18 don't use it, and the answer was caregivers may be reluctant
19 to actually put a family member in an institutional setting
20 when they want to care for them at all. So even though it's
21 available they might not want to use it.

22 Then I also asked whether family members actually

1 know that that's available to them, and maybe there's some
2 question about whether when they hear what they can receive
3 under this benefit that they hear that that's a component of
4 it.

5 With respect to how this has changed over time, we
6 were limited. Drugs are obviously a big piece of this. GAO
7 found when they did their study that in the routine home
8 care day payment category that the mix of services changed
9 over time. There was home health aides, supplies,
10 outpatient service costs as a share of the cost of day, that
11 declined. Then the cost of nursing, drugs --

12 MS. BURKE: I'm sorry, home health aide visits
13 declined?

14 MS. LINEHAN: The cost as a share of the total
15 cost of the day declined.

16 MS. BURKE: What increased?

17 MS. LINEHAN: Drugs, nursing, social services,
18 DME. We don't have data at the patient level. There are no
19 data at the patient level to look at this issue. So we are
20 kind of limited with what we can do with administrative
21 data.

22 MS. BURKE: That make some logical sense. If you

1 assume that the acuity of the patient has increased, the
2 application of a greater range of highly skilled services,
3 the presence of DME, the presence of pharmaceuticals would
4 suggest it's not simply a nursing home check-in. So that
5 logically make sense to me.

6 Query what that tells us about the management of
7 who these patients are.

8 Interesting that the caps don't seem to be --
9 which is about \$19,000 on average-- that the caps don't seem
10 to be being preached to any great degree, which is
11 interesting if in fact the acuity of the patient has
12 increased and the skill set required has increased, where
13 the trade-offs are, particularly since you've got longer
14 lengths of stay.

15 DR. BUNTIN: Actually, I would like to pick up on
16 this issue of the acuity of the patients and I think it's
17 related to the cap issue. As Kathryn was saying, there's a
18 little bit of the bifurcation in this population going on.
19 We might have a predominantly cancer population that maybe
20 is entering hospice later than they used to, this 25 percent
21 that has a stay of a week or less. They are, arguably,
22 higher acuity than they used to be, perhaps because of

1 advances in medical technology that bring them -- preserve
2 hope on until that point. But they're being balanced by
3 this larger population of non-cancer patients many of whom
4 have very long lengths of stay. If you are a savvy hospice
5 you can balance these two populations and not hit the cap.

6 Also a little side point on the respite care. It
7 was interesting when we asked questions about this, when
8 you're talking about a patient who's primarily cared for at
9 home an argument clinically was made to us that it doesn't
10 make a lot of sense to take that patient out of the home,
11 put them someplace else to give the family member respite.
12 It may make more sense to bring people into that home to
13 give the family support. So it's not clear whether not
14 using respite is actually better for the patient.

15 On another point on that is --

16 MS. BURKE: But that assumes you define respite as
17 only involving inpatient. In fact respite can involve a
18 home-based service. So in this case did they provide no
19 inpatient respite but were they providing backup services at
20 home that allowed people to stay home and provide backup?

21 DR. REISCHAUER: Is it continuous home care?

22 MS. LINEHAN: No, that's not the same thing.

1 DR. REISCHAUER: So the margin, I would think, of
2 inpatient respite care which is paid 131 versus routine home
3 care must be hugely different. I suspect the former has a
4 negative margin.

5 DR. BUNTIN: We also saw some evidence that there
6 were patients seen by this particular hospice who were
7 admitted to the inpatient unit but because there wasn't
8 clinical justification for them being in inpatient care
9 Medicare was actually only being charged the routine home
10 care rate. So that may be another way that they're dealing
11 with patients who aren't able to be supported at home.
12 Again, that's anecdotal evidence.

13 MR. HACKBARTH: We need to do a time check here.
14 We're running behind schedule so we can spend I think
15 roughly another 10 minutes or so on hospice, because I know
16 people have planes to catch today.

17 I have on my current list, John, Arnie, Ralph,
18 Jennie and Bill, and we can make it through that list if
19 people ask very focused questions.

20 MR. BERTKO: I'll try to be focused here. I guess
21 what I'd want to do would be to separate out the margin and
22 how much we pay from the methodology. Your slides appeared

1 to me to say that the methodology worked reasonably well.
2 Arguably, you could redistribute. But if it ain't broke we
3 shouldn't fix it. I had a reason personal experience with
4 hospice care. It was a good experience. It was useful.
5 But I can't imagine people tweaking the system once it
6 starts for that. This was a non-profit.

7 So I guess I just wonder, should we continue to
8 say -- we could make it more complex but would it help very
9 much? Knowing more about what we pay for is good but we do
10 need to change?

11 DR. MILLER: Maybe I could say something about
12 that. When I was listening to all of this I had something -
13 - I'm trying to explore sort of case mix. Given the lack of
14 the data and given the lack of a relationship here maybe you
15 don't want to go. But maybe there are more broad structural
16 things, if you are seeing the intensity at the beginning and
17 the end of the day. I think that's the level of adjustment
18 that we're thinking of as opposed to something much more
19 complex than that. You guys may have a --

20 MS. LINEHAN: I think that's what we were
21 thinking. We undertook this because we wanted to explore
22 whether this seemed viable, but we don't have any compelling

1 evidence that it does. So it's really hard to say, yes, go
2 out and collect all these data to redo this payment system
3 in a way that won't necessarily improve it a whole lot.

4 MR. SMITH: Mark, I'm not at all sure why we want
5 to tweak this. It's interesting, more intensity at the
6 beginning and the end. But there's not an end if there's
7 not a middle. It seems to me that this system, assuming we
8 still don't know about adequacy, but that this system has
9 the interesting virtue of being a per diem system that
10 approximates an episode system. We don't exactly know
11 what's going to go on in the second day so why should -- if
12 we figure out the episode payment is adequate who cares how
13 it's distributed? And why make it more complex and create a
14 set of medically unuseful incentives to prefer one behavior
15 on day three and a different behavior on day seven?

16 DR. MILLER: The only thing I would say to that is
17 if you get inside and find -- think of some of Bob's
18 questions about is there differences in different types of
19 facilities, for example, or different kinds of patients,
20 that you may want some torqueing of the payment system if
21 there are some differences. We just haven't gotten deep
22 enough to know. I think your question is fair, but to know

1 whether maybe in a more adequately set payment, if there are
2 underlying differences, that you would want to torque the
3 payments a bit.

4 DR. BUNTIN: If I could just add a little bit to
5 that. I think in all the administered pricing systems that
6 the Commission looks at the desire is to equate marginal
7 costs, to approximate marginal cost pricing. So if we do
8 have beginnings and ends of stay that are more expensive and
9 that is driving hospices to seek longer stay patients, then
10 you're skewing them towards a certain type of patient. What
11 we want to do is make the system neutral across all patients
12 so clinically people get what they should.

13 DR. MILSTEIN: We tested some case mix adjusters
14 and we found that they didn't account for any kind of
15 variance. As I looked at these adjusters I'm not sure I
16 would have predicted they would've accounted for a lot of
17 variance. Maybe Jennie when she comments can amplify on
18 this, but these would not have been the variables I would
19 have tested. I would have focused more on variables that
20 researchers like Judy Hibbard have now begun to develop
21 where you're essentially coming up with quantified indices
22 of patient and caregiver confidence and self-confidence in

1 self-managing their part of the bargain. I wondered is
2 there prior research testing those variables rather than
3 some of these demographic variables, because I would guess
4 they would account for more variance?

5 DR. BUNTIN: It's a good question. I didn't
6 emphasize it but one variable that we had that prior
7 researchers have not looked at to my knowledge was we were
8 able to look at marital status. We actually thought that
9 single patients would need a higher number of visits to be
10 able to be maintained at home. We actually did not find
11 that was the case. If anything, the patients who were
12 married were living with someone seem to get more visits.
13 We don't have a good explanation for that except perhaps, I
14 could hypothesize that they had a better advocate, but that
15 was not borne out by the data from this particular provider.
16 I think it is an interesting question though and it is not
17 something that I know of anyone being able to look at.

18 DR. MILSTEIN: Maybe next time we can test state
19 of the marriage rather than marital status.

20 MR. MULLER: Even with the growth of utilization
21 we know from our reports a year or so ago that there are
22 still some considerable underuse of hospice. For example, I

1 cited earlier in terms of many cancer patients in between
2 the patient, the family and the provider community, people
3 are still pretty awkward in going to the hospice decision.
4 So in terms of the hospice still being a very reasonable
5 cost alternative to the inpatient and nursing home stay it's
6 appropriate to consider that alternative as well. It still
7 relatively cost-effective.

8 So I would say there -- and one can start seeing
9 this especially with more and more people with
10 neurodegenerative disease in the hospice, that there's also
11 going to be a fairly cost-effective alternative to that as
12 well. So I think one could see that even with this growth
13 there are disease categories in which one can and should
14 anticipate more hospice use as people become more familiar -
15 - if not comfortable, more familiar with how to make that
16 decision.

17 MS. LINEHAN: Since you asked I would just mention
18 one recent study on the issue of cost to Medicare of hospice
19 and cost savings done by Diane Campbell. They found that
20 young patients and cancer patients, the use of hospice in
21 young and patients with cancer diagnosis saved Medicare
22 money, but actually cost Medicare money for older and non-

1 cancer patients. Just to wrap some numbers around that.

2 MR. MULLER: Why is that, on the latter category?

3 MS. LINEHAN: I think part of their explanation
4 was that cancer patients have -- their trajectory is a
5 shorter period of obvious decline. So they get into cancer
6 -- they're not long stay patients. It's driven by longer
7 lengths of stay for the non-cancer cohort.

8 MR. MULLER: The older cohort of cancer patients
9 you said it was not cost effective? Did I misunderstand
10 you?

11 MS. LINEHAN: Older and non-cancer, yes.

12 DR. BUNTIN: I guess their rationale was that for
13 the cancer patients, again, they had a shorter length of
14 stay and there was more potential for avoiding a costly
15 hospitalization during that period right at the end of their
16 life. With the longer stay, non-cancer patients it was less
17 certain that they would be avoiding that stay and they were
18 receiving more supportive services at home than they would
19 have in the absence of the hospice benefit.

20 Now whether or not the patients received benefit
21 for this that's completely --

22 MS. LINEHAN: That wasn't included in the

1 calculation of the benefit. It was the benefit to the
2 family, the quality improvement to their life. That wasn't
3 factored into this. It was Medicare costs.

4 MR. MULLER: I think certainly when one has a
5 service that one is not getting then the comparison is it's
6 going to cost more. My point was that when this is an
7 alternative to more expensive institutional, and as we noted
8 either last year or the year before, still in many cancer
9 cases the decision to go to hospice is not made for the
10 reasons we've discussed. To the extent that people become
11 more comfortable making that choice then it truly is a cost-
12 saving alternative. I'm not arguing that if it provides
13 services in patient subsets that have not been receiving
14 before then obviously by definition it costs more.

15 MS. HANSEN: It's interesting, I just have a
16 hypothetical thought about why the non-cancer elderly people
17 might cost more. I think that if many of these people are
18 end stage people with dementia as well as other
19 comorbidities, typically dementia itself is not a payable
20 diagnosis in Medicare. Whether or not this is actually in
21 some ways a new resource for that end of life, because this
22 is not something that nursing homes would normally cover.

1 So just a thought as the question was being raised about the
2 dementia factor.

3 The question I was going to have is I was really
4 intrigued by page 21 where you give the demographics of the
5 hospice participants for the chain vis-à-vis the all
6 Medicare. Something striking to me that I found unusual and
7 it may be relative to this chain, but the use of hospice by
8 racial minorities was extraordinary given the population of
9 Latino-Hispanic population in the general Medicare being 1.3
10 and that the chain's percentage is 11.3. Any explanation?

11 DR. BUNTIN: Yes, that is actually an artifact of
12 where this chain is located I think more than anything else.
13 In the hospice population as a whole we do see lower rates
14 of use of hospice among most ethnic minorities than their
15 proportion in the Medicare population. So it's an artifact
16 of where they're located.

17 DR. SCANLON: I guess this may be multiple
18 questions. It's about the issue about how the hospice
19 benefit differs for persons who are residents of nursing
20 home, not Medicare covered but Medicaid or private pay.
21 Given that the nursing home provides all the supportive
22 services that an individual needs and some of those

1 supportive services for someone living at home are coming
2 from the hospice the question is, is this a characteristic
3 of a hospice patient that should be used to distinguish
4 payment in some kind of a system?

5 Also I guess from the perspective of what's
6 happened over time that we've seen this significant growth,
7 is there a disproportionate concentration of that growth
8 among nursing home residents? And how might that relate to
9 the type of agency that's actually providing the services,
10 since we've also seen a change in the composition of the
11 industry in a relatively short period of time?

12 I think this may also relate to the issue of
13 nursing homes and how the hospice benefit changes relates to
14 Bob's comment about international comparisons, because
15 residential settings of the elderly are often very different
16 in the international settings with respect to the kinds of
17 services that come with your residence as opposed to what
18 happens to people at home here in the U.S.

19 The last thing I guess is a caution about the idea
20 of what we know about the needs of patients being met, which
21 is we don't know virtually anything at all, because what
22 we're talking about here is hospices provide some supportive

1 services of which we have no sense of what share of
2 supportive services that someone is getting. It's the same
3 problem we have with the home health benefit which is that
4 we don't know, in terms of how people's needs are actually
5 being met by just looking at the services that they're
6 receiving because we don't actually go out and measure any -
7 - we have no metric of what unmet supportive services needs
8 there might be.

9 DR. REISCHAUER: Let me just have a final comment,
10 playing off of Dave and John's notion that if it ain't broke
11 don't try and fix it. I'd be a lot more agnostic about
12 whether it's broke or not. What we've done is looked at
13 some information from one for-profit chain and drawn a
14 conclusion that that ain't broke. But who knows. We don't
15 hear a lot of complaints, I don't think, out there. But
16 when you have a 15 percent to 19 percent margin that covers
17 up a whole lot of complaints. Everybody can be happy.

18 The question is, what if the margin were 5
19 percent, what would the situation look like? So let's keep
20 an open mind.

21 MR. SMITH: Bob, I think you're right but I think
22 a traditional MedPAC adequacy analysis can get at that

1 question independent of the differential payment for site of
2 treatment. Just a personal footnote, John and I both have
3 recently come off hospice experience with not-for-profit
4 hospices. Nothing at all systematic but surely it forms
5 part of our reaction.

6 MR. HACKBARTH: Thank you very much. Good job.

7 We are now to our last session on physician
8 practice expense.

9 * MS. RAY: Good morning again. I presented a work
10 plan in November to look at issues about the data sources
11 and methods used to calculate practice expense payments.
12 Ariel and I are back here to follow up on that. Our work
13 today fits into our broad agenda to examine physician
14 payment issues, including the SGR and the unit of payment.

15 Recall that in our March 2006 report commissioners
16 made a series of recommendations to improve CMS's process
17 for reviewing work RVUs. These recommendations addressed
18 the concern about the mispricing of services in the
19 physician fee schedule. The Commission and others have
20 argued that inaccurate pricing may be leading to increased
21 volume in areas such as imaging.

22 We are now turning our attention to the other

1 major component of the physician fee schedule, practice
2 expense. Our analysis of practice expense also addresses
3 this pricing issue. In today's session we are asking you
4 about ways to improve two key data sources CMS uses to
5 calculate practice expense payments. Today's discussion is
6 particularly relevant. We may be on the threshold of a
7 major change. CMS has given a strong indication that it is
8 interested in changing the way it uses to calculate practice
9 expense payments. These changes may be out in this summer's
10 proposed Part B rule. Thus, today's discussion may provide
11 input into the agency's deliberations.

12 Practice expense payments are important. They
13 account for about half of the payments to physicians. Given
14 the magnitude of dollars involved, inaccurate payments can
15 boost volume for services inappropriately and undermine
16 access to care. Some of you have expressed concern that
17 inaccurate payments can make some specialties more
18 financially attractive than others. These are points that
19 you just made in our March 2006 report.

20 CMS divides practice expense into two categories,
21 direct and indirect. Indirect account for at least 60
22 percent of practice costs for most specialties. So like I

1 said, CMS uses two sources. The first source gives
2 information about total and hourly practice costs for each
3 specialty. The second data source provides estimates of the
4 direct resources used to provide each service.

5 Very, very briefly, CMS currently calculates
6 direct and indirect practice expense payments by taking
7 total costs per specialty and allocating those costs to
8 individual services based on resource estimates. This is
9 called the top-down approach. CMS is considering changing
10 how it calculates direct practice expenses by going to a
11 bottom-up approach, or simply summing the resource estimates
12 for each of the 7,000 or so services in the physician fee
13 schedule.

14 So the first data source that CMS uses is called
15 the SMS survey. It's a multi-specialty survey. It was last
16 conducted by the AMA in 1999. So needless to say it is old
17 and it probably does not do a great job at capturing current
18 practice patterns, medical equipment and medical costs. It
19 also does not include information for all specialties paid
20 for under the physician fee schedule, particularly non-
21 physician providers.

22 As a way to update the data, specialties could

1 submit to CMS updated total practice cost data and CMS
2 allows specialties to do so through March of 2005. Few
3 specialties have done so. To date CMS has accepted data
4 from 13 groups and the fee schedule is currently, of those
5 13 groups, from six groups.

6 Under a voluntary updating process the fee
7 schedule may no longer accurately reflect the relative
8 resources required to provide a service because CMS
9 incorporates these changes budget neutral. Therefore
10 payments may shift from specialties without updated data to
11 those specialties with updated data.

12 Medicare needs current data for all specialties to
13 determine if the relative costs of operating a practice has
14 changed across specialties. We would like the Commission to
15 discuss different ways that Medicare could obtain more
16 current information. One way is for a private sponsor, say
17 a consortium of physician and non-physician groups, could
18 collect the data and CMS could purchase the data from the
19 private group. CMS staff have expressed an interest in this
20 approach.

21 Of concern is whether all specialties would
22 participate, particularly the 13 specialties with more

1 recent practice data accepted by CMS. If history is any
2 guide, a voluntary effort, whether it's public or privately
3 sponsored, will have a low response rate. Even when
4 specialties collect their own data the response rate is low,
5 about 20 percent.

6 A non-voluntary public effort may not be too
7 popular with providers. One overarching issue CMS would
8 need additional resources to obtain new data.

9 Moving to the second data source CMS uses to
10 derive practice expense payments, it's called the direct
11 resource database. You may have heard it called the CPEP
12 database. Is it essentially a micro-costing database of the
13 non-physician clinical labor, medical equipment and medical
14 supplies required to provide nearly all of the services in
15 the fee schedule. Here's an example of the direct resource
16 for one urology service. You'll see here estimates for the
17 clinical staff needed before and during the procedure,
18 medical equipment, and medical supplies. So you multiply
19 this by about 7,000 and that's the CPEP database.

20 CMS assigns a separate price to each of these
21 direct resource estimates to estimate the total direct costs
22 of a service.

1 Are the direct resource data accurate and
2 complete? Getting the data accurate is especially important
3 if CMS goes to a bottom-up method. We have found that there
4 are certain challenges in maintaining the direct resource
5 database. There are a lot of values here. Some of our
6 initial concerns surround the accuracy of the database.

7 An AMA subcommittee called the PEAC, the practice
8 expense advisory committee, went about between 1999 and 2004
9 and refined the values that were originated in the mid-1990s
10 by the CPEP panel. The PEAC made assumptions about the use
11 of labor, equipment, and supplies and applied these
12 assumptions to similar codes called families of codes. It
13 is unknown whether these assumptions have been applied
14 consistently to all related services, particularly those
15 services that the PEAC refined early in the process.

16 Having a continuing review process here may be
17 worthwhile. Indeed, the agency has stated that there needs
18 to be such a process but has not proposed any specific plan
19 for doing so for both inputs and prices.

20 With a discussion about updating data you might
21 have a question about the five-year review for practice
22 expense. The statute requires the Secretary to review that

1 make adjustments to the relative values for all physician
2 fee schedule services at least every five years. CMS has
3 not yet proposed a five-year review of practice expense
4 RVUs. The resource-based practice expense RVUs became fully
5 implemented in 2002.

6 Ariel is now going to discuss some of the
7 challenges in keeping the prices assigned to CMS to each
8 direct resource up-to-date.

9 MR. WINTER: Before we discuss the options for
10 keeping the input prices up to date there are some
11 challenges to keep in mind. First, there are over 1,000
12 unique supplies and over 500 equipment items in the database
13 so we need to be aware of CMS's administrative burden.
14 Also, specialties have a weak incentive to request a review
15 of overvalued input prices.

16 With that in mind, these are some options we're
17 going to talk about for CMS to consider pursuing. One is to
18 set a reasonable schedule for updating clinical staff wages,
19 and supply and equipment prices. Second is reviewing the
20 prices of new, expensive supplies and equipment more
21 frequently. And finally, revisiting the assumption that all
22 equipment is used at 50 percent of capacity, which is part

1 of the formula for determining equipment prices per service.

2 CMS last updated clinical staff wages for the 2002
3 fee schedule and has not indicated when the next update will
4 occur. Wage growth for different types of staff varies. At
5 the lower end, wages for lab technicians increased by 14
6 percent between 1998 and 2001. By contrast, wages for
7 medical assistants grew by 63 percent. If wages are not
8 updated regularly, services could become misvalued over
9 time. Although an annual review of wages would be probably
10 too burdensome for CMS, it is perhaps feasible to review
11 them every three to five years.

12 As procedures shift from hospitals to physician
13 offices, supplies and equipment become a more important part
14 of practice expense. Supply and equipment prices were
15 updated between 2004 and 2006. To update the prices CMS
16 examined vendor catalogues and web sites and asked specialty
17 societies for invoices. Manufacturers and specialties can
18 ask CMS to change a price they believe to be incorrect.
19 These groups have a stronger incentive to identify
20 undervalued items than overvalued items. This is
21 particularly a problem with regards to new, expensive
22 supplies and equipment which can account for a large share

1 of a service's practice expense.

2 Prices for new items are likely to drop over time
3 as they diffuse into the market and as other companies begin
4 to produce them. Thus CMS should probably review expensive
5 new items more frequently than older items, perhaps every
6 year or two.

7 In fact, the AMA's relative value scale update
8 committee, or RUC, recently requested that CMS re-price new
9 high cost supplies annually. Because it would be too
10 burdensome for CMS to review all of the remaining older
11 items at the same time it could periodically review a sample
12 of these items. The concept of re-pricing new items to
13 reflect cost changes is similar to a recommendation you made
14 in the March report, that the work RVUs of new services
15 likely to experience reductions in value should be reviewed
16 in a timely way.

17 Unlike supplies which are used only once,
18 equipment is used repeatedly so CMS has to spread the cost
19 of equipment over many uses. To derive the cost of a unit
20 of equipment per service, CMS multiplies the number of
21 minutes it's used for that service by the cost per minute.
22 The cost per minute is based on the equipment's purchase

1 price, how frequently it's used, the cost of capital and
2 other factors.

3 The frequency of use assumption is very important.
4 If equipment is used at full capacity, the cost to spread
5 across many services and the cost per service is lower. By
6 full capacity we mean that is used during all the hours the
7 practice is open for business. If equipment is used at
8 lower capacity the cost is spread across fewer services and
9 the cost per service is higher. Since CMS began using
10 resource-based practice expenses it has assumed that all
11 equipment is used 50 percent of the time.

12 Some equipment may be used less than half the
13 time. This equipment would therefore be undervalued. And
14 other equipment may be used more than half the time and
15 would therefore be overvalued. The rapid growth of imaging
16 services suggests that imaging equipment is used more
17 frequently. Medicare spending for imaging grew by 60
18 percent between 1999 and 2003 to over \$9 billion. This
19 growth could be explained by new imaging providers entering
20 the market, existing providers increasing volume per
21 machine, or existing providers adding new machines.

22 We think that higher volume per machine probably

1 explains at least some of the spending growth because
2 providers have a financial incentive to boost the use of
3 expensive equipment. This is because a large share of the
4 direct costs of imaging services are related to the
5 equipment which is a fixed cost. Once imaging providers
6 cover their fixed costs the marginal profit from each
7 additional service is significantly higher.

8 This table illustrates the impact of changing the
9 assumption of equipment use. Let's say a piece of equipment
10 currently costs \$100 per service using CMS's 50 percent
11 assumption. If we instead assume that this equipment is
12 used 75 percent of the time the price falls to \$66.70, a 33
13 percent drop. This is because the cost is spread over more
14 services. If we assume that the equipment is used 90
15 percent of the time the price falls to \$55.60, a 44 percent
16 drop.

17 It's important to note that the technical
18 components of most imaging services are not currently valued
19 using direct inputs such as equipment costs. Instead they
20 are based on historical charges. Thus the impacts you see
21 here would not apply to imaging under CMS's current
22 methodology. However, CMS has given a strong indication

1 that it will eliminate the charge-based approach and instead
2 use direct inputs to value imaging services. When this
3 happens these impacts would apply to imaging equipment.

4 Here are some options for CMS to change its 50
5 percent equipment use assumption. First, it could develop a
6 range of assumptions for different kinds of equipment. For
7 example, rarely used equipment could be assigned to a 25
8 percent category, average use equipment could stay 50
9 percent, and frequently used items could be assigned to 75
10 percent.

11 One question to keep in mind is whether Medicare
12 should pay for the higher cost of equipment that's really
13 used. On the one hand, we have a principle that Medicare
14 should pay for costs incurred by efficient providers. On
15 the other hand, to not pay more could create access problems
16 in rural areas or for services that are delivered
17 infrequently.

18 A second option to improve this assumption would
19 be for CMS to focus on expensive equipment which has the
20 biggest impact on RVUs. Under either approach CMS would
21 need to collect data on equipment use.

22 One option is to survey providers on their use of

1 equipment, perhaps as part of the practice cost survey that
2 Nancy discussed earlier. Another option would be to analyze
3 volume data from Medicare claims to see how frequently
4 equipment is used.

5 We are testing the feasibility of both of these
6 approaches which regards to two types of imaging equipment:
7 MRI and CT machines. We are focusing on these machines
8 because of the rapid growth of imaging procedures and the
9 importance of pricing them accurately, especially because
10 CMS has expressed a strong interest in using direct cost
11 inputs to value imaging services.

12 First, we are fielding a survey of providers that
13 have billed Medicare for performing MRI and CT scans. The
14 survey includes physicians in freestanding imaging centers
15 in the six markets listed on this slide. We chose these
16 markets because they represent a range of geographic areas
17 and a range of per capita Medicare spending. In addition,
18 we have 100 percent Part B claims data for these areas. So
19 in combination with the survey we will examine claims data
20 on the volume of MRI and CT services performed by providers
21 in these markets.

22 To sum up our presentation, we've highlighted some

1 concerns with the data used to determine practice expense
2 RVUs, both the total practice cost data and the direct cost
3 inputs. We've also laid out some options to improve the
4 data. We're interested in getting your feedback on the
5 issues we've raised.

6 Thank you.

7 MR. HACKBARTH: We have 20 minutes before we our
8 scheduled adjournment and I'd like to allow at least a
9 little time for the public comment period, so we've got
10 maybe 15 minutes for commissioner questions and comments.

11 DR. REISCHAUER: Ariel, in this analysis you're
12 going to do how do you know how many machines an imaging
13 center has, number one? And of course, Medicare is not the
14 only buyer of services. There are all the other folks.

15 MR. WINTER: Good questions. In terms of the
16 number of machines per provider, we're hoping to get data on
17 this from the survey. One of the questions we're asking is
18 both how frequently do you use machines and how many
19 machines do you have. So we can take an assumption from the
20 survey. Another source of data is state certificate of need
21 agencies for states that have these laws that approve the
22 purchase and use of MRI machines. It's true for two of the

1 states in our sample, South Carolina and Massachusetts have
2 these data at the provider level.

3 The other question is about what share of total
4 services, total service volume is accounted for by Medicare.
5 What we plan to do here is use an assumption derived from
6 the National Ambulatory Medical Care Survey which is an NCHS
7 survey. It has data on office visits by type of visit, so
8 you can look at visits in which a radiology service was
9 ordered or performed as well as data on the age of the
10 patients. So we can take for all visits that involved a
11 radiology service, what share were for elderly patients, and
12 that would be our assumption for what share of the volume is
13 for Medicare for these imaging providers.

14 DR. SCANLON: Two different comments. One first
15 about the switch to the bottom-up method which is actually -
16 - HCFA at the very beginning when the first rule for
17 practice expense was proposed but never implemented there
18 was up a bottom-up method too but it was different. I think
19 I would you characterize the differences between what's
20 being proposed now, if I understand what's being proposed
21 now and what was done in the past is that in the past the
22 practice expense values were a combination of the SMS data

1 and the CPEP, or PEAC-improved CPEP information and that
2 right now CMS is proposing to use the CPEP information with
3 price data to calculate the practice expense values for the
4 direct components of these values, if that's right.

5 What it involves is an assumption that your data
6 are good enough through the PEAC and your prices that you're
7 going to get accurate estimates. The SMS data were used in
8 the past to provide you a check on that. Now what we have
9 to admit is that the SMS data are now six years old and for
10 next year they will be seven years old so it's -- at best,
11 some of it actually goes back to '95. So there's a question
12 of how good of a check is that? So the assumption that
13 maybe the PEAC data are better is potentially plausible but
14 not verified.

15 This gets me to the second point which is the
16 issue of the SMS data and what are we going to do into the
17 future. I guess I've often or long felt that maybe what we
18 need to really think about is mandatory reporting of this
19 kind of information by a sample of providers whom we might
20 compensate because they were unfortunate enough to be in our
21 sample. We do not need the universe for this purpose but we
22 do need the information.

1 What we should do in thinking about that is to
2 think about the Medicare fee schedule as a public good
3 because so many of the private plans use it. It's even of
4 value to the physicians themselves in terms of understanding
5 the differences in cost among services that they are
6 providing. So without hearing the objections to that
7 approach, that's where I've been leaning for a long time.

8 DR. KANE: On the input price piece, don't we have
9 proxy inflation indices for all the other, like the hospital
10 index? Why wouldn't we want to have a similar proxy
11 inflation index rather than a direct measurement of wage
12 increases for specific classes of labor in the office? Is
13 there some reason we don't -- that's one of my questions.

14 The other is the 50 percent capacity assumption.
15 I just don't understand how is capacity define? And then
16 why would CMS want a 50 percent capacity rule rather a 75
17 percent? How did they come up with 50 percent? Was that
18 just a political compromise or was it some balance of not
19 wanting to over-incentivize excess volume versus -- they're
20 incentivizing people to buy equipment that they're not going
21 to use efficiently and I'm just wondering what's the root of
22 the 50 percent? And also, why would we want direct price

1 measurement rather than proxy on an inflation index?

2 MR. WINTER: Good questions. On the first one, if
3 you assume that all the inputs increased at the same rates,
4 if all services had equal numbers of those inputs then the
5 relatives wouldn't change. But it makes a difference where
6 you have one service that uses a type of staff where the
7 wages increase significantly, like medical assistants, and
8 if you assume the average increase for that then their costs
9 would be undervalued. If you took a service that used a
10 type of staff where the wages increase slowly like lab
11 technicians, at least based on the previous years they
12 looked at, and you assumed the average wage increase, those
13 services would be overvalued. They're overcompensating
14 them.

15 DR. KANE: But it seems that we do that with
16 hospitals and they have the same skill mix issues. I'm not
17 sure I understand why we wouldn't do the same thing for
18 physician practices.

19 MR. WINTER: With hospitals, that's used really to
20 determine the market basket and here you're talking about
21 estimating a resource for each specific service. You're
22 trying to get the relatives right so the value of one

1 service reflects its true cost.

2 DR. KANE: You would know the mix of hours by
3 skill mix and the input price would be reflecting a proxy
4 for that particular skill mix. In other words, you would
5 have the mix right but you wouldn't have the input. The
6 input would be a proxy rather than a specific measure of the
7 wage increase.

8 DR. MILLER: I'm not necessarily following this
9 myself but let me bring some clarity to it for me. This is
10 just for me. Aren't we talking about two different things
11 here? You're talking about how to take a mix of services,
12 increase them over time. I think part of what we're talking
13 about here is because it's very service specific it's
14 getting the mix right, because unlike in a hospital setting
15 where you've got a large unit, if you've got the mix a
16 little bit wrong and you're inflating it overtime there's a
17 larger unit to put it over.

18 But here, the practice expense for an oncologist
19 is extremely different, or the labor inputs for an
20 oncologist are extremely different than some other and
21 you're paying service by service -- I'm just wondering if
22 we're talking past each other.

1 DR. KANE: I'm just talking about the input
2 prices, not the skill mix.

3 DR. SCANLON: But I think what Mark is saying is
4 what they have from the PEAC are real resource units but
5 their heterogeneous units. They're hours of this type of
6 labor versus that type of labor. In order to create the
7 common measure, which is the estimated overall cost, they've
8 got to start with the prices of those very specific things
9 first. Then over time you could inflate things with an
10 index until you decided that the mix of inputs had changed
11 enough that you needed to go back to this first step, which
12 is where they are now. They're basically at this first step
13 trying to translate real things into monetary values.

14 DR. MILLER: To say it different way, we're trying
15 to build the base that you would then inflate.

16 MR. WINTER: That's right.

17 DR. KANE: I'm just referring to page 10 where
18 you're talking about updating input prices. I guess that's
19 what I'm getting at.

20 DR. WOLTER: Just one comment.

21 MR. WINTER: Can I answer Nancy's second question
22 about the equipment use assumption? This is actually sort

1 of a black box to us. In the 1997 proposed rule when they
2 were developing the practice expense RVU system they said
3 they hired a contractor, Abt, which recommended a 70 percent
4 assumption. They did not cite any data in support of that.
5 Then they said, based on comments we've received we've
6 decided to go to a 50 percent assumption. It seems like
7 that was a default that they went to, because they weren't
8 able to get specific data on the use of different kinds of
9 equipment across all payers and procedures. So because they
10 weren't able to get this data they defaulted to 50 percent.
11 That's the best we can make of it. As far as we can tell
12 they've not revisited that since the decision was made in
13 1997.

14 DR. REISCHAUER: But this is 50 percent for use by
15 everybody.

16 MR. WINTER: That's right, by everybody. Full
17 capacity would mean if it were used during all the hours the
18 practice operates, is open for business. So if you assume
19 the average practice is open 50 hours per week, 50 percent
20 capacity means it's used for 25 of those hours.

21 DR. WOLTER: I have a comment and then a question.
22 The comment is really raised by the fact that you chose

1 imaging as one of the things to illustrate here. There is
2 an interesting conundrum I think developing, and that is if
3 you look at the issue of as the utilization increases and
4 it's used 70 percent of the time or whatever, that would be
5 a goal perhaps and it might drive how we looked at the
6 resource use. As we look at these MRIs and CTs moving into
7 small physician offices we're almost talking about creating
8 an incentive for increased utilization of procedures which
9 may or may not be always appropriate.

10 I'm very worried about what I'm seeing out there
11 now in terms of the acquisition of this expensive technology
12 in very small offices. I think that obviously doesn't get
13 addressed here and wasn't intended to be addressed here but
14 it strikes me as a paradox that we would try to price
15 appropriately for 70 percent or 80 percent use in settings
16 like that. So maybe we'll come back to that at another
17 time.

18 My question is, issues around the geographic
19 adjustment of practice expense have been raised in the past
20 and I believe legislation about two years ago created a
21 floor of some kind, 1.0 or something on practice expense.
22 Am I remembering that right?

1 MR. WINTER: The floor was for the work, not for
2 the practice expense.

3 DR. WOLTER: Thank you.

4 MR. WINTER: We do have on our work plan to look
5 at whether -- the GPCI right now currently reflects an
6 average use of supplies and equipment across all services
7 which for services that use a lot of equipment and supplies
8 like imaging could overstate on the geographic variations.
9 So you might be overpaying in a high GPCI area and
10 underpaying in a low GPCI area. So it's something we want
11 to look at in the future is whether the GPCI could be
12 changed to better reflect the mix of inputs where the prices
13 actually vary geographically.

14 MR. HACKBARTH: Could we go back to Nick's first
15 point because I was pondering the same thing, Nick, whether
16 changing this assumption and making it more aggressive would
17 encourage more inappropriate use. I guess the conclusion I
18 came to is that if you look at it from the incentive facing
19 the practice they profit, regardless of where this
20 assumption is set, their incentive is to use the equipment
21 more. They're going to move down their cost curve. They're
22 going to increase both their total profit and their profit

1 per unit of service provided regardless where this
2 assumption is set. I think that's right.

3 So I guess I persuaded myself that it was in the
4 interest of the program to say that we should have a payment
5 level that reflects a more efficient level of utilization of
6 this service. It's not going to affect their incentive.

7 DR. WOLTER: I agree with that. I think that if
8 the ability to profit on five imaging procedures per week as
9 opposed to 100 that in fact there is a little different
10 incentive there in terms of whether or not you want to put
11 in the fixed cost of acquiring that equipment.

12 MR. HACKBARTH: That would argue for making a more
13 aggressive assumption.

14 DR. WOLTER: Right. But I think my real issue is
15 just at what point do we address the fundamental question
16 about what settings is it appropriate for this equipment to
17 be in, and self-referral and conflict of interest and that
18 sort of thing.

19 DR. REISCHAUER: But once you have the machine, if
20 your profit margin is \$100 per use versus \$5 per use your
21 incentive to do more of it is greater when you're making
22 \$100 off it per unit.

1 MR. HACKBARTH: So again that would argue in favor
2 of increasing the utilization assumption.

3 DR. WOLTER: There's two things. There's the
4 barrier to entry and then there's if you think you can
5 enter.

6 MR. HACKBARTH: Okay, we're going to have to
7 conclude for today. Thank you very much.

8 We'll now have a brief public comment period. We
9 only have about five minutes.

10 [Pause.]

11 MR. HACKBARTH: Thank you very much. Less than
12 five minutes.

13 [Whereupon, at 11:39 a.m., the meeting was
14 adjourned.]

15

16

17

18

19

20

21

22