

## MEDICARE PAYMENT ADVISORY COMMISSION

## PUBLIC MEETING

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

Wednesday, March 5, 2008  
9:52 a.m.

## COMMISSIONERS PRESENT:

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DAVID F. DURENBERGER, J.D.  
JACK M. EBELER, M.P.A.  
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NANCY M. KANE, D.B.A.  
ARNOLD MILSTEIN, M.D., M.P.H.  
WILLIAM J. SCANLON, Ph.D.  
BRUCE STUART, PH.D.  
NICHOLAS J. WOLTER, M.D.

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

2 MR. HACKBARTH: Welcome to those of you in the  
3 audience.

4 Let me just say a couple of words about what we  
5 are going to be doing the next two days. Over the course of  
6 the next two days we're going to be considering seven or  
7 eight draft recommendations on a wide variety of issues,  
8 including among them draft recommendations on bundling  
9 services around a hospital admission, increasing payment for  
10 primary care services, and a medical home pilot. These are  
11 all issues that we have touched on in various forms in the  
12 past several years. Each is, in its own right, fairly  
13 complex.

14 Working with Bob and Mark, I have been eager to  
15 get draft recommendations before the Commission for  
16 consideration. Obviously, with our April meeting being the  
17 end of this cycle, the final meeting before our June report,  
18 we are at our last opportunity to consider recommendations  
19 at least in this cycle.

20 Having said that these are complex issues and we  
21 may or may not have final recommendations for a vote next  
22 month.

1           I do not want people to misinterpret or over  
2 interpret that. Those of you who follow our work closely  
3 are used to a pattern where a high percentage of the time  
4 when there is a draft recommendation discussed, at the  
5 ensuing meeting either that draft recommendation will be  
6 voted on in final form or something very close to it.

7           That may or may not be the case with these issues  
8 and I don't want people to say oh, they didn't vote in April  
9 on something they discussed in draft in March and therefore  
10 they have rejected it. Or worse yet, that they have  
11 rejected the staff recommendation.

12           These draft recommendations are not the staff's.  
13 These draft recommendations are mine and Bob's and they are  
14 drafts. And based on the discussion at this meeting, we  
15 will make a decision about whether to proceed to a final  
16 recommendation in April. So it is a little different than  
17 maybe you have experienced in the past.

18           The first issue that we are going to take up today  
19 is hospital-physician relationships, which will then lead,  
20 in turn, to a discussion of the bundling issue. Anne?

21           MS. MUTTI: Thank you. Last September we  
22 presented a mix of current collaborative strategies between

1 hospitals and physicians designed to align their interests.  
2 We have updated their work and bring it to you again now  
3 because it provides a useful context to assess how hospitals  
4 and physicians are relating to one another and to understand  
5 the effect these relationships have on Medicare and its  
6 beneficiaries.

7 I just want to say right at the beginning not only  
8 does this reflect Zach and my work but also Ariel Winter and  
9 Jeff Stensland's work.

10 In the paper, we focus on both collaborative and  
11 competitive dynamics between hospitals and physicians and we  
12 find ample evidence of competition and tension between  
13 hospitals and physicians, particularly as hospitals open  
14 their own specialty hospitals or ASCs, and are increasingly  
15 reducing their presence in community hospitals.

16 At the same time though in many communities  
17 hospitals and certain physicians are coming together and  
18 aligning. The collaboration may driven largely by their  
19 fear of competition. So the two dynamics, competition and  
20 collaboration, may not be so separate after all. But the  
21 fact is they are coming together in many communities.

22 We have looked at a range of collaborative

1 strategies. You can see the list on the slide. They  
2 reflect a real mix of things. One commonality we see though  
3 that is of concern is that many are, at least in part,  
4 intended at garnering physician admissions and referrals and  
5 then growing them. The presumption here is that more is  
6 better, even though evidence suggests this is not  
7 necessarily true.

8           Of course, there are exceptions. Some of the  
9 strategies are more of a reaction to market conditions and  
10 are about genuinely meeting community needs. For example,  
11 under the first bullet about financial incentives, we talk  
12 about hospitals needing to hire physicians to cover the ER  
13 or paying physicians to attend hospital meetings. This  
14 could be a way to reward physicians for their referrals but  
15 often it is because physicians are increasingly practicing  
16 outside of the hospital and the hospital is caught short  
17 staffed.

18           Similarly in some communities recruitment of  
19 physicians is not about growing volume but about meeting  
20 patient needs. So we certainly want to acknowledge those  
21 crosscurrents at the onset.

22           In this presentation we will focus on a few of the

1 collaborative strategies on this slide. We start first with  
2 hospitalists, not because it is the clearest example of a  
3 strategy to maximize volume -- although we do raise some  
4 concerns here -- but because as we think about bundling  
5 payment policies, and how hospitals and physicians might  
6 work together under bundled payment, the hospitalist  
7 movement provides some context.

8           So Zach will talk about trends in hospitalists,  
9 talk about the reasons for their growth, and the impact on  
10 Medicare. I will then highlight how certain of these  
11 strategies are more aimed at increasing the volume of  
12 services provided.

13           The key point here is that these strategies seem  
14 to be a very rational response to our current payment system  
15 that rewards volume and they help make the case for payment  
16 reforms, things like bundling, to temper that incentive to  
17 increase volume.

18           So with that, I will turn to Zach.

19           MR. GAUMER: Good morning. I will briefly  
20 describe the relationship many American hospitals have  
21 formed with physicians that practice hospital medicine,  
22 commonly referred to as hospitalists. The role of the

1 hospitalist varies by employer but their typical  
2 responsibilities include managing the day to day care of  
3 individual patients throughout the duration of their stay  
4 and contributing to administrative process improvement  
5 efforts aimed at enhancing facility efficiency and quality.  
6 Unlike the primary care and specialty physicians who  
7 traditionally conduct rounds in the hospital setting,  
8 hospitalists are stationed in the hospital full-time. These  
9 physicians often admit patients out of the emergency room or  
10 assist surgeons by managing patients in the postoperative  
11 recoveries.

12           Hospitals are increasingly relying on  
13 hospitalists. In the mid-1990s there were approximately  
14 1,000 hospitals in the United States. However, in the last  
15 five years the number has doubled. In 2003, the American  
16 Hospital Association measured 11,000 hospitalists. Current  
17 estimates from the Society of Hospital Medicine suggest that  
18 there may be 24,000 hospitalists practicing this year, and  
19 possibly 30,000 by 2010.

20           As we might expect, hospitalists are serving a  
21 growing proportion of Medicare patients. From 2004 to 2010  
22 the proportion of Medicare discharges that will have a



1 hospitalist as their attending physician is predicted to  
2 increase from 20 to over 40 percent.

3 Hospitalists and hospitalist programs exist within  
4 the majority of large hospitals, major teaching hospitals,  
5 and urban hospitals. However, they are much less likely to  
6 exist within rural hospitals.

7 Hospitalists are employed by hospitals as either  
8 direct or contractual employees. Data show that in 2005 34  
9 percent were employed directly by hospitals and 31 percent  
10 were employed contractually through a hospitalist-specific  
11 physician group practice.

12 A variety of compensation models are used to  
13 reimburse both directly and contractually employed  
14 hospitalists but the most common model includes a base  
15 salary that is combined with a bonus incentive tied to  
16 volume increases such as relative value units. Some  
17 employers also include a bonus incentive tied to broad  
18 quality performance metrics, such as adherence to practice  
19 protocols, that may lead to reducing length of stay and  
20 cost.

21 The proliferation of hospitalists is widely  
22 considered a response by hospitals to the desires of primary

1 care and specialist physicians who wish to spend more time  
2 seeing patients in their offices. As technology has  
3 improved in the last 20 years and made outpatient treatment  
4 more lucrative, physicians have discovered that traveling to  
5 the hospital to conduct rounds significantly detracts from  
6 revenues they could otherwise be earning from treating  
7 multiple patients in their offices.

8 Surgeons, who are paid prospectively for the scope  
9 of care they provide for each patient, are also generally  
10 supportive of the use of hospitalists. Surgeons rely on  
11 these physicians to manage the postoperative care of his or  
12 her patients with the benefit of not losing any proportion  
13 of their reimbursement for that one patient.

14 In addition, some have suggested that PCPs who do  
15 not visit the hospital also benefit because they are less  
16 likely to encounter malpractice lawsuits and less likely to  
17 have to treat uninsured patients coming through the  
18 emergency room.

19 While hospitalists offer community physicians a  
20 variety of benefits, some in the medical community have  
21 expressed concern about the potential adverse impact on  
22 patient care that may occur as the patient is transferred

1 from the hospitalist's care to the PCP's care outside of the  
2 hospital setting.

3           Hospitals cite various benefits to employing the  
4 hospitalists. First, they value the ability of hospitalists  
5 to fill the patient coverage gap created by PCPs migrating  
6 to the outpatient setting. Second, they recognize the  
7 measurable efficiency gains generated by hospitalists.  
8 Research recently published in the New England Journal of  
9 Medicine concluded that patients cared for by hospitalists  
10 have modestly shorter inpatient stays and lower costs per  
11 stay compared with patients cared for by general internists.  
12 In contrast, the authors also concluded that patients  
13 treated by both types of physicians did not experience  
14 differences in two key quality metrics: mortality rates and  
15 readmission rates.

16           Third, hospitals may derive referral related  
17 benefits from initiating a hospitalist program because  
18 community physicians may be more likely to channel their  
19 patients through a hospital that provides them with this  
20 coverage by hospitalists. Further, in some markets,  
21 hospitalists have become an important part of the hospital's  
22 strategy to gather patient referrals.

1           Finally, the full-time presence of hospitalists  
2 may create a better sitting for initiating patient safety  
3 and process improvement programs because hospitalists adapt  
4 faster to new initiatives than other types of physicians who  
5 are in the hospital less often.

6           While the evidence indicates that hospitalists  
7 lower hospital costs, we believe that compensation models  
8 used to pay hospitalists include incentives that may result  
9 in increased Medicare spending.

10           Volume-based incentives commonly included in  
11 hospitalist compensation formulas may provide these  
12 physicians with the incentive to increase volume in the form  
13 of admissions and consultations. For example, these  
14 physicians may have the incentive to admit patients being  
15 treated in a hospital's emergency room or, when tasked with  
16 heavy caseloads, may have the incentive to call in more  
17 consultations from other physicians within the hospital.

18           While some hospitals hire hospitalists as a  
19 strategy for improving quality and efficiency, we believe  
20 that more often hospitals do so as a strategy to attract  
21 referrals from community physicians. It appears that  
22 hospitals choose volume-based rather than quality-based

1 compensation incentives because they believe they generate  
2 additional volume that more readily recovers the salary  
3 hospitals pay to their hospitalists.

4 By rewarding volume before quality or efficiency,  
5 Medicare payment today favors the first, less constructive,  
6 compensation model used by hospitalists. Other compensation  
7 models may be more constructive for the Medicare program.  
8 For example, models that balance initiatives for volume with  
9 initiatives that target efficiency through quality  
10 improvements, such as reducing hospital readmissions, may  
11 yield greater value for the Medicare program.

12 Anne will now discuss the broader scope of  
13 relationships between hospitals and physicians in the  
14 marketplace.

15 MS. MUTTI: As I mentioned at the outset, in many  
16 communities, most of the alignment strategies are about  
17 attracting physicians and their admissions and referrals  
18 that come with them. Indeed, part of the strategy is not  
19 only to attract these physicians and their current volume of  
20 services but to expand the per physician volume, preferably  
21 in services for which the hospital gets at least part of the  
22 revenue and ones that are profitable.

1           Joint ventures are a clear example. The hospital  
2 puts up the financing and has the marketing resources, then  
3 both hospitals and physicians share in the revenue.

4           Comanagement arrangements are another example  
5 where hospitals can financially reward physicians for not  
6 only improving their unit efficiency and quality but also  
7 increasing their volume.

8           Another example is the innovative arrangement some  
9 places are calling virtual gain sharing where physicians  
10 agree to use lower cost supplies in exchange for the  
11 hospitals using that savings to invest in such services like  
12 additional operating rooms or cath labs where, again, more  
13 services can be performed.

14           Hospital recruitment of community physicians and  
15 aggressively marketing their services can also be a strategy  
16 to increase volume. Just last week Tenet Corporation  
17 announced that its admission rates across nearly all of its  
18 54 hospitals had increased after two to three years of  
19 declines. In identifying the reason for the turnaround, the  
20 COO said that adding physicians to its medical staff is the  
21 key to volume growth in 2007 and beyond. The company added  
22 over 1,000 physicians in 2007 to its medical staffs and

1 expects to do the same for 2008 and 2009.

2           One strategy for volume growth that may be less  
3 intuitive is hospitals hiring physicians as employees. In a  
4 sense, employment is a type of integration and we have  
5 generally thought of integrated systems as being more likely  
6 to produce coordinated care, and to a certain extent the  
7 research has borne that out. But one hospital systems does  
8 provide us some insight into how that strategy can work to  
9 grow volume.

10           This system that I'm going to describe here is  
11 vertically integrated with multiple hospitals, clinics, and  
12 post-acute care services. It employs its doctors, both  
13 primary care physicians and specialists, under what it calls  
14 a partnership model reflecting an aversion to calling  
15 physicians employees. The physicians are paid strictly on  
16 their own volume. They receive a percentage of the revenue  
17 they generate and the revenue generated by physician  
18 assistants and other nonphysician practitioners who the  
19 physician supervises. The remainder is retained by the  
20 system as overhead and profit.

21           The base payment structure is supplemented by a  
22 performance incentive program. This allows physicians to

1 earn additional money for retirement if they meet certain  
2 goals, such as patient satisfaction, cost reduction, and  
3 quality improvement.

4           The system manages the resources available to  
5 physicians in terms of the technology that they bring on  
6 board, the staffing -- whether it's from bringing new  
7 physicians into the system or nurses or other non-medical  
8 staffing. And they provide all of the information  
9 technology infrastructure.

10           By the system taking on these responsibilities,  
11 the physician then has more time to see patients, generate  
12 volume, and increase their income. In fact, as the CEO  
13 stated, the only constraint on their physicians' income is  
14 their time.

15           And this ability to do more is good for the health  
16 system also, because it owns and profits from physicians'  
17 use of ancillary services and downstream businesses such as  
18 DME, pharmacy, physical therapy, and home health services.  
19 The CEO estimates that for each dollar billed in the  
20 physicians' office the system earns an additional \$9 in  
21 other health care expenditures.

22           Perhaps reflecting how adeptly the system has



1 responded to incentives, it was awarded the Malcolm  
2 Baldrige National Quality Award in 2007, the highest  
3 presidential honor for organizational performance  
4 excellence.

5           So on balance, we find that many hospitals and  
6 physicians are collaborating and aligning their interests  
7 and that this collaboration can achieve some of the goals  
8 that you have articulated. It can help improve physicians'  
9 productivity. It can help hospitals improve their  
10 throughput and help contain costs for each unit of service  
11 performed. The ability to do more services in the same time  
12 can be good, particularly if there is an unmet demand for  
13 care.

14           It can also lead to better quality. Hospitals and  
15 physicians need to work better to improve the quality of  
16 patient care. But it is often designed to increase volume  
17 by attracting physicians and their referrals and helping to  
18 grow that volume. The push is for more care rather than the  
19 right mix of care and the coordination of care.

20           In light of the research finding that in  
21 geographic areas that provide more services quality is not  
22 better, this dynamic does not produce value for our health

1 care dollar.

2           Aside from volume growth, alignment has at least  
3 two other benefits to providers that may be of mixed value.  
4 First, achieving clinical integration -- and this can be  
5 sort of a technical job for FTC purposes -- between hospital  
6 and physicians can allow the hospitals and physicians to  
7 jointly negotiate prices with private insurers. Ultimately  
8 that can increase prices.

9           Second, alignment can encourage physicians to be  
10 more mindful of the DRG coding implications of their  
11 documentation. This is particularly important for hospitals  
12 under MS-DRGs where more detailed diagnosis information  
13 recorded by physicians can be key to qualifying patients for  
14 higher reimbursement, higher DRG payments.

15           So with that, I will start and look forward to  
16 your discussion on the implications of these trends. I  
17 would also note that we are intending to put this material  
18 into a chapter for the June report so we would welcome your  
19 comments on the draft, also.

20           MR. HACKBARTH: What I would like to do is this  
21 presentation was the prelude, in some ways, for the bundling  
22 discussion to come. And so what I would like to do is limit

1 our discussion of this to say maybe 10 minutes and then move  
2 on to the bundling presentation so we can allocate as much  
3 time as possible for that.

4 DR. CROSSON: Thank you very much for the work on  
5 this. I think in the end this is going to be one of the  
6 more important things we do this year and probably into next  
7 year. Just a couple of comments.

8 I think, as you note in the chapter, that there  
9 are potentially two things that we can gain by moving to  
10 more physician-hospital coordination, collaboration or the  
11 like. One is the actual coordination of care. And the  
12 second one is opportunities to improve the appropriateness  
13 of services or the mix of services as you mentioned.

14 And that, as you note in the write up and in your  
15 comments, is not automatically a function of physician-  
16 hospital cooperation or collaboration because it can produce  
17 just the opposite. So obviously to get that end, we have to  
18 deal with the payment part and the incentives inherent in  
19 the payment and that's what we're going to get to in the  
20 next part of the discussion.

21 It would like to make a couple of points. You  
22 mentioned briefly on page eight that it bit might be better,

1 assuming we want to see more relationships between  
2 physicians and hospitals, to get more clarity from the  
3 regulators on what is legal and what is not legal to avoid  
4 the multiyear process of getting a letter ruling. Because,  
5 as we mentioned earlier today again, there is a need for  
6 speed and innovation if we are going to address the long-  
7 term costs of the Medicare program.

8           The second notion is that it would be nice, at  
9 least in some areas of discourse, to change the term gain  
10 sharing do something else, something which is more  
11 reflective of what we are trying to get here, shared  
12 accountability, shared savings or something, even though the  
13 gain sharing term itself has become a term of art with the  
14 regulators. It nevertheless, I think, doesn't reflect the  
15 goals.

16           And probably the third notion here is that there  
17 probably are three sorts of integration that are going to  
18 have to take place for this movement to go in the right  
19 direction. One of those is clinical integration and it,  
20 again, has become a term of art. But it is meaningful. It  
21 does talk to the fact that physicians and hospitals can and  
22 should work together for the benefit of patients.

1           The issue of partial financial integration and  
2 what, in fact, would be legal and then what type of partial  
3 financial integration could mesh with new financial  
4 incentives to produce a good result as opposed to a result  
5 which simply drives up volume and costs.

6           And then the last one, I think which is less dealt  
7 with but equally important, is the idea of cultural  
8 integration. It's trying to bridge the gap that exists in  
9 the minds and hearts of physicians and hospital leaders at  
10 the moment and what, in fact, has prevented some of this  
11 from happening and has, in fact in the last decade, sunk  
12 some of the efforts to do this. It has to do with the  
13 development, in my mind anyway, with the development of a  
14 sense of common mission which does not always exist between  
15 physicians and hospitals administrators.

16           And common mission then enables a growing sense of  
17 respect, mutual discourse, and can even create the  
18 opportunity for shared decision-making and changes in  
19 hospital governance. It's my belief as a physician that  
20 unless those are addressed, the physician community will  
21 resist what would otherwise be, I think, some positive  
22 attempts to move in this direction.

1 DR. WOLTER: Just a little bit of an add-on to  
2 some of Jay's comments. In fact, Jay and I were able to  
3 attend a session on systemness that Kaiser, AHA and the  
4 Council of Accountable Physician Practices put on a couple  
5 of weeks ago. Jack Ebeler actually facilitated that  
6 meeting.

7 I did find our discussion at that meeting about  
8 the distinction between economic integration and clinical  
9 integration to have some value.

10 This chapter, by the way, is great. It really  
11 describes very well the state of affairs that's out there.

12 A lot of the economic integration, I think, is  
13 very much designed to drive volume. To the extent that we  
14 can put some payment policy incentives in place that will  
15 truly incent clinical integration in the sense of  
16 appropriate utilization and appropriate quality measures and  
17 that sort of thing, it can make a huge difference in where  
18 health care goes over the next 10 years and longer. But it  
19 is very difficult territory. A year or so ago Health  
20 Affairs had a web issue that Jeff Goldsmith had an article  
21 on. The title of his article was Hospital-Physician  
22 Relationships: Not a Pretty Picture. Unfortunately, that is

1 the case in many communities.

2           Which gets to Jay's issue. In addition to these  
3 sort of economic or clinical reasons to integrate, there are  
4 some very significant underlying cultural issues that will  
5 need to be addressed over these next 10 years and longer.  
6 One of the things at our meeting a couple of weeks ago that  
7 we talked about is that it isn't even just physician-  
8 hospital relationships. It's physician-physician  
9 relationships. And in many cases the history of  
10 professionalism and collegiality that caused physicians to  
11 band together have been replaced by these wildly seductive  
12 entrepreneurial opportunities that currently exist. And how  
13 to recapture some of that and what are the cultural  
14 techniques and skills that we might try to rebuild as we  
15 build new organizations is deserving of some attention.

16           There's some excellent work that's been done in  
17 this area by people like Jack Silverson and Steve Chartell  
18 [ph]. And I think that is almost deserving of a little  
19 attention going forward because we will need be the policy  
20 incentives but some of that grassroots culture building and  
21 recreation of professionalism to get where we'd like to go.

22           DR. KANE: I actually appreciate the comments

1 about the culture change. I think those are very high up in  
2 the priorities of getting everybody rowing in the same  
3 direction.

4 I'm not sure that the payment system is going to  
5 be the driver for that and I think it's really changing  
6 norms of education, not just medical education but the  
7 residency training and the signals that the medical  
8 profession sends as a profession, I think, are -- I'm not  
9 sure how Medicare can deal with that but I agree it's a huge  
10 issue.

11 Just on the research I've done on governance, many  
12 hospitals have physicians on the board. And most of the  
13 board members complain that the physicians don't have an  
14 organizational perspective and they're just there trying to  
15 protect their turf and keep other physicians from being  
16 recruited into their specialty. So there's a real  
17 educational need here. I'm not sure the payment system is  
18 the tool to get at that.

19 On the paper and the presentation, I just had a  
20 comment. I think you've done a great job of pulling out  
21 where the incentives increase volume. Are any of these  
22 systems trying and also to improve appropriateness? And



1 what tools are they using?

2 Even in your comment about physician employment  
3 encourages physicians to order more tests and physical  
4 therapy, that is actually against the hospital's interested  
5 if they're paid on a DRG basis. I agree that you can take a  
6 lot of these incentives as increasing volume, but what are  
7 the more positive things they do that create more  
8 appropriate behavior on the part of clinicians?

9 I guess it's just the emphasis. I think I agree  
10 with all that you're saying. I just felt that we kind of  
11 left out the part that says here are some of the more  
12 positive tools that are out there and how can we foster  
13 those?

14 MS. MUTTI: We can certainly work on that balance.  
15 The first thing that comes to mind is we have definitely  
16 heard of providers saying that they are motivated by P4P  
17 programs and are measuring and looking at quality, trying to  
18 achieve on quality measures. And that some of that involves  
19 appropriateness. Are they adhering -- are their providers  
20 adhering to clinical protocols and trying to improve  
21 appropriateness that way?

22 So I think that there certainly is some of that

1 going on.

2 DR. KANE: Some of that may be more internal  
3 management tools as opposed to the environmental tools.  
4 What kind of incentive systems are managers setting up to  
5 improve compliance?

6 MS. MUTTI: Right. Even aside from a payment  
7 incentive from P4P programs, that they could earn more by  
8 doing better on quality measures, some facilities -- and we  
9 did some site visits in the last year -- decided that they  
10 wanted just to distinguish themselves on quality. So  
11 whether they were required to or not, they were going to  
12 post information on their website showing how they were  
13 performing on certain quality measures and, just as an  
14 institution, made it a priority. And certainly were using  
15 those tools to make sure that appropriate care was given.

16 There are definitely examples.

17 MS. HANSEN: Thank you. I think many of the  
18 points I was going to raise were really nicely brought up by  
19 Jay. But this whole other area of what you just covered,  
20 and a previous speaker we have had here was the CEO of  
21 Virginia Mason.

22 So I wonder if, in the course of the chapter, the

1 ability to talk about what Nancy just raised, as well as the  
2 emphasis of where the incentives can be done. Because right  
3 now clearly they are penalized for not generating the volume  
4 while producing quality.

5           Is there a way to have, in the future, the chapter  
6 reflect that side of it? Because I think you did such a  
7 great job of emphasizing what happens to gin up the  
8 services. In some ways, it's rather scary to think of as we  
9 get more hospitalists the kind of economic incentive right  
10 now is what is going to create perhaps more services,  
11 whether they're appropriate or not.

12           But can we still raise the optics on the programs  
13 that have best practices that weigh quality and  
14 accountability for outcomes to the patients?

15           MS. MUTTI: Just on the hospitalists point, we did  
16 speak to one hospitalist group that was a real good example  
17 of the efforts that they make to improve care not only in  
18 the hospital but to try and reduce readmission rates, too.  
19 So we will be sure to highlight those examples, as well.

20           DR. DEAN: Just a quick comment on the whole  
21 hospitalist issue. First, it's sort of ironic, to follow up  
22 on what Nick said and so forth, that so many of these

1 structures are actually aimed at increasing volume when in  
2 fact we would hope they do just the opposite.

3 My experience with hospitalists, I'm in a setting  
4 where a lot of the times patients that I refer have to go to  
5 a tertiary care hospital 125 miles away. Naturally, I don't  
6 have a chance to see them every day and I really hope that  
7 the hospitalist would step in and be my surrogate during the  
8 time when they were there.

9 And unfortunately my experience is that has not  
10 happened. I send a patient down -- because my previous  
11 experience had been they would see one specialist and he  
12 would ask for a consultation with two and three others. And  
13 before I knew it the second and third consultants didn't  
14 know who I was, they didn't have access to the original  
15 information usually and a lot of things just got totally  
16 uncoordinated.

17 And I was really hoping that the emergence of the  
18 hospitalist would solve that problem. And in fact, it  
19 hasn't. Now maybe it's a local issue. I'm sure it varies a  
20 lot from one system to another.

21 But what really drives me crazy as I will send a  
22 patient down with multiple problems. I send them to the

1 hospitalist and call down the next day to find out what has  
2 happened and what is evolving and how things are going.  
3 It's a different hospitalist. They are largely working on  
4 shifts. And the care gets passed around from one to the  
5 next. And as far as them really acting as the inpatient  
6 primary care doctor, it is not happening.

7           And that drives me nuts because it is just adding  
8 one more layer of fragmentation.

9           Now like I say, maybe this is early in the  
10 development of this idea. Maybe it is a local issue. But  
11 at least my own personal experience is that it has not done  
12 what I really hoped it would do.

13           And I think the whole issue that Nick was just  
14 talking about, the whole cultural change within the medical  
15 profession, is a terribly important issue and one we will  
16 probably get to later. But it's very worrisome.

17           MS. DePARLE: This is a focused around slide eight  
18 where we talk about hospitals and economic arrangements with  
19 physicians. And it may be anecdotal, it may be just adding  
20 a gloss to this. But most of the discussion has been around  
21 the hospitals as the driving force in recruiting physicians.

22           I have heard from a number of hospitals when this

1 was not the topic, but just talking about what's going on in  
2 the hospital world these days -- and Nick, I would ask you  
3 if you're hearing this.

4 But the topic comes up of we are seeing more  
5 physicians approaching us about becoming employed by the  
6 hospital. And talking about it as a model that was  
7 prevalent or growing in the 1970s and 1980s and kind of went  
8 away and now it seems to be coming back.

9 But just tonally, I wouldn't want to suggest that  
10 it's all the hospitals going out and recruiting them. I  
11 think there is some of the other. And Ron and others have  
12 discussed in this room reasons why that might be happening.

13 But I don't know, Nick, if you're hearing that,  
14 but that's what some of hospitals I have talked to have  
15 said.

16 DR. WOLTER: I think very definitely it's a trend.  
17 I think there are some advantages to employment and not  
18 managing personnel and malpractice and all sorts of things.

19 I do think though that the dynamic that still gets  
20 set up tends to be sort of a volume driver in either case.  
21 Although hopefully we are starting to see some focus on this  
22 clinical integration that looks at value as well.

1 DR. CASTELLANOS: Thank you. First of all, I  
2 think you did a great job. I like the tenor of your  
3 presentation. It's very positive and hopefully moving in  
4 the direction that we need to go.

5 It's very elementary and how important policy is  
6 that we set how it effects the delivery of care. I know  
7 it's easy to say that, but the incentives that we set down  
8 are going to determine the behavior that we're doing. And  
9 you see what's happening now with fee-for-service. The  
10 incentive is to increase volume. So we need to be very,  
11 very careful on the policies that we recommend.

12 And how to we align the incentives so it's a win-  
13 win for everybody, to include the patient? That's what we  
14 really need to be careful about.

15 One of the things that Nick said, and I think was  
16 said by a number of people, is the culture in the community,  
17 the physician community, the hospital community, but also  
18 the patient community, what the patient's expectations are  
19 in his or her receiving the care.

20 We need to remember that the policies that we  
21 develop really impact the delivery of care, the cost of  
22 care, and the direction that we're going.

1           From a physician viewpoint, I know there are a  
2 couple of things that change behavior on a physician. And I  
3 have been really thinking about this. One is quality  
4 issues. We are very proud individuals. We are very  
5 particular. We want to be the best. We want to deliver the  
6 care. So quality issues and appropriateness issues of care  
7 is very important.

8           Unfortunately, financial incentives are important  
9 too, not only to get incentives but to be responsible for  
10 the resource use that we do. And I really feel that the  
11 physician needs to be responsible for financial usage of  
12 their resources and also need to be quality issues.

13           The last one is something that the professionalism  
14 within the medical community, the hospital community, even  
15 the local community. We really need to change that and that  
16 approach.

17           Thank you.

18           DR. MILSTEIN: I am a former founder and co-  
19 manager of a hospitalist group and I would say that of the  
20 many comments that have been said, the one that really  
21 strikes through is that this and virtually any other  
22 clinical innovation in American medicine can be used for



1 much value increase or much value decrease. And when you're  
2 running a hospitalist group you see that in spades.

3 So it's very difficult to judge an innovation like  
4 this or any other form of physician-hospital cooperation in  
5 isolation of knowing what the incentives are going to be  
6 because I think this -- and almost anything else -- can turn  
7 to the dark side if exposed to toxic payment incentives.

8 MR. HACKBARTH: Good point, Arnie.

9 Jeff Goldsmith, who Nick mentioned, wrote an  
10 article back in the 1990s on Driving the Nitroglycerin  
11 Truck, is the title of it. Jeff's thesis was that  
12 integrating physicians and hospitals is a very difficult  
13 thing to do, and there are a lot of factors involved. Of  
14 course, economics. Culture is very important, as well. And  
15 his article appeared sort of in the heyday of hospitals  
16 acquiring physician practices, and he expressed skepticism  
17 about how all that would turn out.

18 If you look back from today, he looks pretty  
19 smart. And he is a very smart guy.

20 Having said that, I do think -- as I look at the  
21 work that Anne and others have done on this, physicians and  
22 hospitals can collaborate. And it's easiest for them to

1 collaborate when they're expanding the revenue pie and each  
2 can make more money from it. And various joint ventures  
3 illustrate that.

4           It is way more difficult when it comes to managing  
5 a fixed or a shrinking pie in deciding what the shares are  
6 of that and who needs to change what. But hey, the same  
7 could be said of any other human beings on the planet.

8           Unfortunately, the situation we face is that we  
9 need to, if not shrink the pie, certainly dramatically slow  
10 the rate of growth. It's going to be hard work. Culture,  
11 as Nancy and Nick have pointed out, are going to be an  
12 important part of that. It is going to take savvy  
13 leadership to try to make this happen.

14           But I can't help but believe that the economic  
15 framework within which this happens is going to be a  
16 critical, if not the single most critical determinant of  
17 whether it happens.

18           The arrangement we've got now is, in large part,  
19 an artifact of decades-long payment policy which has  
20 encouraged this behavior, as Ron says. If we are going to  
21 change it I believe -- and I've said this before -- I think  
22 payment policy is going to need to drive organization.

1 Organization isn't going to spontaneously change out of  
2 goodwill or some other factor. Payers are going to have to  
3 not only encourage different forms of collaboration among  
4 physicians and hospitals, they are going to have to persist  
5 in it, which I think is the single biggest failure of the  
6 1990s. We started to get cold feet.

7           Nobody should believe that this is going to be  
8 painless, that it's going to be without error, mistake,  
9 regret at times. And we started to see some bad episodes  
10 and people shrunk back and said oh my God, we can't do these  
11 things. We'll never go anywhere as a country if that's the  
12 mindset.

13           So I think we need to start changing the payment  
14 frameworks, hopefully in a careful, prudent way. And we've  
15 got to be determined. We've got to take steps, as Ron says,  
16 to make sure that the incentives are balanced and they  
17 include quality of care as well as cost reduction. But  
18 there isn't any other path to reform other than to encourage  
19 physician collaboration to better manage scarce resources.  
20 There is no reform without that.

21           That's my speech for today.

22           So let's move on to the closely-related topic of

1 bundling.

2 MS. MUTTI: We have pursued the notion of bundled  
3 payments because of the broad consensus among commissioners  
4 that bundled payment has the potential to temper these fee-  
5 for-service incentives to deliver more care rather than the  
6 right care. In trying to identify exactly how bundled  
7 payment could be implemented, we have uncovered some  
8 challenges and differences of opinion, however.

9 We floated various approaches over the last few  
10 months to get your thoughts, and to today we offer another  
11 one, one that we think reflects broadest consensus among  
12 you. I will go through some of the details of the glide  
13 path and then present draft recommendations

14 A first step in this glide path could be for CMS  
15 to confidentially disseminate information on resource use  
16 around hospitalizations. When we say around  
17 hospitalizations, we're thinking of something like the stay  
18 plus 30 days after discharge. Many providers may not be  
19 aware of the resources they provide around a hospitalization  
20 and, once equipped with this information, they may consider  
21 ways to adjust their practice styles and coordinate their  
22 resource use. But it is likely not enough to fully motivate

1 change.

2           A second step then could be to adjust payment.  
3 Here, because the health care system is disorganized and  
4 many are not ready for bundled payment, we start with  
5 something called virtual bundling. Under virtual bundling  
6 we still make regular fee-for-service payments but we adjust  
7 payment for both hospital and inpatient physician services  
8 based on the services used within the episode window.  
9 Virtual bundling creates the incentive for both the hospital  
10 and physician to be accountable for spending across the  
11 episode. And when complemented with a P4P program, which  
12 the Commission has separately recommended, providers are  
13 also accountable for quality.

14           Concurrently, CMS could conduct a pilot on actual  
15 bundled payment. A pilot allows for CMS to resolve some of  
16 the design and implementation issues we've raised, as well  
17 as to give providers who are ready the chance to start  
18 receiving a bundled payment.

19           You can see that this construct responds to your  
20 feedback that we received at the last meeting, which was  
21 that many providers are simply not ready to be required to  
22 take a mandatory bundled payment.

1           In this path, accepting the bundled payment is  
2 voluntary and it is done in the context of a pilot program.  
3 Providers, both hospitals and inpatient physicians, who are  
4 not ready for the bundle will still be held accountable  
5 though through virtual bundling for the volume of services  
6 provided over an episode that includes this critical post-  
7 discharge period.

8           So first, we'll focus on how virtual bundling  
9 could work. We could first measure average resource use by  
10 hospital over episodes to calculate two benchmark spending  
11 levels, one that reflects relatively high spending and one  
12 that reflects relatively low spending. Each year hospitals  
13 and physicians would be informed of the high and low  
14 benchmark spending levels so they knew the target spending  
15 levels in advance. Then, while hospitals and physicians  
16 would continue to be paid fee-for-service, their claims for  
17 inpatient services for select conditions would be subject to  
18 a withhold.

19           Hospitals with relatively high spending, as  
20 determined at the end of the year or perhaps semiannually,  
21 would not get their withhold back. The withhold on services  
22 physicians provided in these hospitals would also not be

1 returned. All other hospitals and physicians would get  
2 their withholds back.

3 Those hospitals with relatively low spending who  
4 also have good quality performance could receive bonus  
5 payments. Similarly, physicians billing for services in  
6 these hospitals could also receive the bonus payments.

7 Here I'll address some of the specifics on the  
8 design of virtual bundling. We suggest that performance is  
9 measured on a hospital level. All episodes are attributed  
10 to the hospital that had the initial admission. Again,  
11 whether a physician's payment for services provided in the  
12 hospital is penalized depends on the average episode  
13 spending of the hospital. Highly efficient physicians must  
14 work with their less efficient colleagues to improve their  
15 collective performance, fostering systemness.

16 We choose to use an episode of the stay plus 30  
17 days as an example of how to design the policy. We choose  
18 this length because hospitals and physicians' decisions in  
19 the hospital impact the course of care for at least 30 days  
20 subsequent to discharge. And building a payment policy that  
21 encourages them to be mindful of patients' care needs after  
22 discharge can improve the quality of the care transition.

1           Rewards and penalties in this design are for  
2 hospitals and inpatient physicians only. This is in part  
3 because of your concern that to do otherwise -- and hold all  
4 providers in the episode accountable -- might mean that some  
5 providers who had no ability to influence resource use would  
6 be penalized. However, we recognize that some incentives  
7 need to apply to other providers, as well. For example, the  
8 primary care physician needs to be available for a timely  
9 post-discharge office visit and SNFs need to be adequately  
10 staffed to avoid unnecessary readmissions.

11           For this reason other policies, including  
12 physician resource use measurement and SNF P4P should be  
13 pursued to align incentives across all providers.

14           When considering the benchmark for the penalty, we  
15 use an example of the 75 percentile of peer performance  
16 nationwide. By setting the benchmark significantly above  
17 average spending, we leave some room for imprecision in risk  
18 adjustment, targeting only hospitals and physicians with  
19 resource use well above average.

20           I know that some of you have asked for perhaps a  
21 more detailed illustration of how this would work, and in  
22 the interest of time I'm not going to include that in the



1 presentation but I'm happy to provide that on question.

2 Concurrent information dissemination in virtual  
3 bundling that I've just discussed, CMS could be required to  
4 implement a pilot program to test making bundled payments on  
5 a voluntary basis. Providers would not be required to  
6 participate.

7 A pilot allows CMS to explore how best to achieve  
8 Medicare savings or budget neutrality by paying a bundled  
9 payment for a hospitalization episode of care. In addition,  
10 a pilot affords CMS latitude in addressing a range of  
11 implementations like determining what span of care the  
12 payment would cover, what conditions may be best suited for  
13 bundled payment, at least initially, and how to protect  
14 against incentives to increase the number of bundles.

15 This approach also allows providers most ready to  
16 accept a bundled payment to get started. Unlike a demo, a  
17 pilot allows CMS to expand the program nationwide when the  
18 program has met with initial success and it doesn't require  
19 legislation to expand it. That open-ended nature of the  
20 payment policy may be important to encourage providers to  
21 invest in the needed change. That may take a few years to  
22 see some return on that investment.

1           Ensuring budget neutrality may be challenging. We  
2 do envision though that the provider payments will be  
3 determined relative to their own baseline, as opposed to a  
4 national geographic average. This would be similar to what  
5 was done in the bypass demonstration in the 1990s. But we  
6 don't underestimate how complicated it will be in assuring  
7 that this will be budget neutral.

8           Some commissioners have mentioned that they would  
9 be interested in an alternative to the virtual bundling  
10 policy, and instead maybe a policy that focuses only on  
11 excessive readmission rates, like we discussed it last  
12 June's report to Congress. The idea here is that hospitals  
13 with higher-than-expected readmissions would be penalized  
14 with a somewhat reduced payment for admissions.

15           Among the reasons for pursuing this option is the  
16 variation in readmission rates drives much of the spending  
17 in that post-discharge window and readmissions are the prime  
18 outcome we'd like to encourage providers to work to avoid.  
19 Avoidable readmissions are not good for patients and can be  
20 a signal of missed opportunities to better attend to  
21 patients' needs.

22           The issue of readmissions has received growing

1 attention, both in the media and among health policy  
2 organizations, including the Commonwealth Fund and  
3 AcademyHealth. Their work and discussions highlight the  
4 potential of reducing readmissions as a way to both reduce  
5 spending and improve quality.

6           There is a significant savings opportunity here.  
7 We estimate that Medicare spends about \$15 million each year  
8 for readmissions that occur within 30 days of discharge.  
9 And while certainly not all of those are avoidable, some  
10 are.

11           So we have a few draft recommendations for you to  
12 consider. The first is that Congress should require CMS to  
13 confidentially report provider resource use around  
14 hospitalizations. After two years, Congress should  
15 implement virtual binding bundling, which reduces payment to  
16 hospitals and inpatient physicians with relatively high  
17 resource use across episodes of care for selected  
18 conditions. The payment penalty can be used to finance  
19 additional payments to high quality fee-for-service  
20 providers with relatively low average resource use.

21           For spending implementations on this draft  
22 recommendation, we note that the intent here is to decrease

1 Medicare spending. But depending on its design, it could  
2 result in the savings, costs, or be budget neutral. This  
3 gets to the fact that how the penalty and rewards are  
4 actually structured has a big impact on the ability of the  
5 policy to achieve the desired savings and we plan to discuss  
6 those details in the text.

7           For beneficiary and provider implications, we  
8 expect this recommendation to improve coordination of  
9 beneficiaries' care and note that it would redistribute a  
10 portion of hospital and physician payments to reward  
11 longitudinal efficiency.

12           Draft recommendation two reads Congress should  
13 require CMS to create a voluntary pilot program to explore  
14 issues related to actual bundled payments for services  
15 around a hospitalization.

16           On implications for spending, again the intent is  
17 to decrease Medicare spending but the design specifics are  
18 important to whether this is achieved.

19           Beneficiary and provider implications are again  
20 that we expect improved coordination of beneficiaries' care  
21 and that it should align providers incentives, allowing them  
22 to share in savings resulting from greater efficiency.

1           I will stop here for your discussion of these  
2 draft recommendations but will just note that I do have an  
3 alternative draft recommendation on readmissions if you'd  
4 like to pursue that further.

5           MR. HACKBARTH: Thank you, Anne. You've done a  
6 terrific job on this issue over the last several months.

7           I just wanted to say another word about the  
8 context for the virtual bundling piece of this draft.

9           You will recall, when we discussed bundling in the  
10 fall, some of us -- me included -- who felt like well,  
11 offering the option of true bundling is sort of the way you  
12 want to lead this effort. You want to get people who really  
13 feel capable of doing it, where they've got a sufficient  
14 level of physician, medical staff, hospital collaboration.  
15 They are the ones who are going to be most likely to be  
16 successful. So it would be great to just have voluntary  
17 true bundling as your leading edge.

18           The problem with that is that if you just have the  
19 volunteers, you are almost certainly going to have a budget  
20 increasing effect. They are going to look at the data, say  
21 oh, we have a relatively easy opportunity to get below the  
22 benchmark, share in savings. And all of the people who are

1 in the high end of the cost distribution are going to say no  
2 thank you. So you've got an unbalanced situation.

3 So we said we need a way to begin to affect the  
4 people who aren't volunteers, who won't step forward for the  
5 true bundling, who aren't ready for the true bundling. That  
6 was the genesis of -- or at least part of the genesis of  
7 virtual bundling.

8 In my discussions with some of you between the  
9 meetings, one of the concerns I heard -- and John in  
10 particular, from you -- is I understand that logic but the  
11 mechanism of virtual bundling sounds real complex to  
12 administer. And you could potentially use a lot of  
13 resources very ineffectively. And so I think that's a  
14 critical part of this discussion. It was John who suggested  
15 the readmission policy as alternative to virtual bundling.

16 So I just wanted to give you a little bit more  
17 background on how we get to the configuration of the draft  
18 recommendation and the option beneath it that Anne  
19 presented.

20 MR. BERTKO. Glenn has done a good job of  
21 characterizing my position on this. And again, Anne and  
22 Craig, good job on thinking about this. You have been very

1 thorough on it.

2           One of my metaphors is this is like creating an  
3 electrical tool. You've done a very good job creating the  
4 tool and the plug. And I'm running around the room and the  
5 country looking for a socket to plug it into. So how many  
6 PHOs or other kinds of organizations are available where  
7 this would work?

8           I will say a couple of more words in support of  
9 the readmissions limited scope part of this. Readmissions  
10 are a problem today. I think you guys have acknowledged  
11 that. I have at least seen some evidence that the amount of  
12 reduction in readmissions can be substantial, perhaps a  
13 third. So bringing the 18 percent down to 11 percent or 12  
14 percent. So there's money out there, money to be saved.

15           And importantly, I think, putting the burden to  
16 start with on the hospital side of this is something that,  
17 to me at least, makes some sense so that you could say the  
18 handoff, the teach back type of things -- which is one  
19 program that's used to do this -- is probably doable in the  
20 short term.

21           The pilot bundling I would certainly support if  
22 it's targeted properly. Glenn and I had a conversation and

1 I think that the Fisher/Skinner people up at Dartmouth  
2 actually have some of the tools in place that could be used  
3 for a couple of pilots. The flip side of that is the  
4 virtual bundling part of it, having been involved in the  
5 capitation and other things on just one company and in only  
6 a couple of areas, is still a substantial amount of work.  
7 The calculations of that and the explanations of it could  
8 suck up resources at CMS beyond what I think we want to get  
9 to.

10 So limited scope, try it out in several aspects.  
11 I think you could go to a fairly wide readmission limited  
12 scope one. You could even limit it by diagnosis if you want  
13 to, to the diagnoses which are most prevalent for  
14 readmissions.

15 DR. STUART: Thank you. I agree, this is tough.  
16 I mean this is clearly one of those nitroglycerin trucks.

17 But there's some weasel wording in here and it may  
18 be on purpose, because trying to figure out where this is  
19 going -- and I'm worried about on draft recommendation  
20 number one, on the implications of that. It's slide eight.  
21 Which makes me wonder what are we trying to accomplish here?  
22 Because if you look at that first one it says well, it might



1 be saving, it might cost extra, or it might be budget  
2 neutral. And I would think you would want to be pretty  
3 clear about what it is before you went forward on this.

4           And then it says below that it could improve  
5 coordination of beneficiaries' care, but might not. And so  
6 I think some of the objectives here need to be really  
7 clarified.

8           And I like what John has suggested, from the  
9 following standpoint, is that you've got a very particular  
10 kind of problem that everybody -- just about everybody can  
11 agree upon. But I'm not sure why we would want to just  
12 limit it to that. I can see why you would say well, we know  
13 more about that than we know about other things, and so  
14 let's start with that.

15           But I certainly wouldn't take an alternative that  
16 said let's not try to find out more about what resource use  
17 looks like around an episode of care. I would want to look  
18 to know just how important readmission is relative to those  
19 other kinds of post-acute activities that occur in the 30  
20 days following an admission.

21           I guess there are three things here. One, I would  
22 like to see some clarity in terms of the objective. Two,

1 I'd like to see the action related to the -- coming right  
2 back to that objective. And third, I can see us taking --  
3 and maybe this is moving back a bit from the original draft  
4 recommendation number two on virtual bundling. But at least  
5 finding out a little more about what is out there before we  
6 have a recommendation for something that is as complex as  
7 this virtual bundling looks like to me.

8 MR. HACKBARTH: Anne, did you wanted to comment?

9 DR. MILLER: Actually, I'll do that. Anne was  
10 being very careful and there was not an attempt to be any  
11 weaseling in there, just to be absolutely clear about this.

12 DR. STUART: Poor choice of words.

13 DR. MILLER: No, that's fair. And actually this  
14 is, I think, useful for the public to understand, as well.

15 First of all, our intent here is that this does  
16 reduce expenditures in the long run and that this does  
17 improve coordination. That is the intent. But this part,  
18 when we do recommendation -- and this will get more robust  
19 in the April meeting -- we have to come to you and tell you  
20 what the budget implications are and we have to consult with  
21 CBO on that. How those details get discussed may influence  
22 what happens here.

1           Now let me give you an extreme, and I hope no one  
2 does this. If somebody said I don't want to take any  
3 penalties, I just want to reward people, that would cost  
4 money. And that's all Anne is trying to put as a  
5 placeholder out here. We haven't finished all of our  
6 discussions with CBO to get the actual implications. So  
7 here she's trying to be very direct about what a scorer  
8 might say about the proposal. And that will very much  
9 depend on the details.

10           So I want to be clear, the intent is exactly as  
11 you've said. Here we're trying to be clear about, at this  
12 point in our discussions, which way the estimates could go.

13           DR. SCANLON: Let me say about how important I  
14 think that moving somewhere in this direction on bundling  
15 is. I think you've done an incredible job in terms of  
16 identifying all of the issues which we might think of as the  
17 land mines in this process. So I think we have to be very  
18 sensitive to how well we have resolved these issues in terms  
19 of moving forward.

20           One, is I think we maybe need to be careful for  
21 the public who doesn't read everything down to the footnotes  
22 that virtual bundling is not like when you're offered on a

1 website that you can trade commodities, test yourself out  
2 and see whether or not you made money and it's not going to  
3 cost you anything. Our virtual bundling is a payment system  
4 for a bundle, and people are going to be affected by that.  
5 And our alternative, real bundling or actual bundling, is  
6 another payment system for a bundle and the payments are  
7 going to be affected.

8           In reality in some ways there's no difference.  
9 It's issue of how we set the parameters, how we make the  
10 payments and, as John has raised, this issue of  
11 administrative costs. I think that we potentially need to  
12 be careful about that.

13           In terms of issues of land mines, Anne brought  
14 some of them up. Part of this is the idea of extending the  
15 window to 30 days and acknowledging that the primary care  
16 physician plays a role in what happens in that 30 day  
17 period, as well as the acute care providers. And I think  
18 that aspect of this is very critical in terms of -- I mean,  
19 you talked about readiness of whether physicians that  
20 operate in the hospital and the hospital are ready to align.  
21 There's a question of what is this environment that they're  
22 in?

1           I can remember when Elliott Fisher was here and  
2 talking about the hospital staff model, one of the points  
3 that I brought up is this almost, in my mind, created a need  
4 for a new type of risk adjuster which is a risk adjust for  
5 the environment in which a provider was operating. It's not  
6 just the patient's health status but it's what they face in  
7 terms of the influences on the use of services.

8           And I think that comes up in my mind again, which  
9 is that the environment you're operating in matters a lot  
10 here in terms of what's -- if we were to do something on a  
11 national basis, where your use would fall would depend a lot  
12 on where you are geographically. And I'm not sure that we  
13 can expect that anybody is going to be able to buck that  
14 trend very quickly.

15           Now you can say well, they should, and the payment  
16 policy is going to drive structure, it's going to drive  
17 performance. But one of the things about getting payment  
18 policies adopted in Medicare is to say that they are not  
19 unreasonable because we can put out an idea saying we are  
20 motivated by the need to improve the efficiency in Medicare.  
21 And all of those -- as Arnie talked about last meeting --  
22 all of those whose incomes are going to be affected

1 immediately raise the specter of this is an unreasonable  
2 reduction in my income.

3           And so we have to be able to demonstrate, to the  
4 greatest extent possible, that this is not unreasonable,  
5 that we have taken into account and not sort of set up too  
6 high of a hurdle for some group or another.

7           MR. HACKBARTH: I was going to say I agree with  
8 that. And this isn't a new issue in Medicare payment  
9 policy, of course. Often what's been done in the past is a  
10 transition. And you do some sort of a blended weight and it  
11 starts with a mix of hospital-specific performance and  
12 gradually introduces some other benchmark to tie the payment  
13 to.

14           To me that's an important design question more  
15 than a fundamental strategic barrier.

16           DR. SCANLON: I guess the question is in some of  
17 that blending what we've done is we've had payment systems  
18 that have had adjustments other than the kind of patient  
19 risk adjusters that we typically talk about with respect to  
20 patient's health. The question here again would be whether  
21 we need some of those kinds of risk adjustments. In the  
22 hospital PPS we have the wage adjustment. We have whether

1 or not they are a teaching hospital. We have what ever got  
2 implemented extensively, the small hospital adjuster.

3           Again, we may move down that path. And then  
4 there's the whole issue of transitions. You're confident  
5 where you're moving is reasonable, but you're still not  
6 going to do it too abruptly. So that's all I wanted to say  
7 on that.

8           Let me just raise an issue which I think is more  
9 generic, which is the idea of recommending that we do a  
10 pilot, as opposed to doing a demonstration. Because I think  
11 that this is, in some ways, a relatively new world that  
12 we're dealing in. Things have gotten added to Medicare over  
13 time, either directly -- the Congress just says do this.  
14 The Congress has, on other occasions, let's do a demo. On  
15 other occasions, when an idea is proposed coming from a  
16 variety of sources -- often interest groups -- they will say  
17 it's not even worth -- it doesn't rise to the level of a  
18 demo, let's do a study of it, either a MedPAC study or a GAO  
19 kind of study.

20           Hopefully, the decisions as to what you do in  
21 terms of those choices is rationally based on some sense of  
22 how good an idea this is. In this process we have had

1 recently the introduction of the idea of a pilot, which in  
2 my mind should be an idea that's stronger in terms of likely  
3 interest in adopting than a demo. Because I actually think  
4 a pilot, in saying that CMS can test this and then they can  
5 go nationwide without coming back to the Congress. The  
6 Congress is almost sending a signal saying we think this is  
7 a pretty good idea and we want you to test it, but probably  
8 you're going to find that you want to go forward.

9           It actually may be somewhat courageous on the part  
10 of CMS to come back and say this really worked out to be a  
11 bad idea.

12           If that's the kind of dynamic that's created,  
13 marginal ideas may end up being implemented nationwide. So  
14 I have no problem in adopting demo strategies in terms of  
15 trying to test things, but I guess this idea of -- and we  
16 have one case of it, just leaving things to a pilot, does  
17 raise concerns.

18           Now there's also issues of how well do we do  
19 demos? That kind of a discussion has come up lately and the  
20 response to that is we need to do demos the best we can, the  
21 absolute best we can. We have to invest enough in them to  
22 really test ideas. And then to move forward quickly with



1 those ideas.

2           We have discussed here about how the demo  
3 authority or the waiver authority is so broad that amazing  
4 things have happened under it, to the point that we have  
5 expressed concern that they have been too sweeping. And so  
6 it's not that the demo authority is limited. It's just that  
7 it needs to be used as effectively as we can possibly  
8 imagine.

9           DR. CROSSON: Thank you. And thank you, Anne and  
10 Craig again. I favor the primary recommendation, the  
11 primary set of recommendations, number one and number two,  
12 although I have a question on number two.

13           I think the reason is that the bundling idea, even  
14 though it presents all of the problems that have been  
15 raised, presents a potential for a broader scope of savings  
16 than simply focusing on readmission. Certainly, the issues  
17 of the cost of supplies and equipment and very costly  
18 pharmaceuticals and the other kinds of things that  
19 physicians and hospitals can create bargaining leverage for  
20 the institution, in my mind, would be more likely in a  
21 bundled payment environment rather than simply focusing on  
22 reducing admissions.

1           But I think more importantly it seems to me -- and  
2 this is more intuitive than anything else -- that the  
3 bundled payment direction -- and really what we we're doing  
4 here in the choice between these recommendations and the  
5 alternative recommendations, since this is still very early  
6 on, is picking a direction as opposed to, in any way, I  
7 think specifying the details of what is going to happen.  
8 This is early on for us in the process. But I think  
9 choosing that direction is important.

10           I think again my sense of the bundling notion is  
11 that it's more likely to be the kind of change in financing  
12 that we were talking about a little earlier that would drive  
13 physicians and hospitals to new ways of interacting and  
14 potentially positive effects on care coordination. It isn't  
15 that focusing on readmissions would not do that. I just  
16 think it would do it to a lesser degree.

17           I think the bundling idea, again which create, I  
18 think, a lot of waves, would be an indication that the  
19 Medicare program is serious about substantial change in the  
20 way payments are going forward.

21           I think the questions about how difficult the  
22 virtual bundling would be might very well be worked out in

1 that two-year period of time which is created for data  
2 collection. And it could very well turn out that it is too  
3 complex, and I don't know that a lot would be lost in doing  
4 that.

5           With respect to the second recommendation, I guess  
6 my only question is I'm not sure -- and I don't know whether  
7 I favor the pilot or the demonstration project, although I  
8 think events would suggest that things should move more  
9 quickly than more slowly. I'm not sure how the voluntary  
10 pilot program would get around the problem, Glenn, that you  
11 brought up earlier, which is that those institutions who  
12 feel -- whether it's for one condition or multiple  
13 conditions -- that they could easily "make money" on the  
14 bundled payment would jump in and the others would not jump  
15 in.

16           So it seems to me we need to do more thinking  
17 about what we would be proposing there. Would we be  
18 proposing, for example, that if you're going to be in that  
19 you have to be in for a wide range of conditions? Which  
20 might make it more likely that you have some winner and  
21 loser conditions. But I think if we don't think that one  
22 through, then I would have the same concern that you talked

1 about earlier.

2 MR. HACKBARTH: A couple of thoughts on that. I  
3 think the principal response to the concern I raised is, in  
4 fact, the virtual bundling piece of it. So that's the piece  
5 that's going to apply to everybody, including folks at the  
6 high end of the cost distribution presumably -- depending on  
7 where you set the parameters -- would generate some savings  
8 that would offset the expenditures that you would incur for  
9 the voluntary true bundlers. Now whether it all perfectly  
10 nets out obviously depends on a lot of different things.

11 A second variable is, of course, what the sharing  
12 of savings is under the true bundling program, which is an  
13 issue that several of you raised in conversations. One  
14 model is to say Medicare gets the first X percent of the  
15 savings. The people who volunteered know the data, now  
16 where they are, and so we don't want them just cherry  
17 picking. And so Medicare ought to get some compensation for  
18 that.

19 But to the extent that providers achieve more  
20 significant changes in practice patterns, a sort of  
21 breakthrough, then they ought to richly share in that piece  
22 of the savings. So you've got a couple of different

1 variables that can significantly affect the budget outlays  
2 on this, I think. And there are probably others, as well.

3 DR. SCANLON: Can I just ask if maybe for the next  
4 we could get some other information about the other costs  
5 that Jay is talking about, in terms of their magnitude, that  
6 might be influenced? Things like supplies, et cetera, that  
7 are not part of a Medicare packaged payment already, so that  
8 it's possible to try to influence them.

9 MR. LISK: We will try to do that. To give you  
10 some idea though, that does vary by condition. The big  
11 things are readmissions and post-acute care use. We already  
12 know that. But that varies by condition. For instance,  
13 like CHF, readmissions is a large factor. Post-acute care  
14 is a little bit less.

15 But if you go to something like hip replacements,  
16 use of post-acute care setting is a bigger factor than  
17 readmissions, for instance. So it's highly dependent upon  
18 the conditions and so we wanted to make you aware of that.

19 DR. KANE: I think some of them are not dependant  
20 on condition. It's if you have A and B bundled, the  
21 physicians are motivated to work with the hospital to do  
22 things like better scheduling and process improvements that

1 hit all conditions. Or agree on standardization of certain  
2 types of purchasing. So I think it goes beyond condition.

3 Right now you see variability in the post-acute  
4 but you don't see how much hospitals could start to drive  
5 down their own internal costs if they had the physicians on  
6 their side moving in the same direction.

7 So I agree with Jay, I think there's huge  
8 possibilities of process improvement. And once the  
9 physicians can now share in the savings of better process  
10 improvement, standardizing purchasing, then you're going to  
11 see, I think, the hospital piece start to have much more  
12 variability potential on cost.

13 So yes, post-acute is where you see it now. But  
14 you don't see what could happen if the physicians are  
15 motivated and can share the gains with the hospital over  
16 process improvements.

17 I'm sure you can figure out what some of those  
18 might be, but I would guess they are bigger than the  
19 readmission, changing the readmission.

20 DR. MILLER: Can I just say one thing, just to  
21 remind you? We do also have that recommendation out there  
22 that we made a year plus or two years ago on gain sharing.

1 If Congress were to go forward with that, and virtual  
2 bundling was in place, you also build some critical mass  
3 behind that concept, notwithstanding that we should change  
4 the name of it, Jay. I didn't miss your point.

5 DR. DEAN: I just wanted to follow. I think Jay  
6 is right, that this is clearly long-term, the direction we  
7 want to go. It's obviously a complex undertaking and I  
8 think we need to go gradually.

9 I would really be interested in seeing what  
10 happens just with confidential reporting of this information  
11 because I have a feeling, like Ron said, we're all pretty  
12 competitive folks and we all think we're all above average -  
13 - just like Garrison Keillor's folks. And if the  
14 information was presented that you're really not, I think we  
15 might see some behavior change.

16 The other thing is that the readmission part is  
17 sort of attractive just because it's relatively easy to  
18 document -- having just been through one of those myself.  
19 But so much of that is beyond the control of the hospital in  
20 many situations.

21 I was just thinking, Dave, of the presentation  
22 that your group put on with the fellow that is CEO of

1 Parkland in Dallas, and all of the things that they have  
2 done in terms of community development and developing  
3 primary care services within their community and, in fact,  
4 have shown pretty dramatic decrease -- well, in dealing with  
5 a large indigent population they have shown that where most  
6 of the experience around the country is that emergency room  
7 utilization is going up and really been a problem, their  
8 emergency room utilization has actually dropped if I  
9 remember right. And I'm assuming they're readmissions  
10 probably has followed that same trend, although I don't  
11 remember if we spoke to that.

12 But the point is that this could well be a lever  
13 to push hospitals to get more involved in their communities  
14 and say that our mission needs to be broader than just doing  
15 acute care services. And that if we are going to have a  
16 responsible health care system, these cannot be separate  
17 entities. They have to be working together.

18 MR. EBELER: Just quickly, I think Tom captured it  
19 well. I think these are recommendations for a good place to  
20 start.

21 I think clarity about what we're trying to get is  
22 really important because we started there and now we're in



1 the phasing schedule. And I think we're sort of stating in  
2 here where we're trying to drive this in the context of our  
3 previous presentation about what we're seeing about current  
4 hospital-physician relationships, I think would be really  
5 important. We're trying to head for an effective  
6 prospective payment that drives the kinds of behavior you're  
7 describing. That clarity, I think, is important.

8           A couple of comments on features of this. Again,  
9 in getting started, we've consistently said -- and then I  
10 think overlooked the idea that we're talking about starting  
11 virtual and the pilots for selective procedures. This is  
12 not about everything the hospital does. It is trying to  
13 take some procedures, the criteria are laid out in the  
14 chapter, and beginning to drive change that way, which I  
15 think is an important thing to think about in the phasing  
16 schedule.

17           This issue of the release of data, first  
18 privately, I think is important. Although, I guess I would  
19 question whether maybe in year two that should be public.  
20 It's always anxiety provoking when the government has got  
21 data and is sharing it and isn't publicizing it. I would  
22 suggest that those data public might engage some boards of

1 directors and community activists in ways that really  
2 reinforce that competitive pressure that we want in the  
3 professional community. So thinking about that going public  
4 might be interesting.

5           The third thing is on this budget issue. I think  
6 it's a big issue for the Commission, and I have been  
7 moderately outspoken on the need to squeeze the rate of  
8 increase in Medicare spending and will continue to be. When  
9 you think about critically important innovations like this,  
10 I would argue that in the aggregate we need to lower the  
11 rate of increase in hospital and physician spending. We  
12 need to think about the package and sort of there are a  
13 series of update factors and fee factors that one can be  
14 particularly tight on. At the same time, one might be  
15 willing to not necessarily try to achieve savings in this  
16 type of particular initiative in the first three months you  
17 implement it, and that you're really looking at a balanced  
18 package of spending constraints.

19           When I think of what you'd want to know two years  
20 from now in a pilot and the virtual thing, is have we  
21 learned how to create infrastructure -- in John's terms sort  
22 of the socket into which to plug this? Because if you had

1 that two years down the road in the pilot that, in many  
2 ways, that infrastructure -- which really gets to some of  
3 the objectives that Tom mentioned and that I know Nick has  
4 talked about for quite a while -- is far more important.

5           And like I say, we need to be budget responsible.  
6 But I think you can squeeze in a lot of other areas and  
7 allow your positive innovations like this the chance to get  
8 out there and grow as you try to reform the system.

9           I think we just need to make sure that we have a  
10 balanced package of budget constraints but those can include  
11 tight constraints on the stuff that we don't like, as well  
12 as the willingness to innovate in the stuff we're trying to  
13 change.

14           DR. MILSTEIN: I certainly agree with all of the  
15 challenges raised and also with the benefits of going slow  
16 and narrowing our target.

17           Having said that, I favor the recommendations  
18 exactly as written. I think it's a beautifully Solomonesque  
19 cut through a bold and a conservative approach.

20           My reasons are, first of all, we do have -- one of  
21 the few demos that worked quite well was the coronary bypass  
22 graft demo. It was very well evaluated. It worked fine.

1 It wasn't a test of all hospitals but it shows that this  
2 kind of cooperation is possible. And it wasn't only in  
3 hospitals where physicians were on salary.

4           Secondly, I'm going to predict that the sunlight  
5 this would generate as hospitals and doctors of all  
6 specialties begin to understand what the total bundle is  
7 that Medicare is paying out and who is getting how much I  
8 think will be extremely therapeutic and generate, I think,  
9 some very useful dialogue not just between hospitals and  
10 doctors but among doctors.

11           My feeling is if we aspire to target big gains,  
12 we're going to have to target big opportunities. I am among  
13 the group that feels that it is not unreasonable to engage  
14 hospitals and doctors not only on readmissions but also  
15 process reengineering within the hospital stay.

16           I think, based on the work I do in the commercial  
17 sector, I think we're going to find very, very big gaps  
18 between best performance and average performance in terms of  
19 on both quality and total cost. And so I don't think  
20 implementing this kind of a recommendation will require  
21 super sophisticated management inventions by doctors and  
22 hospitals, nor will it require perfect execution by CMS.

1 DR. REISCHAUER: I think we're headed very much in  
2 the right direction here and I want to commend Anne and  
3 Craig and Zach for the work they've been doing on this to  
4 put flesh on the bones and bring forth all the complexities  
5 that are involved here. I just want to have somebody clear  
6 up some of the confusion that I have here.

7 When we're talking about the withhold, we're  
8 talking about applying the withhold to everybody, whether  
9 they are a participant or not?

10 MS. MUTTI: In the virtual bundling.

11 DR. REISCHAUER: In the virtual bundling.

12 MS. MUTTI: It's applied to the hospital and  
13 inpatient physicians for treating these select conditions.

14 DR. REISCHAUER: For those hospitals that  
15 volunteer?

16 MS. MUTTI: No. This is the default.

17 DR. REISCHAUER: For everybody?

18 MS. MUTTI: Yes, there will be the minority that  
19 will go into the pilot.

20 DR. REISCHAUER: So then we set sort of a nick  
21 here that would create a pool of resources that then can be  
22 used to provide bonuses for high performance and efficient

1 utilization.

2 MS. MUTTI: Right.

3 DR. REISCHAUER: And so how many people volunteer  
4 is a critical aspect of where you set the nick, although  
5 there can be some --

6 MS. MUTTI: Again, the virtual bundling is not  
7 voluntary.

8 DR. REISCHAUER: Oh, it's for everybody.

9 MS. MUTTI: That's for everybody. It's only the  
10 pilot that's voluntary. And the pilot is the one that's  
11 testing that -- not mandatory, actual --

12 DR. REISCHAUER: But then the pilot we have to  
13 come up with new money for?

14 MS. MUTTI: The pilot is intended to produce  
15 savings. If we go to the model of the cardiac bypass  
16 demonstration in the 1990s, that was achieved by looking at  
17 the historic baseline for treating a given condition, CABG,  
18 and negotiating discounts from there.

19 Now we have raised other concerns. Does volume  
20 get increased? We've got to take that into account so we  
21 don't want to underestimate our ability -- it's going to be  
22 complicated to achieve the budget neutrality or ensure

1 savings but it's been shown possible.

2 DR. MILLER: [off microphone] You were thinking  
3 there wasn't enough money because you're pulling  
4 [inaudible].

5 DR. REISCHAUER: No, I was thinking that, but I'm  
6 happier now, having heard this. So don't push me.

7 DR. MILLER: Carry on.

8 DR. REISCHAUER: I will find some reason to be  
9 upset, if you give me the opportunity.

10 DR. MILLER: I'll be right here when you do.

11 DR. REISCHAUER: As we go forward on this, having  
12 some more information -- we looked into this a little --  
13 about multiyear stability of these performance measures  
14 within areas. Do these jump around tremendously? Or is  
15 this a pattern that you see in certain hospitals? And some  
16 idea about the geography is always valuable when you are  
17 considering the political viability of some of this stuff.

18 And then there's a rather complicated issue I  
19 think -- and maybe I'm wrong here -- about how outlier  
20 payments fit into all of this. I don't think there's a  
21 right or a wrong answer to that, but we should, as we think  
22 forward, think about how we do this.

1           Just a final comment on Bill's endorsement of  
2 demonstrations over pilots-- and I'm in Arnie's camp on this  
3 one -- in that I think good ideas don't get pushed forward  
4 often, even when the demonstration is "successful."

5           So I'm an advocate of pilots, but only with very  
6 clear and explicit thresholds on when you can go forward  
7 from a pilot to an application. We haven't often had the  
8 metrics we need to set those kinds of thresholds, but I  
9 think with the development of more information, more pay for  
10 performance kind of measures, we can and we should insist on  
11 those being part of the authorization of the pilot.

12           MS. BEHROOZI: Ditto what Jay said a while ago,  
13 Arnie said, and a lot of others have said. So I won't  
14 repeat it. I just want to add my voice of support for the  
15 recommendations.

16           I want to say that what is remarkable about that  
17 as I didn't get a headache trying to figure out what I  
18 thought about it. And that's a tremendous credit to you,  
19 Anne and Craig.

20           MS. MUTTI: Actually, sometimes I tried but Mark  
21 reined me in.

22           [Laughter.]



1           MS. BEHROOZI: I think that you've really done a  
2 tremendous job, just in the short time I've been here, to  
3 really drill down on issues and respond to the concerns that  
4 people have raised. I think, as Arnie said, it's just pure  
5 and beautiful and gets exactly to the kinds of issues we  
6 raised in the last discussion.

7           It's not perfect, but the saying I think that  
8 applies here is let's not let the perfect be the enemy of  
9 the good. And it is movement, and that's what we want to  
10 do. And people have said that.

11           So I really want to commend you for that. And I  
12 just want to make a brief point on the data and maybe going  
13 slowly on the data or releasing it publicly.

14           I think this is one of those cases where the  
15 providers will pay attention to the data if they know that  
16 they are going to need to be accountable for it at the end  
17 of two years. Yes, there's the competitive stuff and  
18 there's the pride stuff and all of that. But they'll pay a  
19 lot more attention if they know at the end of two years  
20 there's money at risk or money to be gained by what that  
21 data says about them. So I would encourage you to maintain  
22 it as exactly as you have it.

1 DR. WOLTER: I thought this was also well done. I  
2 love the phrase glide path for something that's going to be  
3 like landing on the Eastern slope of the Rockies during a  
4 chinook, but it's a great phrase.

5 [Laughter.]

6 DR. WOLTER: A couple of thoughts. I, too, favor  
7 the original, the first draft recommendation one. Because  
8 as I'm recalling from the previous work, there was more  
9 variation in overall cost and performance when you looked  
10 outside the hospital stay itself, out to 15 and 30 days.  
11 And so it seems like getting to that ability to manage the  
12 episode makes a lot of difference.

13 I would agree with Bill, if we had a little more  
14 information about where that is, I know it's condition  
15 specific, but there probably are opportunities.

16 To that point, there's a couple of things in the  
17 recommendation that give me a little pause. One is that  
18 we're using the hospital as the payment recipient, as the  
19 only option the way this is worded. And to the issues we  
20 discussed earlier about culture and physicians and hospitals  
21 and how they come together, I could imagine PHOs that would  
22 wish to be the recipient. That would also foster the shared

1 governance that Jay was talking about earlier. We might  
2 just think about that. I think the hospital thing can work.

3 MR. LISK: Mark is not here. I think one of the  
4 intentions that we have is because our previous  
5 recommendations on the gain sharing is that's part of  
6 potentially what could be done with let's say those bonus  
7 payments or whatever you have within this, that potentially  
8 that would be --

9 DR. WOLTER: Middlesex, for example, that might  
10 work well for them.

11 And then also, if we're going to look at an  
12 episode that goes beyond the hospital discharge, do we want  
13 to be sure that, at least in theory or in practice,  
14 physicians other than the inpatient physicians could be part  
15 of this bundle? I'm quite intrigued with what Geisinger has  
16 done mapping the care of cardiac bypass surgery patients and  
17 making this guarantee. Although I haven't seen the  
18 specifics of the checklist and protocols they have put  
19 together, almost certainly it's very well mapped out which  
20 physicians involved in postoperative care are on various  
21 checklist performance goals that will help reduce  
22 readmissions or other complications.

1           So we could inhibit something that would be very  
2 powerful if we don't find a way to allow the outpatient  
3 physicians to be part of the bundle. We might just think  
4 about that as design moves forward also.

5           Then I was just going to ask if this is positioned  
6 as a pilot, does it allow something like this to move  
7 forward without gain sharing or shared accountability  
8 legislation? Does that all have to happen also?

9           MR. HACKBARTH: Because of the existing  
10 prohibitions -- well, we'd have to get real lawyers, unlike  
11 me, involved in this. But generally, a specific position  
12 that authorizes an activity in the context of, for example,  
13 a bundling pilot overrides a general prohibition. So they  
14 would write it to exempt is from the general prohibition  
15 under these limited circumstances.

16           Nancy-Ann, would you agree with that?

17           MS. DePARLE: That they'd have to get real  
18 lawyers?

19           MR. HACKBARTH: Yes, right.

20           [Laughter.]

21           MS. DePARLE: Include me in that, too.

22           DR. CASTELLANOS: Just to the Nick's point, could

1 you put on slide seven, where it says inpatient physician.  
2 This would include hospitalists. As you remember, we talk  
3 about it. They're just in the hospital and when they turn  
4 that patient over to the primary care provider, they still  
5 are going to be held for the episode of care which may be up  
6 to 30 days.

7           So I really don't think you want to limit it just  
8 to inpatient physicians. I think you want to say hospitals  
9 and physicians. I think you will be pinpointing the  
10 hospitalist and perhaps making him accountable for something  
11 he has no control over; i.e., the post-hospital care.

12           MS. MUTTI: I can say one thing that we were  
13 thinking of why we tailored it that way was the concern that  
14 we thought -- and we thought we heard it from some of you,  
15 but correct us if we are wrong -- is that if we included all  
16 physician visits who saw that patient in that 30 day  
17 interval, it might include something like a podiatrist visit  
18 visited on the 20th day after discharge that was no way  
19 related to that initial admission and the subsequent care.

20           And that that physician then would be subject to  
21 the penalty. And you may be uncomfortable with that because  
22 at that late date that physician couldn't -- now we could

1 think about the kind of logic that Nick mentioned that  
2 Geisinger has where you can specifically map those  
3 physicians that would be related, but we have not  
4 contemplated that yet. So we were being a little  
5 conservative by just applying the penalty to the inpatient.

6 DR. MILLER: Actually, just go a little further,  
7 this recommendation is constructed on, as best as we could  
8 tell, had the broadest consensus. And when we discussed  
9 that point, there was significant reaction from many  
10 commissioners about including the people outside of the  
11 hospital. It's just the reverse of your point.

12 And we felt that on balance this was -- and you've  
13 raised the point so people may want to comment -- but this  
14 was the best representation of where most people were.

15 MR. HACKBARTH: Maybe we want to ask then, having  
16 heard the argument that Ron and Nick and some others have  
17 made for extending including strictly outpatient physicians  
18 in the bundle, what do people think about that?

19 DR. KANE: I think it depends on how well we can  
20 associate those physicians with that particular patient  
21 condition. So if it's a podiatrist who had nothing to do  
22 with the congestive heart failure or whatever, then pull

1 them out. Technically, I just don't know how hard that is  
2 to do. If you're saying there's a 30-day window, can you  
3 pull out the window, the services that have nothing to do  
4 with this episode of care?

5 MR. HACKBARTH: Let we phrase it this way, do  
6 people agree --

7 DR. REISCHAUER: Are there related codes which we  
8 could identify?

9 DR. KANE: Is there a way to do that that is  
10 technically manageable? John is going nuts over here.

11 MR. HACKBARTH: To me, the logic of what has been  
12 said about including outpatient physicians involved in post-  
13 acute care, the logic seems powerful to me. And it boils  
14 down to how well you can execute it fairly and accurately.  
15 And that's probably not a question that we can answer right  
16 now off the top of our heads. We can think some more about  
17 that. So we will try to figure about how feasible that is.

18 And it may be one of those things that -- these  
19 things will evolve over time. You start without them as the  
20 first step and then the second step is you develop the  
21 attribution mechanism. You add that as a new feature to  
22 make the system even more powerful over time.

1           I'm really anxious to move on at this point. Have  
2 I missed anybody who was in the original queue? We're about  
3 15 minutes behind schedule, for those of you in the audience  
4 who are keeping score.

5           We now have another presentation on producing  
6 comparative effectiveness information and the recommendation  
7 on comparative effectiveness information. We will see if we  
8 make up any time. If not, we will just go to lunch late.

9           MS. RAY: Good morning. Spending on health care  
10 is substantial and increasing rapidly. Nonetheless, the  
11 value of services furnished to patients is often unknown.  
12 Frequently, new services disseminate quickly with little or  
13 no basis for knowing whether they outperform existing  
14 treatments and to what extent.

15           Increasing the value of health care spending  
16 requires knowledge about the outcomes of services.  
17 Comparative effectiveness, a comparison of the benefits and  
18 risk of different treatments for the same condition, could  
19 help payers and patients get greater value from their  
20 resources. By treatments, I mean drugs, biologics, medical  
21 devices, surgical procedures, diagnostic procedures, medical  
22 care, and no care.



1           Our June 2007 report had a chapter that discussed  
2 the importance and the need for more comparative  
3 effectiveness research. In the past year, there has been a  
4 lot of interest from policymakers about the need to develop  
5 comparative effectiveness research in a systematic way. In  
6 particular, there has been a great deal of interest about  
7 obtaining more details about establishing a comparative  
8 effectiveness entity.

9           To be supportive of the process, we are planning a  
10 June 2008 chapter that provides options and details for  
11 financing comparative effectiveness research and for  
12 organizing the effort. That is to say what an entity that  
13 produces comparative research could look like.

14           We would like your input and comments on what we  
15 are going to present. At this point, as Glenn said, we  
16 don't plan on making any recommendations in the June 2008  
17 chapter.

18           Last year, the Commission concluded that there's  
19 not enough credible empirically-based comparative  
20 effectiveness information available. The Commission also  
21 agreed that comparative effectiveness is a public good  
22 because the benefits of the information accrue to all users,

1 not just to those who pay for it. There is no one public  
2 entity whose sole mission is to produce comparative  
3 effectiveness research. The U.S. lacks a systematic  
4 approach in setting the research agenda and sponsoring the  
5 work.

6           This led the Commission to recommend that the  
7 Congress charge an independent entity to sponsor comparative  
8 effectiveness research and disseminate it to patients,  
9 providers and payers.

10           In the June 2007 chapter, the Commission stated  
11 that the entity would be independent, produce objective  
12 information, and operate under a transparent process, seek  
13 input on agenda items from patients, providers, and payers,  
14 disseminate information to multiple audiences, and have no  
15 role in making or recommending coverage or payment  
16 decisions. The decision to use the comparative  
17 effectiveness information would be left to private and  
18 Federal payers.

19           In last year's report the Commission explained  
20 that establishing a public-private entity would reflect the  
21 benefit of comparative effectiveness information to the  
22 government, private payers, and patients and that an

1 advisory board to help ensure that the research is  
2 objective. The Commission concluded that a Federal role  
3 need not result in a large expansion of the government. The  
4 entity could make use of other organizations, both public  
5 and private, that already conduct such research.

6           Here are some of the activities of a comparative  
7 effectiveness entity. To carry out its activities, the  
8 entity will need a clear rationale for selecting the  
9 services to study and get input from constituents. It could  
10 sponsor unbiased research, including systematic reviews of  
11 public literature, analyses of administrative claims data.  
12 It could establish medical registries. When available, it  
13 could analyze electronic medical records. And it could  
14 sponsor head-to-head clinical trials. It could sponsor  
15 studies that re-examine the service's effectiveness if  
16 practice patterns change. It could develop programs that  
17 train investigators and institutions to do the research.

18           To summarize then, last year the Commission stated  
19 that it preferred a public-private entity with an advisory  
20 board to sponsor comparative effectiveness research. The  
21 Commission also called for the entity to have stable and  
22 secure funding.

1           Now we are going to drill down to discuss some  
2 issues to fund and organize the comparative effectiveness  
3 effort.

4           MS. NEPRASH: The following discussion of funding  
5 levels is not intended to arrive at a specific dollar  
6 amount, but instead to provide a reference point for future  
7 discussions as policymakers will need to determine the  
8 funding level necessary to establish and maintain a  
9 comparative effectiveness entity.

10           One way to do this is through a bottom-up approach  
11 that uses assessments of current comparative effectiveness  
12 spending levels to estimate required expenditures based on  
13 the scope and research capabilities of the entity.

14           This list presents the best funding estimates  
15 available for entities that currently conduct comparative  
16 effectiveness research. Funding for a comparative  
17 effectiveness entity should match the activities it  
18 undertakes. An entity that sponsors retrospective research  
19 would require lower funding levels than an entity sponsoring  
20 prospective research.

21           Alternatively, a top-down approach can be used to  
22 determine an entity's funding. Some prominent health care

1 researchers have proposed such an approach by specifying a  
2 dollar amount or a percentage of current national health  
3 expenditures that should be used to fund comparative  
4 effectiveness research. It is worth noting here that most  
5 of the top down financing strategies would funnel around \$1  
6 billion into a new comparative effectiveness entity.

7           When the Commission last discussed how to fund a  
8 comparative effectiveness entity, there was agreement on the  
9 importance of a stable and secure funding source. You  
10 suggested that this could come from a public-private or  
11 purely public financing mechanism. This slide outlines the  
12 most stable public and private funding mechanisms that can  
13 be combined to finance the entity.

14           One option for mandatory public funding is to set  
15 aside a fixed percentage of the Medicare trust funds.  
16 However, with the fiscal pressures facing Medicare, this may  
17 not be the best way to go.

18           Alternatively, mandatory Federal financing could  
19 come from general revenues.

20           One possible mandatory private sector financing  
21 approach is to institute a levy targeted towards insurance  
22 or manufacturers.

1 MS. RAY: So the next issue concerns the design of  
2 an advisory board. Recall that last year the Commission  
3 stated that an independent advisory board could help develop  
4 the research agenda and ensure that the research is  
5 objective and rigorous.

6 The first question is who should appoint the  
7 members to the advisory board. Most Federal commissions,  
8 for example the FTC, the SEC, are appointed either by the  
9 president or by the president and confirmed by the Senate.  
10 But this may not offer the independence one might desire.  
11 Disagreements could occur, which may lead to gridlock, that  
12 is vacancies on the advisory board. This could undermine  
13 the stability of the comparative effectiveness entity by  
14 affecting its ability to move forward.

15 This might be circumvented by having a neutral  
16 individual, for example the Comptroller General, appoint  
17 members to the advisory board. Also, having the  
18 appointments staggered so that everybody's term is not up at  
19 once is also another way to ensure the entity's stability.

20 What are the options for structuring the advisory  
21 board? Well, many Federal commissions have between five to  
22 seven members. However, these boards are typically making

1 policies or issuing regulations. Given the entity's  
2 research mission, a larger advisory panel that includes  
3 experts from different areas may be warranted.

4           Who should be able to serve as advisory board  
5 members is another question. Last year the Commission said  
6 that board participants could include patients, health care  
7 providers, and representatives from private and public  
8 health plans and payers. Some argue that representatives  
9 from drug, biologics, and device companies should also be  
10 able to participate.

11           In sharing with the board members and staff, our  
12 objective will be important for constituents to review the  
13 comparative effectiveness research objective and credible.  
14 There is a potential for conflicts of interest to occur when  
15 individuals have personal or financial interests that could  
16 compare their judgment in carrying out their  
17 responsibilities.

18           Consequently, establishing ethics rules to  
19 minimize bias and ensuring the impartiality of the board and  
20 staff will be important. Ethics rules could address issues  
21 such as whether staff can accept compensation from outside  
22 sources and requirements for the regular reporting of the

1 financial interests of the board and staff.

2 Now let me take you through three options for ways  
3 the advisory board and staff could operate. What is common  
4 to the three options is that a director and staff manage the  
5 functions of the comparative effectiveness entity. The  
6 director and staff contract out studies to public and  
7 private sector researchers. The three alternatives differ  
8 in the design and function of the advisory board.

9 Here is the first option. Here you have a  
10 director and staff, and they could consult with several  
11 different advisory boards, one on the general priorities for  
12 the year's research agenda, one on the standards of evidence  
13 for studies, another on plans for dissemination and  
14 education, and another that is composed of representatives  
15 from stakeholder groups.

16 Individuals with expertise could be appointed to a  
17 specific board. For example, individuals with expertise in  
18 communication could be appointed to the dissemination board.  
19 Folks from academia with expertise in designing studies  
20 could be appointed to the methods board.

21 Here is a second option. Under this option, there  
22 is just one advisory board and it serves multiple functions.



1 It sets the research agenda. It advises staff on the study  
2 methods and it advises staff on dissemination plans. Staff  
3 would oversee and manage the key functions of sponsoring  
4 comparative effectiveness research. Under this option,  
5 stakeholders could meet as needed with staff.

6 Option three is similar to option two, except that  
7 committees could provide direct input to the advisory board.  
8 You could have a committee on setting priorities, another  
9 committee on methods, another committee on dissemination,  
10 and another committee composed of stakeholders.

11 So like the first option, you would more  
12 opportunities for individuals to have a formal role in the  
13 process of producing comparative effectiveness research.  
14 But the role of the committees would be advisory only.  
15 Having formal advisory committees is not uncommon. For  
16 example, CMS has established the Medicare Evidence  
17 Development Coverage Advisory Committee to provide the  
18 Agency advice and recommendations about clinical issues.  
19 FDA, as well, has a series of advisory committees. But  
20 having the advisory committees would certainly add another  
21 layer to the comparative effectiveness entity.

22 Regardless of the board's structure, there are

1 various public-private options to consider for housing a  
2 comparative effectiveness entity. They vary on whether they  
3 are a Federal agency or privately operated organization and  
4 who the entity is accountable to.

5           The first option is an FFRDC, a Federally Funded  
6 Research and Development Center. They are independent non-  
7 profit entities sponsored and funded by a Federal government  
8 agency, usually to meet a long-term technical need. FFRDCs  
9 typically assist government agencies by conducting  
10 scientific research and analysis. So the FFRDC actually  
11 conducts the research. FFRDCs are managed by universities  
12 or private companies and they are accountable to their  
13 sponsoring Federal agency.

14           So for example, the National Cancer Institute at  
15 Frederick is an FFRDC. Its sponsoring Federal agency is  
16 NIH. And it is administered by four private companies.  
17 There are currently 38 FFRDCs. About two-thirds of those  
18 are associated with Defense or Energy.

19           FFRDCs typically enter into a multiyear contract  
20 with its sponsoring executive branch agency.

21           Another option is an independent Federal agency,  
22 sort of what we call the Federal Reserve model. Under this

1 option, an agency of the U.S. Government not in an executive  
2 branch department could be established to develop the  
3 comparative research.

4           A third option is a Congressionally chartered  
5 nonprofit private organization. For example, IOM and its  
6 parent, the National Academy of Sciences, is such an  
7 organization. And some policy experts have suggested  
8 augmenting for IOM to be a part of the comparative  
9 effectiveness research.

10           In terms of funding, some Congressionally  
11 chartered nonprofit organizations rely heavily on Federal  
12 funding. Again, IOM is one example but there are others  
13 here.

14           There are trade-offs in the independence and  
15 accountability among these three public-private options.  
16 For example, an independent Federal agency and a  
17 Congressionally chartered nonprofit organization may have  
18 more autonomy than an FFRDC, which is usually accountable to  
19 its sponsoring executive branch agency through a multiyear  
20 contract.

21           In terms of accountability, nonprofit private  
22 organizations are not usually subject to regular

1 governmental oversight. The statute, however, could specify  
2 and address this by specifying the oversight and review of  
3 the entity. For example, it could require regular  
4 submission of reports to the Congress and key Federal  
5 agencies and regular auditing of its functions by outside  
6 independent groups.

7           So Hannah and I have talked about the various  
8 design issues of a comparative effectiveness entity. We are  
9 putting together a chapter in the June 2008 report to  
10 respond to requests from policymakers to obtain more details  
11 about the next steps involved in producing research. We are  
12 interested in your comments, if there are any additional  
13 topics you'd like to see. And again, we were not planning  
14 on making recommendations here.

15           DR. CROSSON: Thank you for moving this ball a  
16 little bit further down the field. There are a lot of  
17 moving pieces and elements to this and I just wanted to  
18 comment on two of those.

19           One of those is the funding stream. My sense from  
20 previous attempts at this have suggested that the most  
21 likely funding source, in the end, may include the users of  
22 the information, and there are some arguments to be made

1 there.

2 My only thought would be that if that's where it  
3 ends up, that the users be broadly defined and that it  
4 include, for example, self-funded employers and perhaps even  
5 the public payers themselves so that we're not funding this  
6 off of a narrow base.

7 A second one is, in terms of the structure of the  
8 board versus the executive. I would strongly favor the  
9 first option. My sense of this, again in the past, looking  
10 back to the history of AHCPR and other things, is  
11 undoubtedly there will be considerable pressure of all kinds  
12 brought on the entity. It's going to be necessary for it to  
13 make some difficult choices. And to have those choices made  
14 by a board versus a strong executive, my sense is, would end  
15 up with a less effective organization.

16 DR. SCANLON: My comment relates to Jay's last  
17 point. And that is I think the issue in terms of if we have  
18 a board and the board has decision-making authority, there's  
19 a question of how do we assure that it is independent  
20 enough? And it goes to the question of conflict of  
21 interest.

22 And that kind of raises the option of this is a

1 full-time board. You work for this organization, as opposed  
2 to that you try and sort of somehow control, through either  
3 disclosure or some other means, conflict of interest. And  
4 when you have a full-time board then you can have very  
5 strong conflict of interest rules. But that would be, I  
6 think, something that would help insulate the entity from  
7 some of the criticisms that might come up.

8           When you have a board that is part-time,  
9 regardless of what you do people point and say that there is  
10 potential here. And we need to be concerned about it.

11           DR. REISCHAUER: I think this is good and I'm a  
12 big advocate of going in this direction. It strikes me  
13 that, as is always the case, everything is connected to  
14 everything else. And what the entity looks like will depend  
15 very much on where the funding comes from. And both what it  
16 looks like and where the funding comes from will have  
17 implications for what kind of governance structure there  
18 should be.

19           It strikes me that the important role of the board  
20 is to help insulate the entity from political pressure. So  
21 one has to think about how one builds that in. Option one,  
22 where we have a whole bunch of mini boards, which serve very

1 important functions, I think can't serve that role really at  
2 all.

3 Bill was talking about, I think, a small but full-  
4 time group of individuals and I think that's right. And my  
5 view would be that you also have these functional boards and  
6 the members of the trustees, in a sense, would serve as  
7 chairs of these various boards or serve on them, as well.

8 But the role is really to have a lot of visibility  
9 and an ability to speak out for the long run interests of  
10 the country against the short run concerns of the political  
11 system and that that should be part of our thinking here as  
12 we go forward.

13 There's also the whole issue of how is the  
14 director chosen and removed, which is usually one function  
15 of a board like this, that you might not want to -- you  
16 might want to structure a board that can do that clearly.

17 MR. HACKBARTH: A question for Bob and Bill. If  
18 you have a board made up of a full-time people, how is that  
19 different from a multi-headed executive? These are  
20 employees.

21 Now I guess the board could be a subordinate to  
22 the director, but that seems like an odd model. If the

1 board is superior to the executive, you've got employed  
2 people of some number -- multiple employed people leading  
3 your organization. Help me think through that.

4 DR. SCANLON: We have talked before about the  
5 Federal Reserve model. And the Federal Reserve is governed  
6 by a board of governors, seven of them. There is a  
7 designated chairman. But the chairman only has one vote, in  
8 terms of making a decision.

9 The issue here is -- it's not just a question of  
10 the day-to-day administration of this agency or this entity.  
11 But it's this question of okay, now we've got this evidence.  
12 What are we going to say about it? What's our pronouncement  
13 in terms of the conclusion?

14 At this point in time we have something like the  
15 FDA is in that position and we have one decision-maker.

16 But this, in some ways, is different, and maybe  
17 even higher stakes. And the question is whether we  
18 shouldn't have various interests represented in terms of  
19 that decision. So the board would do it and the board would  
20 vote on things. So that's the kind of model.

21 And then the issue in that context, if it's a  
22 full-time board, who is the management of the organization,



1 sort of the operating officer? That may be somebody outside  
2 the board but it's just an employee of the board and not  
3 someone -- they're critical but their selection is a  
4 function of the board's responsibility.

5 DR. REISCHAUER: The Fed is a good model because  
6 the members of the governing board do also then serve as  
7 chairs of various functional committees that operate our  
8 monetary system and our financial institution oversight. So  
9 they're kept busy. And the chairman is, in a sense, a CEO  
10 of the entire system.

11 So what you might have is the director, in this  
12 diagram, being the chairman of the board.

13 MR. HACKBARTH: That's what I was getting at. And  
14 then also, under the Fed model, the chairman is not chosen  
15 by the board, as is the case in corporate. But they're a  
16 separate appointment.

17 DR. REISCHAUER: By Congress or by the president.

18 MR. BERTKO: A couple of things. First, just to  
19 reaffirm my strongest possible support for going forward on  
20 this. And along the lines of the last discussion, as soon  
21 as possible.

22 Secondly, I'm going to be on Jay's train here and

1 say the people benefitting from this, public payers and  
2 private payers, ought to have a mandatory contribution.  
3 It's got to extend it to everybody, including the big self-  
4 insured employers. They're going to get as much benefit, if  
5 not directly, at least from the spillover effect.

6           Thirdly, let's assume that the top-down approach  
7 is about right and there's about \$1 billion that would be  
8 spent on this. I have subscribed, in the past, to something  
9 called a pipeline analysis which showed, at least for 2008  
10 in Medicare, that the amount of stuff in the pipeline could  
11 be as much as 4 percent. I support the appropriate use of  
12 care.

13           But if we can restrain that to the historic 2 or  
14 2.5 percent, that is over an \$8 billion saving. So you  
15 would have an eight-to-one payoff. And if we can get it  
16 down below that, that's even better.

17           But the dollars here are really big. They swamp  
18 almost anything else we've talked about today. So this is  
19 incredibly important.

20           DR. MILSTEIN: My question pertains less to  
21 governance and more to content. That is, what would be the  
22 scope of the comparative effectiveness research we envision

1 such a creation sponsoring.

2           The distinction I wanted to make and then ask for  
3 your input on this, in terms of what is contemplated, is  
4 there's basically two opportunities to improve effectiveness  
5 of American health care. One is choosing the treatment  
6 option that's likely to generate the most clinical benefit.  
7 The second is, having chosen the treatment option, selecting  
8 the treatment administration approach that is more  
9 effective.

10           An example of the latter might be whether or not,  
11 on average, if someone is going to have -- they are clearly  
12 a candidate for surgery and they are going to benefit from  
13 it and it will be effective for them to have the surgery.  
14 But it has to do with issues like how many minutes before  
15 the patient is opened up do they get their antibiotic?  
16 That's an aspect of treatment administration and not  
17 treatment selection.

18           So my belief is the current weight of health  
19 services research would suggest that there is at least as  
20 much opportunity to improve the effectiveness of American  
21 care by building a body of knowledge as not only with  
22 respect to what treatments are more effective and under what

1 circumstances, but which treatment administration  
2 approaches.

3 And so I don't know whether that was contemplated  
4 in the scope of what we had in mind. But if it's not, I  
5 want to ask that it be considered.

6 MR. EBELER: Building a little bit on Bob's  
7 comment, that everything relates to everything, I would  
8 endorse the idea of mandatory funding across a variety of  
9 payers. We should all recognize, having done that, the idea  
10 of insulation from political interference is a tough one  
11 because the interference -- the mandatory funding comes from  
12 one and only one place, and that's the United States  
13 Congress. You can insulate governance all we want, but any  
14 time they want they can simply reach in and revise that  
15 funding base. So that's something that needs attention  
16 here.

17 Functionally this entity, it sounds to me as  
18 though it either has to contract with or build on its own a  
19 research prioritization selection management infrastructure  
20 comparable to that which AHRQ has or NIH has. Are we  
21 talking about creating a new thing that does that? Or are  
22 we talking about setting priorities within which existing

1 infrastructures do that? I assume it's the latter.

2 MS. RAY: Part of the answer to that is that, in  
3 general, this entity would work with other existing agencies  
4 in determining the research agenda. But I think, in  
5 particular, with the different structure options that we  
6 gave as examples, in the one -- sorry.

7 For example, when you look at option two, where  
8 it's just an advisory board and the director and the staff,  
9 in this case, clearly the director and the staff with the  
10 advisory board would have more -- what am I trying to say? -  
11 - would have a greater role in putting together the research  
12 agenda, presenting it to the board, and then having the  
13 board go through the options.

14 In option three, on the other hand, you would be  
15 having formal advice, direct advice, from the different  
16 committees. And one could be a research priority committee.

17 And going back to something the Commission said  
18 last year, the intent here is not to build a big  
19 bureaucracy, not to reinvent the wheel. We have stressed  
20 all along that the entity should be working with existing  
21 organizations, both public and private, that conduct  
22 comparative effectiveness research, including AHRQ,

1 including NIH.

2 MR. HACKBARTH: Just a word on this. The model  
3 that we discussed in the June 2007 report really emphasized  
4 that this entity would perhaps do some intramural research.  
5 But a big piece of what it does would be done through  
6 extramural work, taking advantage of existing government  
7 entities that have developed capabilities, as in the case of  
8 AHRQ and its research centers, or private entities engaged  
9 in the same activity.

10 Dave cautioned us against an approach that the  
11 first step was to build a big new Federal building and hire  
12 lots of employees, which would get us off on the wrong foot  
13 in a lot of different ways. And so we want to take  
14 advantage of existing capabilities wherever they might be  
15 found.

16 I just want to underline also, Jack, your initial  
17 point about independence. I think you're absolutely right.  
18 If there's a lot of Federal money involved, Congress can --  
19 under our Constitution --- always undo that. One man's  
20 meddling is another man's responsible oversight of Federal  
21 tax dollars.

22 I think one of the most important ways to sort of

1 draw the distinction between where we want to be and where  
2 we don't want to be is in terms of the independent  
3 credibility of the board members. I think that's what Bob  
4 was getting at. If you've got some really strong people  
5 with strong reputations, it becomes more difficult -- albeit  
6 not impossible -- for Congress to act in retribution because  
7 some particular interest has been offended. But it's never  
8 100 percent insulation. And nobody should kid themselves  
9 about that.

10 DR. DEAN: I would just like to add my voice to  
11 the idea that this is terribly important. And as a  
12 practitioner, we look for this data almost on a day-to-day  
13 basis and usually it isn't there. So in terms of deciding  
14 rational approaches, it really is a desperate need. And if  
15 it's going to be done properly, it obviously has to be  
16 independent. And I'll certainly leave the comments about  
17 how you accomplish that to people that know more about  
18 governance than I do. But it's a terribly important  
19 undertaking.

20 I guess I would see this entity as more of sort of  
21 a clearinghouse function. There are lots of sources of  
22 existing data and there are some gaps in that data. And if

1 they could both -- if I had one place to go to when I needed  
2 to know is this drug better than this drug -- because right  
3 now it's a pretty laborious thing to track down that data or  
4 even to find out if it even exists -- and it frequently  
5 doesn't even exist. So my paranoid state says the  
6 pharmaceutical industry probably has all of the data but  
7 they're not real anxious to share it with me. I don't know  
8 if that's true or not but I'm suspicious.

9           Anyway, it would really simplify the clinicians'  
10 day to day work if there was a single source where we could  
11 go to to look at this.

12           And just as a thought, one small step that  
13 probably is not really related to this, it has always struck  
14 me that if the FDA was required to not only require  
15 performance measures of new drugs against placebo but also  
16 against existing drugs in the class, it would help us  
17 immensely. Because we hear lots of presentations say that  
18 this drug works better than placebo. Well, I really don't  
19 care. It damn well better work better than placebo or I  
20 don't even want to hear it. But in fact, that's what we get  
21 presented with.

22           And then we get a complicated pathophysiological



1 pharmacologic assessment of why this one goes through a  
2 different pathway or does something else and that's why it's  
3 preferable. But in terms of outcome data, in comparison to  
4 what we already have available, we really get that data.

5           And if we did have that data, that shifts the  
6 argument so that price then really becomes an issue. And  
7 you shift back to what they should be a market solution to  
8 some of these issues, that if it really isn't any better in  
9 its performance, then does it cost less? Of course, most  
10 new drugs certainly don't cost less. But if they're going  
11 to put a drug on the market, it either ought to have a  
12 performance advantage or it ought to be cheaper, one or the  
13 other. And we just don't have that data.

14           MS. DePARLE: This is a relatively small point in  
15 the paper but I just wanted to quickly note. You make the  
16 point that Medicare hasn't used clinical information very  
17 much, and certainly not this kind of information, and that  
18 under the Medicare law Medicare pays for things that are  
19 reasonable and necessary for the diagnosis or treatment of a  
20 disease or a malformed body member -- I think is the exact  
21 language.

22           It might be useful to point out, and we've talked

1 about this here over the years, that I don't believe there's  
2 any prohibition -- you kind of suggest there may -- there's  
3 no prohibition against Medicare using such information. The  
4 problem is that you need to define what is reasonable and  
5 necessary. And that hasn't really been done, although it's  
6 been attempted a few times.

7           It would be helpful, though I don't know if it's  
8 politically feasible or possible, if Congress does decide to  
9 create such an entity, that they're explicit about this and  
10 say -- yes.

11           Now that adds political complexity to this whole  
12 thing, but let's just put it out on the table, that's what  
13 we're talking about here. If we want to have the impact on  
14 this -- any impact on it, even at the margins, like John was  
15 talking about for the Medicare program, that's where it will  
16 have to go. So we might as well be explicit about that  
17 being an issue and it needs to be dealt with.

18           MR. HACKBARTH: I'm thinking back to our previous  
19 conversations about this. I think everybody agrees that  
20 ultimately that needs to be part of the destination. I do  
21 remember, though, that David Eddy, for example, when he met  
22 with us now what, two years ago or whatever it was, he said

1 those coverage decisions ultimately need to be made. Cost-  
2 effective needs to be part of it. But there are, somewhat  
3 easier, targets where this information can be used without  
4 starting first with the coverage in terms of how you price  
5 things and so on.

6 MS. DePARLE: And it doesn't have to be coverage.

7 MR. HACKBARTH: P4P priorities or a lot of  
8 different places this information could be used, in addition  
9 to coverage decisions.

10 MS. DePARLE: Right, and I should have been clear.  
11 I wasn't limiting it to coverage, because at least one of  
12 the efforts wasn't to limit it to coverage. It was to say  
13 it will be covered, it just would be influential in  
14 determining the pricing.

15 DR. REISCHAUER: What Tom is pointing out is it  
16 should have a big impact on professionals and what they do.

17 MR. HACKBARTH: Dave, you've got the last word.

18 MR. DURENBERGER: Thank you. And I contemplate  
19 not saying anything because somebody might remember what I  
20 said about tall buildings and new buildings. And sure  
21 enough somebody did.

22 I guess the two small points I wanted to make, I

1 told Nancy earlier, I just think this is a fantastic  
2 compilation of everything this national government has ever  
3 tried to do to do something right. It's just incredible.  
4 You listed this all out, and eventually somebody gets to one  
5 of these things as a solution to a problem, and many of them  
6 work fairly effectively, as she pointed out.

7 I wanted to add to the Medicare's national  
8 coverage process also the fact that they've long had a local  
9 coverage process. And in some cases, it's worked well, in  
10 some places it's work less well. CMS could probably get it  
11 to work a lot better and it certainly ought to have  
12 effectiveness added to it.

13 Also, the observation that before I ever went to  
14 the Senate in 1978, I did some research on another  
15 organization was a cost-containment medical technology which  
16 isn't in here. I don't know that it exists.

17 But I know that NCHTC, that commission or whatever  
18 it was called which had a very short life in 1978, that  
19 existed. But I thought there was something even prior to  
20 that, as well.

21 But the point I wanted to make is not that we  
22 shouldn't deal with this, I guess, but to try to remind us

1 that we live in a -- and all this talk about NICE and all  
2 the rest of this stuff is really nice. But we live in a  
3 very different kind of a health care system.

4 Even the Congress of the United States has 44  
5 committees or subcommittees that have something to do with  
6 health, health policy, health financing, whatever it is.

7 So we just live in an environment in which the  
8 idea that all the really important and costly decisions are  
9 going to be delegated to some ethereal bunch of experts  
10 sitting on a board, in a new building or not, is going to be  
11 and always has been a huge challenge. I served on OTA, I  
12 went through that experience. And then after I left the  
13 Senate, trying to help prevent it from happening and working  
14 on other things like that.

15 So I guess my point was that I'm hopeful, and I  
16 think Arnie's comment reminded me of this a little bit, that  
17 if we would really -- and this is Atul Gawande in me. If we  
18 would really focus on building a capacity for effectiveness  
19 science in this country, particular as applied to health  
20 medicine and so forth. If that were housed in NIH or  
21 wherever our institutes of health research are, if we would  
22 focus on that so that we all understood what it was and what

1 its many applications might be -- one of them being what  
2 you're talking about here. But another could be that  
3 intensive care checklist kind of approach or the process  
4 engineering or whatever Arnie calls it.

5 But it's an incredible void that exists in  
6 nationally sponsored support for private entities like that  
7 doctorate at Hopkins and so forth.

8 And I would just hope that however we go through  
9 this process that we take in advantage of the opportunity to  
10 stress the importance of some kind of an investment in the  
11 basic science and that sort of thing, in addition to how do  
12 we go about the decision-making process.

13 MR. HACKBARTH: To me that's what this is about.  
14 If we go back to our June 2007 report, this is an  
15 information development organization. It isn't a decision-  
16 maker about coverage for Medicare or for anybody else. It's  
17 an information entity. So that all of the participants in  
18 the system, whether it's the 40 Congressional committees or  
19 Tom Dean practicing medicine, or a patient, has the best  
20 information that we can muster to guide their decisions.

21 I think that is our best hope for getting the  
22 entity and preserving an entity's independence in support,

1 it's producing good information. Good information won't  
2 magically make the controversy disappear. Hard decisions,  
3 controversial decisions will need to be made by public and  
4 private payers. But hopefully, they will at least be better  
5 informed.

6 So I think it is very important to say this is an  
7 information entity. We are trying to advance the state of  
8 knowledge for the benefit of everybody who participates in  
9 the system.

10 MR. DURENBERGER: Can I just add this? In the  
11 context of -- and you know how one sort of fortuitous event  
12 or whatever it is leads to assumptions. But Tom Daschle, my  
13 former colleague, has written this book on health care and  
14 so forth. And he comes to the conclusion that it's  
15 impossible to get the political process to make decisions,  
16 so we ought to have a Federal Reserve-like board.

17 I just read Scott Gottlieb's little piece  
18 critiquing it yesterday in the Wall Street Journal. And  
19 it's almost predictive of the arguments that will take place.

20 But Tom has scoped it for the larger system and  
21 we're a much smaller part of it. But I think it's going to  
22 fall into that same kind of assumptions, if you elect a

1 Democratic president of the United States, this is likely  
2 what's going to happen. We're going to turn this big  
3 multibillion-dollar industry over to some Government agency.

4 I'm exaggerating to make a point.

5 MR. HACKBARTH: That's an important point, Dave,  
6 that when we write this chapter we may want to be very clear  
7 about. There are people who want to conflate very different  
8 ideas. There's some people who talk about the Federal  
9 Reserve model as an entity to handle all sorts of  
10 controversial decisions that they feel are too political  
11 right now. And that has merits and demerits. That's a  
12 distinctly different idea from what we're talking about  
13 here. And we ought to take care in this chapter, I think  
14 Nancy, to explain that this is a separate idea. This is  
15 about producing information. This is not about creating an  
16 alternative decision-making mechanism to bypass the Congress  
17 or anybody else.

18 Okay, thank you for the good work on this, Nancy.

19 We will have now a brief public comment period.  
20 For those of you who have not participated in our comment  
21 periods before, would you please keep your comments to no  
22 more than a minute or two, begin by identifying yourself and



1 your organization. If you see this red light come back on,  
2 it's because you're nearing the end of your comment.

3 MR. HOGAN: Thank you.

4 I'm Mike Hogan. I am with the Society of Thoracic  
5 Surgeons. I hate to be the guy standing between you and  
6 lunch, so I will be brief.

7 But we have good experience with both bundling and  
8 comparative effectiveness that I want to share with you  
9 briefly, and hopefully it will help inform your  
10 consideration.

11 With the experience from the HCFA bypass demo in  
12 the late 1980s, early 1990s I should say we are very  
13 supportive of bundling and we think that there are some good  
14 economies.

15 In the interest of sunshine, in bypass surgery the  
16 surgeon gets about \$2,000 for a 90-day global period. The  
17 hospital gets almost \$30,000, in terms of Medicare payment.  
18 I'm not saying that that is wrong or making any judgment  
19 there, but surgeon's payments are currently bundled and the  
20 growth in that area has been very low. So whatever happens  
21 in those 90 days, we're paid one amount.

22 But we have evolved since then. And now we can

1 measure the outcomes of every patient that gets cardiac  
2 surgery, that gets bypass surgery. And we know the  
3 complications that arise. We measure the mortality as well  
4 as renal failure, atrial fibrillation, stroke, all the  
5 complications. And that's where the cost is driven.

6           So I would express a brief concern that if you set  
7 your bundling payment policy based on resource utilization,  
8 you may put the outcomes at risk. Because what we've found,  
9 we matched quality with Medicare payment cost data. And we  
10 found that if you spend more on ICU time and blood products,  
11 you can reduce the reoperation and stroke, which costs  
12 \$20,000 and \$30,000 respectively. If you do your drug  
13 spending a little bit higher, you can reduce atrial  
14 fibrillation, which saves \$3,000 per incident.

15           So our perspective is we can measure outcomes in a  
16 risk-adjusted sophisticated way. Why don't we set the  
17 payment policy to reward the outcomes? And that will drive  
18 the utilization as well as the organizational structure in a  
19 way that's most appropriate for patients.

20           Real quickly, on comparative effectiveness, AHRQ  
21 just came out with a comparative effectiveness study of  
22 bypass surgery versus stents. And you may not have heard of

1 it, which I think is a wonderful thing. Because it's a very  
2 controversial area. It's a huge spending area. It's the  
3 number one killer of Americans, is coronary artery disease.

4 And AHRQ did a really good, clinically  
5 sophisticated slice of which patients with which kind of  
6 severity of disease is which procedure better for. So they  
7 said for these, bypass is better. For these, stents are  
8 better. For these, medical management is better.

9 What has happened since then is the College of  
10 Cardiology and us have come together and developed clinical  
11 appropriateness guidelines that are about to be published.  
12 So the profession is taking the responsibility from that study  
13 and disseminating appropriateness criteria to the  
14 professional community.

15 We think that on comparative effectiveness our  
16 position is sort of a takeoff on the old saw: if it's fixed,  
17 don't break it.

18 That's all. Thank you.

19 MR. HACKBARTH: Okay, we will reconvene at 1:15.

20 Thanks.

21 [Whereupon, at 12:23 p.m., the meeting was  
22 recessed, to reconvene at 1:15 p.m. the same day.]

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AFTERNOON SESSION

[1:25 p.m.]

MR. HACKBARTH: First up this afternoon is a session on reporting of physician relationships with drug and device manufacturers, hospitals, ASCs, and whoever else.

MR. WINTER: That is the list.

MR. HACKBARTH: Laundromats, car washes.

MR. WINTER: Baseball teams.

Good afternoon. We will be discussing the issue, as Glenn just said, of physicians' financial relationships with drug and device manufacturers, hospitals, and ASCs, and whether public reporting of those relationships should be required.

Why should the Commission be concerned about this topic? Medicare has spent a lot of money, \$44 billion, on Part D in 2006 and \$10 billion on Part B drugs in 2005. Medicare also spends a significant amount on implantable devices such as artificial knees and hips, spinal implants and stents, although it's difficult to estimate a precise number because the cost of devices is usually included in the payment rate for the associated surgery.

There's also been growth of physician investment in ASCs and specialty hospitals.

1           There are extensive financial relationships  
2 between physicians and manufacturers. A survey of  
3 physicians conducted in 2003 and 2004 found that most  
4 physicians have some type of interaction with drug  
5 manufacturers. Over 75 percent received food or free  
6 samples in the last year, and 28 percent received payments  
7 for consulting, giving lectures, or enrolling patients in  
8 clinical trials. Physicians also met frequently with sales  
9 representatives. For example, cardiologists had nine  
10 meetings per month with sales reps, on average.

11           In addition, legal cases and media reports provide  
12 evidence of financial relationships between device  
13 manufacturers and physicians. Device manufacturers may pay  
14 physicians consulting fees and royalties when they help  
15 develop and test new products, pay them to conduct post-  
16 marketing research, and offer them investment interests in  
17 their companies.

18           A Federal investigation into relationships between  
19 four orthopedic implant companies and physicians found that  
20 these companies paid physician consultants over \$800 million  
21 between 2002 through 2006. According to investigators, many  
22 of these payments were legitimate but some were actually

1 kickbacks designed to reward physicians for using the  
2 company's products.

3 Relationships between physicians and manufacturers  
4 have both benefits and risks. Physicians play an important  
5 role in developing new drugs and devices by running clinical  
6 trials, providing expert advice, and inventing and testing  
7 new products.

8 In addition, marketing efforts directed at  
9 physicians may lead to greater use of beneficial treatments.  
10 But physician industry ties may also undermine physicians'  
11 independence and objectivity. According to studies in this  
12 area, industry interactions are associated with rapid  
13 prescribing of newer, more expensive drugs; lower use of  
14 generic; and requests to add drugs to hospital formularies.  
15 Most of the drugs that were requested to be added had little  
16 or not therapeutic advantage over existing drugs.

17 The private sector and government have made many  
18 efforts in recent years to curb inappropriate relationships  
19 between physicians and manufacturers. The Federal  
20 government has brought several legal cases against companies  
21 under the fraud and abuse laws which have led to large  
22 settlements and compliance agreements.

1           Driven in part by this legal scrutiny, the  
2 industry developed voluntary guidelines for relationships  
3 with physicians in 2002 and 2003. These codes try to  
4 distinguish between arrangements that are intended to  
5 benefit patients and clinical practice and those that reward  
6 physicians for using a company's products. For example, the  
7 PhRMA and AdvaMed guidelines permit occasional gifts to  
8 physicians if the gifts are worth less than \$100 and  
9 primarily benefit patients. They also allow bona fide  
10 consulting arrangements with physicians. However, the codes  
11 discourage providing physicians with entertainment and  
12 tickets to sporting events.

13           Physician groups such as the AMA and the American  
14 College of Physicians, have also developed codes of ethics.  
15 According to the ACP guidelines, before physicians accept  
16 anything of value from a company, they should ask themselves  
17 what their patients and colleagues would think about this  
18 arrangement and how they would feel if the arrangement were  
19 disclosed.

20           In 2003, the OIG issued guidance to drug  
21 manufacturers to help them comply with the anti-kickback law  
22 which prohibits paying physicians to induce the use of an

1 item or service.

2           So are these guidelines adequate? There is some  
3 evidence that companies are now focusing much more on  
4 compliance, for example by shifting resources from gifts and  
5 entertainment to education. However, there is no mechanism  
6 to measure and enforce compliance. With the exception of  
7 some state laws, there is no requirement to report these  
8 relationships.

9           There is also evidence that some inappropriate  
10 practices may still occur. For example, the physicians  
11 survey I discussed earlier found that some physicians are  
12 still receiving tickets to cultural or sporting events. And  
13 the recent Federal investigation of orthopedic device  
14 companies alleged that some consulting deals were actually  
15 illegal kickbacks to physicians.

16           Finally, critics claim that the guidelines are too  
17 vague and not sufficiently stringent. For example, they  
18 permit modest gifts and meals, despite evidence from the  
19 literature that even small gifts may influence behavior by  
20 creating an expectation of reciprocity.

21           In response to these concerns, some organizations  
22 and states are adopting stricter policies to regulate these



1 relationships and there are several examples on this slide.  
2 Some academic medical centers, such as Stanford and UMass,  
3 prohibit their physicians from accepting drug samples and  
4 gifts of any size from companies and also impose  
5 restrictions on industry-sponsored research and education.

6           The Permanente Medical Group forbids physicians  
7 from accepting payments, gifts, or travel expenses from the  
8 industry to give talks or presentations and also prevents  
9 physicians who have financial ties with the company from  
10 making decisions involving that Company's products.

11           The state of Minnesota bans drug companies from  
12 giving meals and gifts to physicians that are worth more  
13 than \$50, but there are exceptions for honoraria, education,  
14 and consulting.

15           Finally, four states and D.C. require drug  
16 manufacturers to report payments to physicians, and 17 other  
17 states introduced similar bills in the last year.

18           We will now turn to Hannah for a discussion of  
19 these law.

20           MS. NEPRASH: As Ariel mentioned four states,  
21 Minnesota, Vermont, Maine, West Virginia, and the District  
22 of Columbia have laws that mandate the disclosure of

1 physicians' financial relationships with the pharmaceutical  
2 industry. This chart provides a comparison of the types of  
3 payments disclosed in these five statutes, but the writing  
4 is small so I'll highlight a few key points.

5 Vermont, Maine, and D.C. require disclosure of  
6 payments over \$25, while Minnesota and West Virginia require  
7 disclosure of payments exceeding \$100. All existing laws  
8 exempt pharmaceutical samples intended to be free for  
9 patients, and most laws exempt payments for research and  
10 medical conferences.

11 Vermont, Maine, West Virginia, and D.C. compile an  
12 annual report of payments in aggregate. However, Minnesota  
13 is the only state that makes detailed information about  
14 individual physicians available online but this information  
15 is not searchable. A recent Health Affairs article examines  
16 Minnesota and Vermont's payment disclosures and highlights  
17 additional data completeness and availability problems.  
18 These include vague definition of payment type and purpose  
19 that make it difficult to distinguish between payments for  
20 consulting, research or gifts.

21 Additionally, Vermont's statute allows  
22 manufacturers to broadly designate payments as trade

1 secrets. As a result of this designation, the Vermont  
2 Attorney General withholds all information relating to these  
3 payments. In fiscal year 2006, 72 percent of total payments  
4 in Vermont were designated trade secrets and withheld from  
5 public disclosure.

6 MR. WINTER: This brings us to the question of  
7 whether there should be a Federal law requiring  
8 manufacturers to report their relationships with physicians.  
9 As Hannah said, data collected under existing state laws are  
10 difficult access and the state laws do not apply to device  
11 companies. It's worth noting that two bills have been  
12 introduced in Congress to mandate public reporting by drug  
13 and device manufacturers.

14 In the next few slides we will explore how  
15 national data on physician-industry relationships could be  
16 helpful to payers and health plans, hospitals, the general  
17 public, and researchers.

18 Public information could be used by payers and  
19 health plans to examine physician practice patterns. For  
20 example, do financial relationships influence physicians'  
21 use of drugs and devices, as well as overall resource use  
22 for an episode of care? As one example, reporters analyzing

1 data from Minnesota found that psychiatrists who received  
2 more money from manufacturers of a new class of drugs,  
3 called atypical antipsychotics, prescribed them to children  
4 much more frequently and use of these drugs for children has  
5 been controversial.

6 Plans could also use this information to tier  
7 providers or make other network decisions.

8 Hospitals could use data on physician-industry  
9 relationships to check for potential conflicts of interest.  
10 Hospital formulary committees usually include physicians.  
11 Although these committees generally require that their  
12 members disclose their financial interests, a public  
13 database could be used to verify this information.

14 When physicians request that a drug be added to  
15 the hospital formulary, the hospital could identify whether  
16 they have relationships with the manufacturer of the  
17 product.

18 In addition, when a surgeon requests that the  
19 hospital purchase a specific implantable device, the  
20 hospital could check on whether the physician has a  
21 financial tie to the manufacturer.

22 The general public and researchers could use a

1 public database to examine whether manufacturers are  
2 complying with industry guidelines. For example, do  
3 companies only provide occasional gifts to physicians that  
4 are worth less than \$100? They could also evaluate whether  
5 physicians who develop clinical guidelines and publish  
6 journal articles have potential topics of interest.  
7 Guidelines and articles are very important because they  
8 influence the practice of medicine.

9           A study found that most physicians who wrote  
10 guidelines had relationships with drug companies whose  
11 products were considered by the guidelines but very few of  
12 those relationships were disclosed.

13           It's important to acknowledge concern about public  
14 reporting. First, it's unclear if the data would be useful  
15 to patients. Patients often lack the medical expertise to  
16 judge if a physicians' recommendation is appropriate. This  
17 information might be more useful to payers, plans, and  
18 researchers.

19           Second, transparency will not eliminate conflicts  
20 of interest. Some have argued that stricter limits on gifts  
21 and payments are necessary.

22           A third issue is that there would be a burden on

1 manufacturers report the information and on the government  
2 to administer the law and maintain the database. But it  
3 might actually be easier for companies to comply with a  
4 national uniform law rather than state laws with varying  
5 rules. It's important to note that under the existing state  
6 laws and the two bills in Congress, there would be no  
7 obligation for physicians to report information, only for  
8 manufacturers.

9           If a reporting law is desirable, then policymakers  
10 would need to consider several design and implementation  
11 issues. Should the requirement apply to both drug and  
12 device manufacturers? Although state laws exclude device  
13 companies, it might make sense for a national law to include  
14 them because they often have extensive relationship with  
15 physicians.

16           Which types of relationship should be reported?  
17 There is a continuum of potential relationships, ranging  
18 from physician ownership of a company all the way down to  
19 physicians getting pens, notepads, and free samples.

20           Where should the dollar threshold be set for  
21 payments that must be reported? State laws have thresholds  
22 ranging from \$25 to \$100.

1           Should each payment made to a physician be  
2 itemized separately? This would allow for analyses of the  
3 size and frequency of payments.

4           Should companies be allowed to withhold  
5 information as trade secrets? The experience in Vermont has  
6 shown that this exception can lead to significant under  
7 reporting.

8           How could the information be made easily  
9 accessible to the public? It would help a great deal to  
10 create an online, searchable database with standard payment  
11 categories.

12           And finally, which agency should collect the data  
13 and maintain the database?

14           Since we sent you our draft paper, the Senate  
15 Aging Committee held a hearing on relationships between  
16 device manufacturers and physicians. At that hearing, an  
17 OIG official expressed support for increased transparency of  
18 financial relationships. In addition, AdvaMed and three  
19 device manufacturers said they supported a public reporting  
20 law in concept, although they did flag specific issues they  
21 would like to see addressed.

22           Now, Jeff will discuss reporting of physician

1 relationships with hospitals and ASCs.

2 DR. STENSLAND: There may be a need for disclosure  
3 for more than just drug and device companies. As we've said  
4 in the past, there has been a rapid increase in physician  
5 investment in ASCs and specialty hospitals. We also hear  
6 anecdotes of increasing physician involvement in imaging  
7 joint ventures and lease agreements.

8 Currently, hospitals and ASCs are required to  
9 comply with an assortment of disclosures, but the current  
10 disclosure policies do not always disclose information to  
11 the right people at the right time. For example, CMS,  
12 private payers, and researchers often lack information on  
13 physician investment in ASCs or hospitals. They may want  
14 this information to test the relationship between ownership  
15 and utilization and possibly use this information when  
16 setting up provider networks.

17 While hospitals must disclose ownership  
18 information to patients, and CMS has proposed requiring ASCs  
19 also do the same, these disclosures are not available to  
20 patients prior to selecting their physician. Hospitals do  
21 disclose 5 percent owners to CMS when the hospital enrolls  
22 to be a Medicare provider but this information is not



1 available to patients or plans. In addition, CMS is not  
2 aware of smaller ownership stakes.

3 Finally, CMS has also proposed a detailed survey  
4 of 500 hospitals, but this information may be confidential  
5 and not available to patients or health plans. So as you  
6 can see, providers are required to give an assortment of  
7 disclosures but the information is incomplete and may not  
8 get to the appropriate people at the right time.

9 An alternative to current assortment of disclosure  
10 policies is to have a single online searchable database  
11 where hospitals and ASCs would annually report physician  
12 ownership information. Hospitals would also report joint  
13 venture arrangements and lease arrangements with physicians.

14 Now we would like to hear your thoughts on whether  
15 the manufacturers of devices, drug companies, hospitals, and  
16 ASCs should be required to report their financial  
17 relationships with physicians.

18 MS. BEHROOZI: This is such an interesting topic.  
19 Thanks. Great work.

20 Another cliché, I think, that's particularly apt  
21 here is that sunshine is the best disinfectant. So how much  
22 of the conflicts of interest will be mitigated by exposing

1 them to the sunlight isn't the issue. It's why not expose  
2 the relationships to the sunlight? If the providers say  
3 we're not influenced by them, then they shouldn't have a  
4 problem with it. And if the device manufacturers and the  
5 pharmaceutical companies say we don't intend to influence in  
6 an inappropriate way, then they shouldn't have a problem  
7 with it.

8           In my role as a payer entity, we get to -- no  
9 offense to my colleagues here -- get to say we're not an  
10 insurance company because were a not-for-profit Taft-  
11 Hartley, all the money has to go for benefits, it doesn't go  
12 to shareholders, that kind of thing.

13           But still, we face resistance by our  
14 beneficiaries, by our participants, to trying to manage,  
15 trying to divert people away from inappropriate, excessive  
16 care if their providers are saying that this is what they  
17 need. They say I don't want an insurance company telling me  
18 what the care is I should be getting. I want my doctor to  
19 tell me.

20           Well, they wouldn't, it seems to me, want a drug  
21 company telling them what drugs they should be taking. If  
22 they don't know that their provider may be sort of acting as

1 an agent -- and this isn't to cast aspersions that just  
2 because you receive a pocket protector or a desk pad or  
3 something like that from a drug company that that makes you  
4 an agent of a drug company. But let the beneficiaries, let  
5 the patients know what the various interests are. They know  
6 who we are. They know what we are. They know what our  
7 interests are.

8 The trust of the providers when there is some  
9 evidence, and the evidence obviously is limited by the  
10 ability to gather the evidence and make the analysis of  
11 whether conflicts of interest actually do play out in  
12 inappropriate or excessive prescribing patterns or treatment  
13 patterns. Let the evidence be out there. Let it be  
14 analyzed. Let's see. Let's see.

15 DR. KANE: In theory, I would be very supportive  
16 of this, except that I know the let's see part would never  
17 really happen at the level that we wish it would. Even  
18 hospital community benefit reporting, people don't use it.  
19 A small group of people figure out how to use it and use it  
20 effectively, and that's a lot more straightforward than  
21 this.

22 So I'm a little worried that you've got this huge

1 database that people really don't know how to use very  
2 effectively.

3 I guess I'm also concerned, having seen some of  
4 these in action, I work with an educational institution that  
5 occasionally sponsors educational activities by private  
6 interests. And in one of them, I actually how saw how they  
7 measured whether it was worth continuing. And it turned out  
8 it was because their sponsorship of our educational activity  
9 led to a measurable increase in their drugs being on the  
10 participants' formulary.

11 So even educational activities, I think, end up  
12 influencing behavior. So for me it's kind of hard -- it's a  
13 terrible problem. It's endemic. It's pervasive. There's  
14 many ways that the industry reaches into physician behavior  
15 -- not just physicians, but I think hospitals, too.

16 So I guess I wonder if it's really a good thing to  
17 put resources into trying to catch up to them and disclose,  
18 as opposed to resources that look at the outcomes of the  
19 clinical practices and really try to figure out what the  
20 right level is and measure publicly.

21 What you're really worried about is that the  
22 providers, physicians, are doing the wrong thing for

1 patients regardless of the reason and trying to catch up to  
2 the root cause might just be too much effort and not enough  
3 output, compared to putting the resources into measuring  
4 performance and saying here's what you should be doing and  
5 let's put our resources to that instead.

6           It's not that I don't think it's a problem. It's  
7 just that I don't know that we can catch up to it this way.

8           DR. CROSSON: First of all, I would just like to  
9 make one clarification. In fact, the Permanente Medical  
10 Group has a policy which does not allow physicians to accept  
11 any gifts or payments from pharmaceutical or device  
12 manufacturers for any purpose, including the ones that you  
13 listed.

14           I think the relationship between drug and device  
15 manufacturers and the physician community has been  
16 problematic for a long time. I think we talked earlier,  
17 when we were discussing comparative effectiveness research,  
18 about the fact that Tom, on occasion, is not able to find  
19 certain studies which would indicate the superiority of one  
20 drug versus another.

21           I think the reason for that is that industry has a  
22 significant relationship now, has had a growing relationship

1 over 20 years, with the research community, with the medical  
2 research community. That impacts, for starters, what drugs  
3 are going to be studied and what comparisons are going to be  
4 studied and what gets published. And I think that has  
5 become quite manifest.

6 And that has a significant impact throughout the  
7 health care system and it has an impact, I think, both on  
8 quality in terms of -- on occasion -- inappropriate use of  
9 pharmaceuticals, and it has an impact on cost structure.

10 I don't particularly understand any good reason  
11 for providing gifts from pharmaceutical manufacturers or  
12 device manufacturers to physicians or anybody else engaged  
13 in health care. There doesn't appear to be any useful  
14 social or other purpose to that.

15 Now it isn't to say that if the manufacturers need  
16 physicians, as they do, to provide expertise about what  
17 clinical problems need to be solved or to help evaluate  
18 devices in clinical settings and to create strictly business  
19 relationships that that should be impeded. It should not  
20 be. I think it's useful to innovation.

21 But there needs to be a way to draw a line between  
22 that and what is fundamentally the provision of dollars to

1 influence providing one drug or using one device or the  
2 other.

3 I'm torn about whether the reporting is going to  
4 have a significant influence over that. I think it would,  
5 in some cases. I think it would give some individual second  
6 thoughts. It's the New York Times test that I think all of  
7 us should use in our life broadly, what would it look like  
8 if this was on the front page of the New York Times? And I  
9 think some individuals are sensitive to that internalization  
10 of ethical values and some are not.

11 To me it would depend upon, I think, the  
12 complexity and difficulty of doing it versus the likely  
13 impact. I think in the end -- and I like to return to this  
14 theme whenever I can -- I think in the end that if we can  
15 move towards a health care system which is more organized  
16 into integrated delivery systems who can actually -- as many  
17 of the universities have done, as we have done -- actually  
18 begin to set internal guidelines, that a lot of this will  
19 ultimately disappear. I think it's going to be difficult to  
20 consider enforcing this in a disaggregated health care  
21 system like we have at the moment.

22 DR. CASTELLANOS: This is a subject that I deal

1 with most every day. I can tell you that the scientific  
2 benefit that I get from a drug salesman coming into my  
3 office is minimal to none. It's interruptive to the patient  
4 care. It's disruptive. And I would love to be able to make  
5 a policy to say we're not going to see anymore drug  
6 salesman. Because it really isn't worth it. I think Tom  
7 probably will agree with me on that, too.

8           The problem is it's a culture. And I don't know  
9 how to change that. But we talked a little bit about  
10 culture this morning. We talked about appropriateness. We  
11 talked about changing of a culture. We talked about  
12 changing of ethics and responsibility. I think this goes  
13 along right down the line.

14           I agree with what Jay said. I don't see any  
15 benefit. I do have a pen here from the Ronald Reagan  
16 building but I don't have my Viagra hat or whatever else you  
17 call.

18           The concern I have is the reporting, and I'm glad  
19 it's not going to be the physician that's responsible to  
20 report what gifts he or she gets. But this may be somewhat  
21 of a burdensome problem to hospitals and ASCs. I own an ASC  
22 and I'm not ashamed of that. I think we provide good care.



1 But again, I always tell my patient I have ownership in  
2 that.

3 I think the patient comes in because one, they  
4 trust me to begin with. And they trust that I'm going to be  
5 doing the best thing. I've never had a patient say I don't  
6 want to go to your center, I want to go here. I'm not sure  
7 that's going to make a big difference but I think ethically  
8 it's important that we continue to report that.

9 But the burden to the hospital or to the ASC, if  
10 it can be done simply or with no significant impact as far  
11 as paperwork goes, I would agree with it.

12 When I received this material, I did show this to  
13 my local hospital, specifically the disclosure of the  
14 financial relationship report, or DFRR. And the Pavlovian  
15 response I get was impressive. I mean, they just shook  
16 their head and went like this and said it's not going to be  
17 cost-effective. It takes too much time and burden. So I  
18 think if you're going to do any kind of reporting it needs  
19 to be done on a simple, easy method.

20 There's one other thing, and I know it's not part  
21 of this, but there was an article in USA Today yesterday  
22 talking about direct consumer advertising. There's an

1 article that says one-third of the Americans who ask their  
2 doctor for an advertised medicine, of those one-third, 82  
3 percent who ask their physicians recommend a prescription.  
4 That's a pretty sad statistic.

5 I would love to expand this advertising or this  
6 financial relationship with really stopping the direct  
7 communication to the patient. It's disruptive to my  
8 practice. I don't not how many little old ladies ask me for  
9 Viagra, but I'm tired of it. It really am.

10 [Laughter.]

11 DR. CASTELLANOS: It takes an awful lot of time.  
12 It takes an awful lot of effort on my part. So it's not  
13 just this financial relationship, but I think it's  
14 advertising in general.

15 Thank you.

16 MR. EBELER: I'd weigh in, and I think Mitra  
17 started the comment, on the general side of sunshine here.  
18 I think this is something that is undermining trust in the  
19 health care system. I'm very impressed that some of the  
20 physician organizations have stepped up with guidelines.  
21 And you want to sort of support those with the kind of  
22 disclosure that would be helpful here. It just strikes me

1 as essential.

2           So my answer to the questions would be yes. It  
3 seems the next steps is sort of beginning to try to define  
4 what are the thresholds and how would make that happen in a  
5 way that's consistent with the -- again -- the professional  
6 standards.

7           But this is something that I think really does  
8 need to be on the table. At a minimum, that subsequently  
9 allows people to investigate it and determine whether all of  
10 this is the right way to go.

11           The one cultural question I would ask is would we  
12 include some of the activities with teaching institutions,  
13 medical schools, and residencies? Because as I understand  
14 it from colleagues, that is where the negative acculturation  
15 begins. It that included in this reporting, type of  
16 reporting requirement?

17           DR. CASTELLANOS: I can answer a question. I know  
18 the American Association of Medical Students have a blanket  
19 policy that they have no communication with the drug  
20 companies.

21           DR. STENSLAND: You could just have it include  
22 students and residents. That's certainly an option.

1           MR. WINTER: The state laws, I believe, the ones  
2 I've looked at, they refer to gifts or transfers of value to  
3 health care providers. So that's pretty broad. That could  
4 include pharmacists, it include nurse practitioners, it  
5 could include residents.

6           In terms of whether it would apply to payments to  
7 an entity, so if it is a research grant to Stanford or  
8 University of Pennsylvania, I'm not sure how the state laws  
9 deal with that.

10           We'll take a look at what the bills introduced in  
11 Congress say about that.

12           DR. DEAN: I guess my bias, I find this a  
13 troubling issue because I really see my profession as we  
14 should be advocates for patients. And we can't be if we  
15 have these other conflictual kinds of relationships. And  
16 yet we know that some of those are legitimate and certainly  
17 some of them are not.

18           So I think the first step, I totally support the  
19 idea of reporting. I understand it's subject to  
20 misinterpretation and all of that sort of stuff. But I  
21 still think it's the first logical step. And then if it's  
22 misinterpreted, you try and perfect it and refine it and do

1 the things you need to do.

2           But what Jack said about it undermining trust is  
3 terribly important for a profession that I'm proud of. And  
4 I think we have compromised our position over the last  
5 decade or two as we've become more enthralled with sort of  
6 the whole entrepreneurial kind of approach that does change  
7 your perspective on whether -- on what really are the forces  
8 that drive your decisions? Are we doing things to improve  
9 our lives? Or are we really living up to the fiduciary  
10 responsibility that we theoretically have with our patients?

11           So I think that there has been movement, as has  
12 been said, from professional societies and various places to  
13 address this. But it seems to me that it still exists. I  
14 was shocked when I read that story about \$800 million from  
15 device manufacturers to implant recipients. That's not  
16 small change. That's real money. Maybe it's legitimate,  
17 but I'm a little skeptical.

18           One question I have is there is legislation in  
19 Congress right now, I understand, but I don't know the  
20 details. How effectively would it respond to these  
21 questions?

22           And then just to stop, in response to Ron's

1 comments, I have the same feeling. I rarely get useful  
2 information from the drug reps. As a result I don't see  
3 many of them because I guess they got tired of getting a  
4 rather hostile response when they come to see me. You know,  
5 it's occasionally they have new information but most of the  
6 time not.

7 I guess the other issue, sure, trivial gifts are  
8 probably trivial gifts. On the other hand, they keep doing  
9 it. And so that says to me that it does have an effect.  
10 Even though we would think it probably doesn't, and most of  
11 my colleagues will say that doesn't affect me. Well, if it  
12 really didn't affect you -- the pharmaceutical industry is  
13 squeezed economically right now. They wouldn't be spending  
14 that money if they didn't think it had a payoff.

15 MS. HANSEN: I'd like to just probably lean on the  
16 side of sunshine in some form. But I think the  
17 implementation issue and the threshold issue probably is  
18 definitely something to really consider. On the other  
19 aspect of what was in the report with some of the  
20 professional societies themselves coming forth with  
21 guidelines. And especially I think the medical schools. If  
22 there is frankly more sunshine to the fact of those stories

1 to the general public to understand that would be very  
2 helpful.

3           The last point I would underscore is even though  
4 it's not the subject of this report, but what Ron brought up  
5 relative to the direct to consumer side of it is part of  
6 this equation. I wonder if some of that could be written.

7           Because even speaking to the device companies  
8 beyond the \$800 million that was relative to these four  
9 companies to physicians, what's happening in popular press  
10 now, people with aches and pains in their hips are being  
11 guided to ask their physicians for replacements, whether  
12 it's elbow joints or hip procedures, frankly usually before  
13 evidence-based types of approaches would be there.

14           So there's a whole kind of gradual socialization  
15 of both the educational community and now the direct to  
16 consumer community beyond pharmaceuticals but really about  
17 devices.

18           So as I say, it's not direct to the chapter about  
19 the topic at hand, but that is a very -- that's kind of  
20 under the current -- that will rise because the same kind of  
21 issue will occur with patients asking physicians for these  
22 drugs. Patients are beginning now to be guided to ask their

1 physicians for these devices.

2 DR. WOLTER: Again, a very nice summary, and I  
3 think beginning to define the breadth and depth of these  
4 relationships is important in and of itself, to say the  
5 least.

6 I am a very big fan of doing the public reporting  
7 or the reporting, so to speak, from hospitals and from  
8 vendors because I think in the act of reporting, some self-  
9 reflection about what is the nature of these relationships  
10 is inevitable.

11 That's probably more important, I think, than the  
12 reporting to the patient because, as you point out in the  
13 paper, the relationship between the physician and the  
14 patient is such that the trust in the physician usually is  
15 such that you're sort of really questioning the relationship  
16 is more difficult for the patient.

17 It's been a year or longer ago, I think somewhere  
18 I read that we're going to approach over the next few years  
19 40 percent of hospitalizations will have -- there will be  
20 some type of implantable device during that hospitalization,  
21 as we look into the future with all the new technologies  
22 unfolding.



1           I totally agree with Nancy that the comparative  
2 effectiveness and really understanding what's the right  
3 utilization and the right outcomes is the most important.  
4 But I think if you couple the fact that you're needing to  
5 report these relationships, that information, along with the  
6 comparative effectiveness data, can maybe help us understand  
7 a little bit what's driving some of this.

8           Many of these relationships clearly are about  
9 driving volume. And that doesn't mean that there are all  
10 bad intentions. And I certainly agree that we need to allow  
11 relationships that are done in an appropriate way to drive  
12 innovation. But I think it is concerning to see some of  
13 what's unfolding.

14           In my organization over the past about 18 months  
15 we went through a very long internal discussion in our  
16 physician group practice about how we wanted to intersect  
17 with the pharmaceutical representatives. I wish I had saved  
18 all the e-mails because it would make a fascinating case  
19 study. We had all over the map opinions from our physicians  
20 about this is an outrage that this would be decided and it's  
21 up to me and other physicians who were so concerned about  
22 the ethics of some of what was going on that they were upset

1 at the organization for not having acted more quickly.

2 We ended up with, I think, quite a reasonable  
3 compromise. Maybe not quite as far as Stanford has gone.

4 But what I learned from that is that most  
5 physicians aren't consciously making decisions that they  
6 believe are unethical that bring them something. But in  
7 many cases, they haven't thought through the slippery slope  
8 of what some of these relationships can mean. And so the  
9 reporting, especially if we can make it happen in a way that  
10 isn't too terribly burdensome, the reporting is going to be  
11 a significant act in and of itself.

12 So I certainly support the direction that you've  
13 created here.

14 MR. DURENBERGER: I am glad the physicians on this  
15 group have spoken up, so I won't try to add anything to that  
16 dimension.

17 I'm also glad that Nick and Jay and Jack went off  
18 and did this systemness thing because today we have talked a  
19 lot about culture. I think that's the reason why it's  
20 important that we talk about it here, because we've talked  
21 about doctor-patient relationships. We've talked about  
22 physician-hospital relationships. And all of that is we're

1 talking about it because the culture of medicine today is  
2 such that it is has left a lot of us feeling uneasy about  
3 what's right policy.

4           An important part of the definition of ethics is  
5 the appearance of a conflict of interest on the part of  
6 someone who has some power or control over you or over  
7 decisions that relate to you, to people who don't have a way  
8 in which to determine what's the right answer or the  
9 reality. Any of us who have followed the evolution of  
10 ethics in the congressional or the political side are quite  
11 well aware of the fact that constituents have no way of  
12 judging, in many cases -- even though they're asked to every  
13 two years or four years -- do I trust this person and all  
14 the rest of that sort of thing.

15           And so the whole notion of ethics and the  
16 avoidance of conflict of interest is around the issue of  
17 appearance. It's a critical part of it. And it isn't the  
18 actuality that you take \$25 or \$50 or \$100 or blah, blah,  
19 blah, blah, blah. It's the appearance that is critically  
20 important.

21           So the distinction, it seems it's important to  
22 draw, whether we draw it or somebody else draws it, has

1 already been raised here. And that is that is that in  
2 American medicine today and in the evolution of technology  
3 today the relationship between medicine and medical  
4 researchers and the industrial community which in effect  
5 takes those ideas and creates the innovation that all of us  
6 benefit from is very, very important. And it's really  
7 important at the academic level and it's important at the  
8 practice level and so forth.

9           And so focusing on that particular interface and  
10 how do you compensate America's medical professionals in a  
11 way that they can continue to make a contribution to the  
12 research and the development not only of the innovative  
13 products but some of the regulatory requirements in safety  
14 and efficacy, the ones that have to be on the expert panels  
15 at FDA and so forth, that is a challenge that I haven't  
16 noticed anybody -- a lot of people have tried to make it,  
17 the AdvaMeds and the PhRMAs and the professional  
18 organizations work at this in various forms. But defining  
19 that one is a really big challenge.

20           On everything else that we have talked about here,  
21 from the fountain pens to the free trips and so forth, I'm  
22 basically a Jerry Kacir [ph] on those kind of things, get

1 rid of them all, do the Permanente thing.

2 One of the reasons Minnesota is a leader on this,  
3 just a current example that I've been working with is the  
4 chief medical officers at all of the major hospital systems  
5 in Minnesota have been meeting together at the Physician  
6 Leader Policy Forum for the last couple of years to try to  
7 change the ethics within their own systems on vendor  
8 relations in a general way.

9 And the conclusions I think that we've drawn from  
10 that that relate to the questions that the staff has raised  
11 here relative to reporting will not eliminate conflicts of  
12 interest, but it sure as hell will discourage the practice.  
13 Everybody has already said this.

14 All that Minnesota information that's coming out  
15 of that reporting from 1998 on -- thank God it's being  
16 reported by the New York Times or wherever, it wasn't being  
17 reported by our local papers -- is really, really important.  
18 It helps people within the professions, both on the industry  
19 side and on the professional side, to do something about the  
20 greed that exists in the professions. Everybody in the  
21 professions knows that there's a whole lot of people that  
22 can't wait to get their hands around the next opportunity

1 and so forth and use it in a variety of ways that usually  
2 ends up reflecting more on the device or drug companies than  
3 it reflects on the individual docs.

4 But it is a reality. And the only way to begin to  
5 get at that is through the professions and the professional  
6 associations themselves. And so I think reporting is really  
7 important.

8 The last thing I would say is relative to trying  
9 to push this -- I think this discussion ought to come up  
10 periodically in this organization. But the idea that we  
11 need some kind of Federal standards and so forth, I have a  
12 lot of problems with because I'm basically, on the  
13 preemption issue, I think at the local level and the state  
14 level -- whether it's in Minnesotas and the Vermonts or  
15 whoever it is -- you're going to get a lot more progress  
16 than if we ever decide we've got a national reporting  
17 standard and it's all going to be \$100 or it's all going to  
18 be this, that, or the other thing. Then that becomes  
19 everybody's ethics instead of something else.

20 So I'm just not sure, from the experiences that  
21 I've been through, this establishing the rules and the  
22 reporting requirements and making national and stuff like

1 that is necessarily a really great idea.

2 DR. DEAN: I was just going to say I love Uwe  
3 Reinhardt's comment in that report to the governor. He said  
4 some of our colleagues are morally flexible.

5 [Laughter.]

6 DR. DEAN: I thought that really summed it up.

7 I didn't give you folks a chance to answer about  
8 the current legislation. How well does it address that?

9 MR. WINTER: Which particular issues do you want  
10 us to answer in the context of the bills?

11 DR. DEAN: [off microphone] You made the statement  
12 that there is legislation in Congress. And I understand  
13 [inaudible.] I wondered how effectively does it address  
14 these issues?

15 MR. WINTER: The House bill, which was introduced  
16 by Representative DeFazio and cosponsored by Mr. Stark, Mr.  
17 Waxman and some others, sets a threshold of \$50 per payment.  
18 Anything above that would have to be reported.

19 It applies to a wide range of payments. It  
20 specifically excludes to payments related to clinical  
21 research and free samples and one other area which I can't  
22 remember.

1           But it does allow manufacturers to designate  
2 information as trade secrets, which would not be disclosed  
3 to the public. And as we saw in Vermont, that led to  
4 significant under reporting or disclosure of payments to  
5 physicians.

6           The information that would be disclosed eventually  
7 would be done so through a public database on a website. It  
8 would be searchable. They have addressed that issue.

9           The other bill that's been introduced was in the  
10 Senate by Senator Grassley, cosponsored by Senator Kohl who  
11 is the Chair of the Senate Aging Committee, and some other  
12 Senators. That is a broader bill. It's broader in terms of  
13 disclosure. So the threshold is set lower set at \$25 per  
14 payment. It applies to a wide range of payments and gifts  
15 and transfers of value. It also excludes free samples and  
16 payments related to clinical trials.

17           There's no provision for a trade secret to  
18 withhold information. It would also create a database that  
19 would be on the website and publicly available. It would  
20 designate the Secretary of HHS as being responsible for  
21 implementation. And it does create civil penalties for  
22 violations.



1           The House bill designates the FDA commissioner as  
2 being responsible for implementation. So those are the key  
3 differences.

4           DR. DEAN: [off microphone] Any sense of where  
5 those stand? Any chance they're moving?

6           MR. WINTER: Good question.

7           The House bill was referred to the Energy and  
8 Commerce Committee and I've have not heard anything further  
9 about it. The Senate bill was referred to Senate Finance.  
10 I've not heard that the Finance Committee has scheduled  
11 hearings on it, but the Senate Aging hearing has held two  
12 hearings on this issue, one in the summer with regards  
13 relationships with drug manufacturers and one last week with  
14 regards to relationships with device manufacturers.

15           At the hearing last week there seemed to be  
16 significant industry support for the concept of a reporting  
17 bill. They raised issues about state preemption and what  
18 the threshold should be for companies that have to report  
19 because the Senate bill sets a threshold of \$100 million in  
20 revenue for companies that have the report, and AdvaMed  
21 supports a lower threshold.

22           But there seems to be more momentum, judging from

1 the Senate Aging Committee hearing last week. But that's  
2 where things stand now, as far as I know.

3 DR. DEAN: Thank you.

4 MR. HACKBARTH: Two final comments and then we  
5 need to move ahead. I have Arnie and Bob.

6 DR. MILSTEIN: Doing everything we can to assure  
7 that Medicare beneficiaries believe that their physicians'  
8 decision-making is solely pretexted on their health is very  
9 important to the patient experience, quality, and I think  
10 even efficiency of the Medicare program. One of the reasons  
11 that some patients don't take their meds is perhaps related  
12 to this question of physician motivation. Not in all cases,  
13 but perhaps in some cases.

14 I agree with Nancy's point that the right way to  
15 fix this is to get the Medicare program incentives for  
16 doctors right, which we're working on. But my view is that  
17 until such time as we get close to where we want to be --  
18 and I don't think we're quite there yet -- that I would tilt  
19 toward disclosure. And I think, based on the social  
20 psychology literature and cognitive psychology literature,  
21 if we're going to favor disclosure I think the scientific  
22 evidence suggests that it needs to A, be readily salient to

1 beneficiaries.

2 I would not force my mother to have to go on some  
3 website to figure it out. I would view something very  
4 simple and clear like a large type face posting that --  
5 first of all, it can say no, we don't accept -- this office  
6 does not accept any payments from any entity from which our  
7 referrals might benefit. Or yes, we do. And if we do, here  
8 is from whom it came and how much it was.

9 If we're going to make a recommendation, I just  
10 think it has to be really easy for beneficiaries to grasp  
11 and for them to get a sense as to order of magnitude how  
12 much money is involved here.

13 My view is let it apply to all categories of funds  
14 received by physicians from entities that potentially --  
15 that benefitted perhaps in the prior year or two years from  
16 referral decisions or device or drug selection decisions.  
17 And keep it simple. And in the meantime do everything we  
18 can to address Nancy's point, which is to fix the  
19 fundamental incentives so this kind of administrivia is not  
20 necessary.

21 DR. REISCHAUER: Let me react to just what you  
22 said and then say what I was going to say.

1           I think that doesn't make a whole lot of sense.  
2   We have lots of procedures like Fair Labor Standards Act and  
3   EEOC statements that are supposed to be posted on the wall  
4   of places, and they are. How effective is it when I'm  
5   coming in with my hacking cough on the second day to see the  
6   doctor and they either hand me something with fine print  
7   that I'm supposed to read or sign or I'm supposed to look at  
8   the wall? I just don't think that's the way to go on this.

9           I think an awful lot of this discussion makes it  
10   sound like medical professionals and suppliers in this  
11   industry are different from the rest of mankind. Dave is  
12   out of the room, but I would argue that greed, in a certain  
13   sense, is the engine of capitalism and it's everywhere in  
14   our society.

15           Every supplier tries to curry the favor of every  
16   decision-maker in a demand place. And I'm sure every one of  
17   us has gotten a box of chocolates at Christmas or a plan or  
18   a free ticket to a Redskins game or something like that from  
19   the law firm that handles our businesses.

20           And so this is, in a sense, pervasive throughout  
21   our society. And it's a little more troubling in this area  
22   for a couple of reasons. One is, as people have pointed

1 out, because the way we buy things in this area is not the  
2 way we buy things everywhere else. We don't buy on the  
3 basis of outcomes or efficiency. If we were "paying right"  
4 for performance, for efficiency, for patient centeredness, a  
5 lot of this would go away.

6           The second aspect that makes this a little worse  
7 than the rest of the world is a lot of it's paid for through  
8 third-party payments. And so the sensitivity of the various  
9 decision makers, whether it's the doctor or the patient, is  
10 really not the same as it is when you're buying groceries in  
11 a store or signing a contract for your firm for legal  
12 services.

13           I think the long-run solution is changing the  
14 payment policy, but we're all going to be long dead before  
15 we get to the point where this happens to reduce this. So I  
16 think transparency is the way to go. I don't think we  
17 should worry about whether Arnie's mother is going to go  
18 online and try to find this.

19           Having it available guarantees that some cub  
20 reporter in every city will check it every couple of years  
21 and it will end up, if not on the front page of the New York  
22 Times, on the front page of the Sioux Falls, South Dakota

1 kind of --

2 MR. DURENBERGER: Argus Leader.

3 DR. REISCHAUER: And that has a tremendous impact  
4 on behavior.

5 And then I think we also need to recognize that  
6 this is a cultural change that's occurring in all walks of  
7 life in America. I bet every one of us signs 10 times more  
8 conflict of interest reports, not the least of which are the  
9 ones for MedPAC. Every organization I belong to I have to  
10 fill out one of these things. It's part of life now.

11 So I think actually things are changing in a good  
12 direction. Not fast enough. And they're changing in the  
13 medical area because there been a number of very good  
14 journal articles, which you folks have summarized, bringing  
15 out this is a problem. People didn't pay attention to it 20  
16 years ago. So we are on the right way. Push it,  
17 transparency, and make it available to those who can bring  
18 it to the front page of the local newspaper.

19 DR. KANE: So Rob, what have you stopped doing  
20 since you started disclosing your activity?

21 [Laughter.]

22 DR. MILLER: We don't need that for the record.

1 DR. REISCHAUER: I want to know why I'm not  
2 getting more to put on these things. That's what upsets me.  
3 I mean, I look at everybody else's and I think God, you  
4 know...

5 [Laughter.]

6 MR. HACKBARTH: Okay, on that happy note -- which  
7 was better than the note about how we're all dead before we  
8 accomplish anything, let's move on.

9 This was our first discussion on this particular  
10 topic. Hence, there were no recommendations contemplated.  
11 We will review the discussion here and perhaps come back  
12 with something not next time but in the fall. So thank you.

13 Next up is promoting the use of primary care.

14 MS. BOCCUTI: The Commission has expressed  
15 interest in exploring ways to promote the use of primary  
16 care and the professionals who provide them.

17 Today we're going to review the importance of  
18 primary care and its risk of under provision and then  
19 introduced two initiatives to promote the use of primary  
20 care services in Medicare. So the two initiatives are fee  
21 schedule services aimed specifically at primary care  
22 services provided by primary care clinicians. And also,

1 we're going to talk about medical home programs.

2           Survey research repeatedly shows that Americans  
3 value having a primary care physician who knows about their  
4 medical conditions. The Commission's SGR report stated that  
5 one way to improve value in Medicare is to increase the use  
6 of primary care services and reduce reliance on specialty  
7 care. This goal can improve the efficiency of health care  
8 delivery without compromising quality, as shown in research  
9 by Elliott Fisher and Barbara Starfield and several other  
10 colleagues.

11           So despite these findings, Medicare's fee-for-  
12 service payment system really doesn't provide any  
13 encouragement for beneficiaries to seek services, when  
14 appropriate, from primary care providers before or instead  
15 of specialists when appropriate. So indeed, we're seeing  
16 that primary care services risk being undervalued.

17           Previous MedPAC work, which I know you're aware  
18 of, has found that compared to procedurally based  
19 specialties, cognitive services, which are a main component  
20 of primary care, are less able to realize efficiency goals.  
21 And thus, they risk becoming undervalued and consequently  
22 under provided when physicians view the primary care



1 services as less profitable.

2           The IOM has noted the multidimensional nature of  
3 primary care. For the purposes of today's discussion, we  
4 consider primary care to be comprehensive health care  
5 provided by personal clinicians who are responsible for the  
6 overall ongoing health of their individual patients.  
7 Primary care offers first contact care that encompasses  
8 preventive, acute, and chronic care. It means keeping track  
9 of appropriate patient referrals and requires teamwork.

10           Physicians who specialize in primary care are  
11 trained in family practice, internal medicine, geriatric  
12 medicine, and pediatrics. Nurse practitioners and physician  
13 assistants are additional, important professionals who  
14 provide primary care. Some specialists also provide primary  
15 care to their patients, particularly those who specialize in  
16 chronic conditions.

17           Results from a large beneficiary survey, the MCBS,  
18 shows that most beneficiaries have a usual source of care  
19 that they want and that the value. In fact, they're much  
20 more likely than non-Medicare population to have this usual  
21 source of care.

22           But the Commission has raised some concern

1 regarding access to primary care. In our 2007 beneficiary  
2 survey, although only a small share of beneficiaries report  
3 that they are looking for a primary care physician, among  
4 those who are, 30 percent said that they had some problems.  
5 It was 12 percent said small and 17 percent said big.

6 We also see a decline in the share of U.S. medical  
7 students who are entering family practice and primary care  
8 residency positions.

9 Also, we see that internal medicine residents are  
10 increasingly going into subspecialties.

11 So with those issues about primary care before  
12 you, Kevin is going to take you through a payment adjustment  
13 initiative.

14 DR. HAYES: For this part of our presentation, the  
15 question is whether you wish to recommend a payment  
16 adjustment for primary care as part of Medicare's physician  
17 fee schedule. This adjustment would be a major change in  
18 the payment system, a change aimed at promoting primary  
19 care. I will take the next few minutes to develop this idea  
20 with an endpoint of two draft recommendations for your  
21 consideration: one on the adjustment itself and another on  
22 an administrative issue of how physicians choose a specialty

1 designation for themselves when they enroll to receive  
2 payments from Medicare.

3           As listed here, the adjustment could be available  
4 to selected practitioners. Those practitioners could  
5 include physicians with a specialty among those often  
6 thought of as furnishing primary care, namely internal  
7 medicine, family practice, geriatric medicine, pediatric  
8 medicine. The adjustment could also be available to nurse  
9 practitioners and physician assistants.

10           The services selected for the adjustment could be  
11 the ones defined in the statute as primary care. Those  
12 services include certain types of evaluation and management  
13 services, that is office, home and emergency department  
14 visits, and visits to patients in certain non-acute facility  
15 settings.

16           The adjustment would be budget neutral. As such,  
17 it would redistribute payments toward primary care  
18 practitioners and help reward a career in primary care.

19           To begin, let me summarize the rationale for the  
20 adjustment which, as Cristina said, centers around concerns  
21 about under valuation of primary care. Recall that the  
22 specifics on this were discussed in previous MedPAC reports.

1           Briefly, the concern is that, unlike other  
2 services, primary care services do not lend themselves to  
3 efficiency gains. Instead, they are composed largely of  
4 activities such as taking a patient's history, examining the  
5 patient, medical decision-making, counseling, and  
6 coordinating care, activities that require the physician to  
7 spend time either with the patient or before and after  
8 seeing the patient.

9           By contrast, for services other than primary care,  
10 efficiency can improve with advances in technology,  
11 technique, and other factors. As an example, research on  
12 open heart surgery clearly showed early on that, as  
13 techniques and technology developed, physicians became more  
14 proficient in performing the procedures, taking less time  
15 per procedure.

16           When this occurs, what some have called learning  
17 by doing, we would expect that the fee schedule's relative  
18 value units for the affected services would go down. If  
19 that were to happen, RVUs would go up for other services,  
20 including primary care, because changes in RVUs in the fee  
21 schedule are budget neutral.

22           As we have seen, that two-step sequence, lower

1 RVUs for overvalued services and higher RVUs for other  
2 services, tends not to occur because of problems with the  
3 way RVUs are reviewed. Hence, the concern about under  
4 valuation of primary care.

5           This table shows that the concerns about the  
6 valuation of primary care services are not typical of the  
7 services furnished by specialists. To interpret the table,  
8 recall the list of primary care services I went over a few  
9 minutes ago. It included office visits and other types of  
10 evaluation and management services. Specialists tend not to  
11 derive a large share of their payments from these services.  
12 The specialists listed here are ones that have the highest  
13 levels of allowed charges billed to Medicare. As you can  
14 see, for these specialists, the percentage of allowed  
15 charges from furnishing primary care services ranges from a  
16 low of 0.2 percent for diagnostic radiology on up to 22.1  
17 percent for urology.

18           By contrast, primary care practitioners derive  
19 much higher percentages of their allowed charges from  
20 primary care services. Here the range is 43 percent for  
21 pediatrics to well above 60 percent for geriatric medicine,  
22 family practice, and nurse practitioners. Thus, a fee

1 schedule adjustment directed at the primary care services  
2 furnished by these practitioners could have a meaningful  
3 impact.

4 A fee schedule adjustment for primary care would  
5 be a major change in the purpose of the fee schedule.  
6 Currently, it is intended only to account for differences in  
7 resource costs among services. Further, the statute  
8 prohibits differentials in payment based on physician  
9 specialty designation. Thus, a purpose of promoting primary  
10 care would be a very different goal for the payment system.

11 Instead of just accounting for current resource  
12 costs, the fee schedule could be a way to look ahead and,  
13 for instance, support investment in infrastructure such as  
14 IT and staffing for the medical programs that Cristina will  
15 discuss in a minute.

16 If you decide to recommend a fee schedule  
17 adjustment, there are two issues to consider. The first is  
18 setting the level of the adjustment. The second is an  
19 administrative one of physician specialty designation.

20 On setting the level of the adjustment, we can say  
21 that this is a case with there is no one formula or  
22 analytical approach to making the decision. In other words,

1 judgment would be required. In making that judgment,  
2 existing policies may provide a guide. Currently, there is  
3 a 10 percent bonus paid for services furnished in health  
4 professional shortage areas. There is also a 5 percent  
5 adjustment for services furnished in areas defined in the  
6 statute as physician scarcity areas. These payment  
7 adjustments show where the Congress has gone on this issue  
8 previously.

9 A conversation about the level of the fee schedule  
10 adjustment could also include consideration of historical  
11 under valuation of primary care. The paper we sent you for  
12 the meeting provides estimates of this, and they are in the  
13 range of 7 to 13 percent.

14 The other issue to resolve is how to reliably  
15 determine physician specialty. This is a problem for a fee  
16 schedule adjustment that relies in part on specialty  
17 designation. Physician specialty is self-designated. That  
18 is, physicians declare a specialty when they apply to bill  
19 Medicare. Further, they can change their information when  
20 they add a billing location or for some other reason. With  
21 payment adjustments that depend partly on physician  
22 specialty, further policies may be needed that would define

1 physician specialty and set criteria for a change in one's  
2 specialty.

3           To resolve this, perhaps the Secretary could  
4 establish further criteria for how and when physicians  
5 designate a specialty for themselves. It is likely that  
6 multiple criteria would be necessary. As an example, Board  
7 certification would not be sufficient. Physicians could be  
8 board certified in a subspecialty but actually practice as a  
9 primary care physician.

10           Another option might be to look back say over the  
11 past year at the pattern of claims submitted by a physician.  
12 There could be a minimum threshold established for the  
13 percentage of claims that are for primary care services.  
14 Only those physicians at or above the threshold would be  
15 able to receive the adjustment.

16           This brings us to the first draft recommendation,  
17 which reads as follows: the Congress should establish a  
18 budget neutral payment adjustment for primary care services  
19 billed under the physician fee schedule. The adjustment  
20 would increase the payment for a primary care service if a  
21 practitioner designated by the Secretary has a primary care  
22 practitioner furnishes the service.



1           What are the implications of this recommendation?  
2   As a budget neutral policy, it would not affect Federal  
3   benefit spending relative of current law. For  
4   beneficiaries, it would be intended to improve their access  
5   to primary care services. It would have redistributive  
6   effects on physicians and other providers, depending on the  
7   services they furnish.

8           Now we have the second draft recommendation.  
9   Recall that a moment ago I spoke about the problem of  
10   physicians' designation of their specialty. To address this  
11   problem, the second draft recommendation reads as follows:  
12   to implement the fee schedule adjustment for primary care,  
13   the Congress should direct the Secretary to identify the  
14   physician specialties the can receive the adjustment. The  
15   Secretary should use rulemaking to determine the criteria to  
16   identify qualifying primary care practitioners.

17           Implications of this recommendation are the same  
18   as the ones listed for the first recommendation. Because of  
19   budget neutrality, there would be no change in Federal  
20   spending. Better access to primary care services for  
21   Medicare beneficiaries and redistributive effects for  
22   physicians and others.

1           That's all we have on the fee schedule adjustment.  
2           Cristina will now discuss medical home programs.

3           MS. BOCCUTI:   So medical programs are gaining much  
4           more attention of late.   In fact, private insurers are  
5           starting them in their programs.   John, who did more than  
6           just flip the slides here, John did a lot of work on looking  
7           at some private models and some of those in Medicaid.   We  
8           didn't include that in our formal presentation because of  
9           time, but he can certainly speak to them during the question  
10          and answer period if you'd like.

11          So medical home initiatives have the potential to  
12          add value to the Medicare program.   Ideally, through better  
13          care coordination, medical homes could enhance communication  
14          among providers and thereby eliminate redundancy and improve  
15          quality.

16          They may also improve patients' understanding of  
17          their conditions and their treatment and thus reduce their  
18          use of high-cost settings like emergency rooms and inpatient  
19          care.

20          Another important goal of medical home programs is  
21          to enhance the viability and the role of primary care  
22          practice and increase access to primary care for

1 beneficiaries.

2           In its June 2006 report, the Commission discussed  
3 care coordination programs, which are a major component of  
4 medical homes. Through literature reviews and interviews,  
5 we identified three key features of care coordination  
6 programs. That's a care manager, usually a nurse,  
7 information systems, and integration with the physician  
8 office.

9           In our last meeting in January several of you  
10 suggested specific capabilities essential for a medical in  
11 Medicare. So I've listed them here and I want to spend a  
12 little time running through them.

13           In addition to providing or coordinating  
14 appropriate preventive maintenance and acute health services  
15 medical homes must first furnish primary care. Medical  
16 practices that include primary care physicians and other  
17 related clinicians, such as nurse practitioners and  
18 physician assistants, would be eligible to participate.  
19 Geriatric medicine practices are a natural candidate for  
20 medical home programs. And in some cases, patients may  
21 choose a specialty practice, as in the endocrinology example  
22 for patients with diabetes.

1           Going on to the second bullet, previous MedPAC  
2 work has shown that health IT has the potential to improve  
3 the quality, safety and efficiency of health care. So I'm  
4 talking about electronic medical records to track  
5 encounters, referrals, test results and follow up. We're  
6 talking also about registries, e-prescribing, and clinical  
7 decision support.

8           And finally, health IT offers a mechanism for  
9 patients to access their personal health information in a  
10 timely manner.

11           An essential component of medical homes is their  
12 commitment to follow up on patients between appointments and  
13 health events. So typically directed by a nurse, case  
14 management focuses on patient adherence to treatment plans,  
15 patient education on self-care, coordination of patient  
16 referrals, and tracking results from tests and referral  
17 services.

18           You also brought up the importance of  
19 communication between the patient and the medical home. So  
20 medical homes should be accessible and responsive to  
21 patients in a timely manner 24 hours a day. In addition to  
22 being responsive during regular office hours, medical homes

1 should include a mechanism for clinician-patient contact  
2 during non-regular office hours to respond to patients'  
3 urgent and emergent needs after hours.

4 Another suggestion that you made is that medical  
5 homes be a place for maintaining advance directives, signed  
6 documents of their patient's wishes for end-of-life care.  
7 This requirement encourages patients and their personal  
8 physician to have a discussion to clarify patients' wishes  
9 for the last months of life and, in fact, ensure that these  
10 do play out.

11 And finally, an external accrediting organization  
12 could verify that these medical home capabilities and  
13 functions are in place. Additionally, further efforts from  
14 CMS would be needed to maintain program integrity,  
15 particularly considering that monthly payments would not be  
16 linked to patient-physician encounters.

17 In the January meeting, you discussed the payment  
18 mechanism for medical homes in Medicare. The one that  
19 seemed to have the most consensus was a modest monthly  
20 payment per beneficiary for medical home infrastructure and  
21 activities. The medical home could continue to bill for  
22 Part B services on a fee-for-service basis. But note that

1 there wouldn't be any beneficiary cost-sharing for that  
2 medical home fee.

3           Introducing a medical home program, I think,  
4 provides an opportunity to implement real pay-for-  
5 performance incentives for physicians. It would allow P4P  
6 to focus on widespread, high cost conditions that may be the  
7 best ones to initially target. I think Nick has brought  
8 this up in the past. In fact, a large share of quality  
9 measures used by private insurers apply to primary care  
10 physicians.

11           So the P4P program that is referred to on the  
12 slide would be consistent with the MedPAC recommendations of  
13 physician quality incentives, that is rewarding for  
14 attainment and improvement on selected quality measures. It  
15 would be based on a small share of physicians fee-for-  
16 service Medicare revenue.

17           We start with beneficiaries with multiple  
18 conditions because they're the population most in need of  
19 improved care coordination. As the number of medical  
20 conditions increases, encounters with different health care  
21 professionals and settings also increases, as does Medicare  
22 spending. A medical home program that targets this

1 population will in turn target the very clinicians who  
2 provide their primary care.

3           Participating beneficiaries would select a single  
4 medical home. Medical homes would need to obtain a signed  
5 document from each participating Medicare patient indicating  
6 his or her medical home designation. And this document  
7 should include principles for encouraging beneficiaries to  
8 seek care from the medical home first when appropriate, and  
9 discuss the medical home's role in coordinating patient  
10 care.

11           Medicare should also engage in a public education  
12 campaign to inform beneficiaries about the health and cost-  
13 effectiveness benefits of primary care, as well as the  
14 medical home program.

15           An important implementation question that remains  
16 is beneficiaries' ability to seek care outside of the  
17 medical home without a referral. Currently, Medicare does  
18 not require beneficiaries in fee-for-service to have a  
19 referral to see physicians, and changing this premise may be  
20 challenging. However, doing so may give medical homes a  
21 tool for managing and tracking their patients' overall care.  
22 Note though that beneficiaries may object to apparent

1 restrictions on access to specialists. And similarly, some  
2 specialty physicians may raise concerns.

3 Medicare could counterbalance any perceived  
4 restriction by offering beneficiary incentives for  
5 participating in the medical home, such as a reduction in  
6 Part B premiums. But this incentive creates several  
7 significant implementation problems. First, it would be  
8 lost on low-income beneficiaries who don't pay a premium.  
9 They are a key population that we would want to target in  
10 the medical home program.

11 Second, premium discounts may be seen as  
12 inequitable because some beneficiaries -- specifically those  
13 in good health -- would be ineligible.

14 And third, premium discounts could be expensive  
15 for the Medicare program.

16 Finally, I'll mention that other implementation  
17 details also need to be worked through regarding beneficiary  
18 participation such as selecting the qualifying medical  
19 conditions and other beneficiaries that have special  
20 circumstances.

21 So with all that, I will bring us to a draft  
22 recommendation which I will read, in part.



1           The Congress should initiate a medical home pilot  
2 project in Medicare. Eligible medical homes must meet  
3 stringent criteria, including at least the following  
4 capabilities -- and I will not read through them because  
5 these are the same ones that were on -- I think it was slide  
6 14, before.

7           Skipping down to the last line, additionally, the  
8 pilot should require a physician pay for performance  
9 program.

10           Though it's not on this slide in the bold-faced  
11 recommendation, we can add text in the chapter that  
12 discusses strong criteria for continuing or discontinuing  
13 the pilot in Medicare.

14           Beneficiary implications for this recommendation  
15 are that it would improve access to primary care services  
16 for beneficiaries who participate and it could improve  
17 quality of care. Primary care providers would have  
18 increased resources for improving care for their patients  
19 and would encounter incentives for improving quality.

20           And then regarding spending implications, a  
21 spending analysis requires some sense of size for this  
22 pilot. As a pilot itself, it's difficult to imagine how it

1 could be established budget neutrally. So I think we're  
2 looking at something that's going to cost some money. But  
3 we need further analysis and your discussion today will help  
4 in getting a better sense of the spending implications.

5 That concludes our presentation, but we're very  
6 interested in your discussion.

7 MR. HACKBARTH: So we have two proposals on the  
8 table, a conversion factor bonus and a medical home pilot.  
9 I think it might be useful to try to separate the discussion  
10 into two -- John is saying no.

11 MR. BERTKO: [off microphone.] No, they are  
12 either/or to some degree.

13 MR. HACKBARTH: My premise, just to be clear, is I  
14 don't think they are either/ors. And that's why I was  
15 inclined to separate the discussion of the two. Let's just  
16 give that a go. Do you want to wait until I fail at that,  
17 and then you'll launch your --

18 MR. BERTKO: Yes.

19 [Laughter.]

20 MR. HACKBARTH: Fair enough. We're going to do  
21 the conversion factor first.

22 DR. STUART: I don't think they're either/or

1 either. And part of that gets to the question about what  
2 are we trying to promote here? Are we trying to promote  
3 organized provision of primary care services, which is going  
4 to work some places in the country, it's not going to work  
5 other places? Or are we really interested in promoting  
6 primary care?

7 I'm curious about draft recommendation one and two  
8 in that regard. If we could go back, it's page 13.

9 You note in your presentation and in the  
10 discussion some of the difficulty of identifying who primary  
11 care physicians are, because most physicians are either --  
12 they think of it as either being certified in a particular  
13 specialty, which you've indicated isn't going to work here  
14 because you could be certified in one area and be working in  
15 another area. Or it could be self-proclaimed. But then  
16 there are obvious problems with that.

17 And so the question I have is how close could you  
18 get to the goal of promoting primary care -- not medical  
19 homes but primary care -- by simply increasing the  
20 reimbursement for evaluation and management services? And  
21 if it's not all evaluation and management services, then  
22 those that would be considered as primary care?

1 DR. HAYES: There's a couple of ways to come at  
2 this. The one would be that, as we could see in that slide  
3 with the table, that for certain specialties we have a large  
4 share of their allowed charges coming from what we have  
5 called primary care services.

6 Your question is how close could you get?

7 DR. STUART: I can see that you're going to get  
8 close. The question is why wouldn't you use the increase in  
9 the primary care service reimbursement rate as your  
10 mechanism, as opposed to trying to identify who is a primary  
11 care physician or not?

12 DR. HAYES: Then that takes us to the preceding  
13 slide, which the point that I made with this slide was that  
14 well, large percentages of allowed charges for these  
15 specialists are not attributable to primary care services.  
16 But nonetheless, we do have a fair number of dollars flowing  
17 in the direction of these specialists and others not on the  
18 table.

19 And so the thought was that if we had a two-part  
20 toggle on this, so to speak, of considering both specialty  
21 and the service, that we could better target the dollars.  
22 That was the point.

1 DR. MILLER: It's pitched as redistributive. So  
2 you could do what you said, but what you would be  
3 redistributing would be a larger number.

4 DR. STUART: It would be larger but it would be  
5 supporting primary care. If you look at the bottom of that  
6 list, if you de-identify these people as being primary care  
7 physicians, then patients who are receiving primary care  
8 from these physicians are going to be disadvantaged.

9 MR. BERTKO: This is kind of the either/or. In  
10 this case sure, you pay more to primary care physicians per  
11 office visit. I'll take my own case. I'm now with a new  
12 physician appropriately managing my cholesterol.

13 So I have one visit where the guy measure its and  
14 prescribes. And now I've got a bunch of phone calls with, I  
15 think, no reimbursement which he sends me to get the  
16 cholesterol checked again. The either/or here is he gets  
17 paid nothing here today or, under the case management at  
18 some time, he will get \$2 a month. I think that's why  
19 there's either/or if we're going to try to promote this.

20 Now that's a very weak case, it's chronic but  
21 tiny. The more expensive ones could even be an exaggerated  
22 version of this.

1 DR. SCANLON: I'm on the same wavelength as Bruce.  
2 I guess I have a question about this. These primary care  
3 services are basically E&M costs?

4 DR. HAYES: They are the E&M codes of the type  
5 that we talked. So consultations -- visits to hospital  
6 inpatients are excluded. This would be visits of patients  
7 to physicians in the office. It would be home visits. And  
8 it would be physician visits to patients in certain non-  
9 acute settings like nursing homes, SNFs and such.

10 DR. SCANLON: I guess I would sort of posit that  
11 some of those are primary care and some of them are not.  
12 One of the things that I have felt since we started with the  
13 RBRVS is that we're playing this incredible game of Twister,  
14 trying to get everything into the numbers of E&M codes we've  
15 got, regardless of the specialty providing the service.

16 If I go to somebody with a sprained ankle and I  
17 only have an E&M code for that. It's very hard to think  
18 about that the same as if I go to an internist with a set of  
19 vague symptoms of fatigue, et cetera. They're very, very  
20 different. I know we've got seven dimensions of E&M that we  
21 work on to try and make them all work out to be equivalent.  
22 But I think it's potentially asking for a mapping that can't

1 occur, that we can't really distinguish different kinds of  
2 visits. So that's the one part of this.

3 I think why I'm sympathetic to where Bruce is that  
4 I feel like we're re-stating a recommendation we've made  
5 before, which is that the RVS values are inappropriate.  
6 They're not updated frequently enough. We need to make some  
7 kind of change. That would accomplish the same thing as  
8 some kind of a differential. It's no major change in the  
9 fee schedule.

10 I think that we've, at various times, talked about  
11 this issue of we don't have enough codes to deal with the  
12 different kinds of things that are happening. If we have a  
13 E&M encounter that results in an hour outside of E&M for  
14 some kind of coordination, that's a different kind of an E&M  
15 encounter than one where you say goodbye to the patient and  
16 that's the end of it.

17 We need to think about how can we reliably  
18 classify the differences in terms of encounters and follow  
19 up so that we pay for them appropriately.

20 But that's all within the context of our current  
21 framework whereas what we're talking about now is trying to  
22 distinguish specialties, creating a separate conversion

1 factor. And I think that's not necessarily the right step.  
2 I think it's more we should be back to the fundamentals,  
3 which is what are we trying to do? If we have not done it  
4 well, how do we improve on doing what we were trying to do  
5 if it's a solid idea?

6 MR. HACKBARTH: This is one of the first issues  
7 and sort of foundational to where you go from here. We have  
8 made a recommendation, as Bill points out, to improve the  
9 RUC process. You can look at this recommendation as being  
10 just sort of a variation on that. What we're trying to do  
11 is make up for past failures in the RUC process. That was  
12 one of the options for how you figure out how much you pay  
13 here. The RUC process isn't fixed and it's been inequitably  
14 distributing money and we want at least a temporary  
15 conversion factor bonus as a makeup for past failures.  
16 That's sort of one mindset here.

17 A very different mindset is to say we want to  
18 break out of the basic RVU mentality. The RBRVS system is  
19 based on the notion that the right relative prices is based  
20 on the inputs that go into producing the service, including  
21 professional time, intensity of effort, as well as staff  
22 inputs and the like.



1           What this is about is saying that's not the only  
2 thing that should go into a Medicare payment policy. And  
3 what we want to do is reward a category of services not  
4 because they've been incorrectly calculated by the RUC, but  
5 because of their value to the health care system and its  
6 patients.

7           Those are very different notions about what you're  
8 trying to do here, and they may drive you in a little  
9 different path.

10           My own view is that ultimately we need to be about  
11 recognizing the value to the health care system. We may  
12 start with a bonus that's based on past inequitable payment  
13 through the RUC process. But that's not the end of it. I'm  
14 not thinking about a temporary makeup payment while we fix  
15 the RUC. I'm thinking about something enduring.

16           DR. SCANLON: Let me just respond, because you  
17 raised an issue which I also have a view on. I was going to  
18 save it for later.

19           But it's this idea that do all E&M codes have the  
20 complexity, have the same value? My contention would be no,  
21 that the part of the value variation is attributable to what  
22 is being done in this visit.

1           I have great respect for what can be accomplished  
2   in seven years of postbaccalaureate education, in terms of  
3   how skilled we can make a person. And so that we should be  
4   valuing that skill.

5           I think that in all lot of E&M visits that we're  
6   underutilizing the skills of that person. And so there is a  
7   question of should we be doing something that tries to take  
8   advantage of the skill of a primary care physician and  
9   looking for other types of personnel to be doing some of the  
10  more routine things?

11           None of this discussion, when we're talking about  
12  changing the incentives, none of this discussion is dealing  
13  with the beneficiary. Because one of the things that if we  
14  were to have a world in which we had sort of the  
15  appropriately trained individuals to provide different kinds  
16  of service, how are we going to overcome the patients' bias  
17  that the only thing that matters is what the doctor says and  
18  whether I see the doctor? If I don't do that, it's not  
19  going to do any good.

20           In terms of thinking about transformation of the  
21  system, we've got to go more fundamental than this. This is  
22  like a Band-Aid to deal with some problems at the moment.

1 That's not the way we've written this recommendation. If it  
2 was written as a Band-Aid, it would fill very differently  
3 about it than if it was as a temporary thing and pointing to  
4 where we want to be in the longer term.

5 DR. REISCHAUER: My reaction to what you said,  
6 Bill, was that this was intended to recognize and encourage  
7 generalists. And a lot of primary care can be done by  
8 specialists for people who have chronic conditions, like a  
9 cardiologist or a gynecologist. But that's recommendation  
10 three. That's the medical home. They could be a medical  
11 home.

12 Just one thing with respect to this information.  
13 It strikes me that given that these different specialties  
14 have wildly different incomes, what is more relevant is the  
15 dollar value from these activities for a cardiologist versus  
16 somebody else. And that's what will tell you what the  
17 incentives will be to move, not the percentage of their  
18 total take.

19 DR. MILLER: Both Bob and Glenn got close to this  
20 and I want to say it. I think part of some of the other  
21 reasoning for putting this proposal on the table were very  
22 strong statements made by the Commission in previous

1 conversations about concern on the pipeline of physicians,  
2 and that if we don't send signals to certain specialties  
3 over the long run -- and I kind of expected -- you guys got  
4 close and I thought that was part of it but maybe I got --

5 MR. HACKBARTH: The reason I stopped short of  
6 saying that is that if the rationale is around supply of  
7 physicians in training, I think you've come up with a  
8 potentially much broader -- it's not only in primary care  
9 that we have potential issues with long-term supply and  
10 training.

11 So I don't think that differentiates or focuses  
12 the discussion sufficiently. Maybe we need to come back at  
13 some later time and look at general surgery or urology or  
14 other specialties that have similar looming issues. I think  
15 that rationale is too broad for the current purpose. Hence,  
16 I want to look at this as -- and you don't have to go along  
17 -- but I look at it as fundamentally a value proposition.

18 These services, adequate payment for them, are  
19 critical to a well functioning, efficient, high-performing  
20 health care system.

21 That also leads me, Bruce, back to your initial  
22 point. I don't want to just spread this money around. I

1 want it concentrated on the people that are intensively  
2 engaged in this activity, not incidentally engaged in it.  
3 So I would be inclined to look at physicians that -- in  
4 fact, Arnie proposed this to me on the phone, so let me give  
5 due credit. Give this to physicians who have a percentage  
6 of this activity of their total Medicare billings that  
7 exceeds some high threshold.

8           This is a bonus for the people that are really  
9 focused on this.

10           We've got to start going through our list, and I  
11 apologize for yakking too much.

12           MR. EBELER: I think recommendations one and two  
13 make sense in the context of recommendation three. I don't  
14 mean to lump them when we're splitting, but you need to  
15 shore up in the short-term the existing if fee schedule,  
16 inadequate as it is as a transactional fee-for-service --  
17 stipulate to all the issues we have with it. But it is how  
18 we do things.

19           And sort of shoring that up, at the same time we  
20 move to a different way of streaming money out to primary  
21 care physician for medical home, I think makes sense. So I  
22 think this is the way to go.

1           The other thing is we've got to go. This is one  
2 of those things, we can talk about it a lot. But folks are  
3 being paid today under these structures. We're worried  
4 about it. And recommendations for action are needed.

5           So I think this is the right way to go. Like I  
6 say, if and only if we also go with three, which is the  
7 longer term train heading a little bit out of this structure  
8 in getting a different stream of money.

9           MR. HACKBARTH: Let me abandon my splitter. John  
10 wins. In the interest of time, if nothing else, feel free  
11 to address both recommendations we don't have to go around  
12 separately.

13           MR. BERTKO: Do I get another turn now?

14           [Laughter.]

15           DR. REISCHAUER: No, you won the battle.

16           DR. CROSSON: Thanks very much. I'd like to start  
17 with just one technical question, if we can look at slide  
18 nine for second.

19           That gets to what Glenn was talking about a few  
20 minutes ago now about targeting this and targeting primary  
21 care services. I want to pick on the pediatric number. And  
22 that may be unfair since this is MedPAC, but it happens to

1 be an area that I practiced it.

2           When I looked at it, it seemed a little low. So  
3 as I reflected on my pediatric practice some 20 years ago,  
4 it would have seemed to me that pretty much everything I  
5 did, I guess most of it that was office practice, would have  
6 been primary care.

7           I'm just using that number because it's here and  
8 because that's --

9           MR. HACKBARTH: It's probably an artifact. This  
10 is Medicare data.

11          DR. REISCHAUER: This is Medicare data.

12          DR. CROSSON: Oh, this is only Medicare data?

13          MR. HACKBARTH: Yes, so that's an artifact,  
14 probably, of the data.

15          DR. REISCHAUER: There are two people.

16          [Laughter.]

17          DR. CROSSON: All right, then I can't speak to it  
18 directly. But I would just wonder even internal medicine,  
19 what is considered a primary care service by an internist  
20 versus a non -- that would be procedures? Or what would it  
21 be, that's a non-primary care service.

22          DR. HAYES: Yes, it would be procedures. It would

1 be visits to hospital inpatients. It would be if they do  
2 any consultations. But it would be primarily procedures.

3 It would be chest x-rays in the office. Some of  
4 them do colorectal cancer screening services, that kind of  
5 thing.

6 DR. CROSSON: Thanks. Later, I'll ask you about  
7 where you got the pediatric data from.

8 MR. HACKBARTH: Jay, just for the record on that,  
9 since this is Medicare data, those are disabled that qualify  
10 for Medicare through that channel, who would tend, I would  
11 think, to be specialty dependent to a greater than average  
12 degree.

13 DR. CROSSON: Thanks, that's helpful.

14 On the larger question, now that we have developed  
15 a unitary approach, I would support all three  
16 recommendations. I think they do get together.

17 I think, in terms of what we are trying to do  
18 here, I would agree with what Glenn said. In fact, in the  
19 definition on slide four, it says what we're trying to do is  
20 promote primary care. And that is defined as comprehensive  
21 health care provided by personal clinicians who are  
22 responsible for the overall ongoing health of their



1 individual patients.

2           And I think that may, in fact, exclude some of the  
3 E&M services, for example, delivered by some of the  
4 physicians who are on that slide that would not qualify to  
5 meet this definition.

6           So I do think if this is the definition, then  
7 trying to target the payments here -- and that would be by  
8 both selecting the specialty as well as the services --  
9 makes some sense because we're going to have to shift money.  
10 And to the extent that it's properly targeted, we're going  
11 to do better. So that is not a shotgun approach but a  
12 narrow shotgun approach.

13           I think the third recommendation speaks to much  
14 more of a rifle shot approach, which is really targeting it  
15 with strict criteria at that level.

16           Now having said all that, I do think in thinking  
17 about what we're doing there's a little bit of the chicken  
18 and the egg part here, at least in the short term. And that  
19 has to do with the fact that while there may be long-term  
20 projected shortages of various specialties, there is a very  
21 short-term projected severe shortage of internists and  
22 family practitioners. And in fact, if we don't do something

1 about that, given the lead time for individuals to choose  
2 specialties, we may not have the individuals around to do  
3 what we would like to see.

4           So while the goal is value in the delivery of  
5 certain services, I don't think we should shy away from --  
6 nor I think do we in terms of the first two recommendations  
7 -- shy away from the short-term effect on trying to make  
8 sure that we have an adequate supply of physicians who can  
9 provide the value later on.

10           MR. HACKBARTH: A couple of weeks ago GAO  
11 submitted a report to Congress on the supply of primary care  
12 physicians. There was a table in the report showing the  
13 growth in various specialties over I think like a 10-year  
14 time horizon or something like that. If you look at the GAO  
15 data, it actually shows that the number of primary care  
16 practitioners is stable, even growing modestly, and growing  
17 faster than some other specialties.

18           Of course, what they're including there is foreign  
19 medical grads who are coming into the system as primary care  
20 clinicians in large numbers. And I make this mistake often,  
21 I see the numbers on U.S. medical students choosing general  
22 internal medicine or family practice, and those numbers are

1 collapsing. But to some degree, the void is being filled by  
2 foreign medical grads, which raises a whole bunch of other  
3 issues including the impact on their home countries among  
4 them.

5 But strictly speaking, the total supply, including  
6 foreign grads, is stable to modestly increasing.

7 MS. BOCCUTI: Can I just mention one other thing  
8 with regard to that report? The other issue is you can be  
9 an internal medicine resident and go through the residency,  
10 and then subspecialized later. So there is some issues  
11 about looking at practicing primary care versus just  
12 residency selection. So we want to look at that a little  
13 further, too.

14 DR. DEAN: Just on that very point, I've had a  
15 conversation with the fellow that runs the general internal  
16 medicine residency at the University of South Dakota. And  
17 he made exactly that point, that most of his residents see  
18 it as a stepping stone.

19 So I think it's dangerous to count the people in  
20 training.

21 DR. MILSTEIN: I certainly support the first  
22 recommendation. I think it's a terrific idea. My metaphor

1 is this is not a Band-Aid, this is a tourniquet, given  
2 what's going on in the pipeline of primary care. And the  
3 evidence that if you want really good primary care for sick  
4 people, you have to make it a little bit more muscular than  
5 it is today.

6 I support the second point based on the point that  
7 Bill made, that is if you were to ever take apart what's  
8 currently going on in many primary care physicians' offices  
9 and ask for what percentage of the work activity do you need  
10 a physician, an M.D. degree, it would not be a pretty  
11 picture.

12 So that's why I support the general direction of  
13 the second recommendation because what we want to do is  
14 figure out how we incentivize and encourage physicians to  
15 figure out how to generate more health with less total  
16 spending, including substituting for their own labor when  
17 it's not really adding value -- which I think is Bill's  
18 point and I think a very valid one.

19 Let me now move to the second recommendation and  
20 say that I wholly support its directionality. But I would  
21 hope that we would consider substantially strengthening its  
22 content. I will just pick three things in particular that I

1 hope we might consider.

2           The first is use information technology. I know  
3 this is not the intent of it, but information technology has  
4 been used very effectively for physician billing for quite a  
5 while. I hope what we mean here is use information  
6 technology for those applications that have been shown to  
7 make a material difference in quality and efficiency. And I  
8 think the term of art for this is active clinical decision  
9 support. That's what the research suggests. Active  
10 clinical decision support supported by health IT generally  
11 both the numbers in the right direction on both quality and  
12 efficiency.

13           On the 24-hour patient communication and access, I  
14 hope that means rapid access. Because when you take apart  
15 delivery systems that are doing a great job on both  
16 efficiency and quality in the Medicare program, one of the  
17 things that they have done is they have won the patient's  
18 confidence that if you call, you're going to get a rapid  
19 call back from someone who knows about you. And so  
20 hopefully in the details we can spec that out.

21           And last but not least -- and this is the one I  
22 feel most strongly about -- has to do with the nature of the

1 rewards that we have in mind for these medical homes. My  
2 fear is that if we keep it pegged as low as the current  
3 recommendation, which is a quality only modest reward, it's  
4 under scaled to the nature of the problem we're trying to  
5 solve.

6           And so my view would be to unleash the creativity  
7 of physicians and nurse practitioners that are running these  
8 medical homes and model this closer, in terms of reward  
9 structure, on the physician group practice demo, where  
10 there's really no limit on the upside associated with  
11 knocking the ball out of the park on quality improvement and  
12 efficiency improvement.

13           And I think per our last discussion, we also would  
14 want to make some sort of a provision for substantial  
15 rewards for those that are already at the absolute top of  
16 the list, top decile on efficiency and quality, who may have  
17 a little bit less upside.

18           But I think the physician group practice demo is a  
19 terrific model for reward. I think what's exciting about it  
20 is it potentially generates some very substantial rewards  
21 for primary care physicians who are willing to take  
22 responsibility for the patients that are in their panel to

1 improve both quality and total spending over the course of a  
2 year.

3 MR. HACKBARTH: I want to flag this last issue and  
4 I hope we'll get some other people to react to it. When I  
5 talked to a few of you about how to structure the rewards  
6 for the medical home, I heard two broad schools of thought.  
7 One, which Arnie just stated.

8 A second was boy, you need to be really careful  
9 about strong rewards for reducing costs because the model  
10 starts to look too much like primary care capitation with  
11 gatekeepers of the 1990s, which did not always work out  
12 well.

13 And so I hear two different messages from  
14 commissioners. And so I'd like to hear more discussion of  
15 that issue.

16 DR. MILSTEIN: Can I clarify what my  
17 recommendation is? Because it's not to turn -- as we did 10  
18 years ago -- turn the physicians loose on -- primary care  
19 gatekeepers whose primary role was to lower costs.

20 I think what I have in mind was something closer  
21 to the physician group practice demo where, in order to  
22 generate substantial rewards, you have to move those quality

1 numbers up substantially.

2           It also raises, Glenn, something that we did not  
3 discuss but I think it's probably worth bringing out before  
4 somebody else does. It has to do with the denominator size  
5 for smaller practices. It's absolutely right, if we want to  
6 have some confidence when the numbers move that it's real  
7 and it's not statistical noise, it will be biased toward  
8 aggregations of primary care doctors rather than single  
9 physicians. But I don't think that's all bad.

10           DR. WOLTER: A few thoughts that I have are, and I  
11 know this will go against everyone's grain, but I wish we  
12 could do most of this in a way that's not budget neutral.  
13 The reason I say that is the budget neutrality thing is  
14 going to create some push back from many places, and I think  
15 there's ample literature that increasing the percentage of  
16 primary care tends to be associated with more efficiency and  
17 lower annual costs per beneficiary.

18           And just as a general thing, when we do every  
19 little niche project budget neutral, sometimes it gets in  
20 the way of the bigger picture being managed in a more cost-  
21 effective way.

22           So I do worry about the budget neutrality effect



1 on this project over time, because it's budget neutral only  
2 to this specific set of payments. It's not necessarily  
3 looking at what an investment in primary care might do in  
4 the big picture of serving the Medicare program.

5           And then the conversation earlier about the  
6 dollars going to all of the primary care E&M codes, you know  
7 that one list of specialists who do E&M codes, this is a  
8 little bit related to the point Bob made. Having  
9 administered physician compensation plans for many years  
10 now, and the scars that go with it, most of those  
11 specialists, in the work they do outside of those E&M codes,  
12 end up with incomes of 50 to 200 to 300 percent above  
13 primary care doctors at the end of the day because of the  
14 other types of work that they're able to do.

15           So I think we're on the right track to have this  
16 sort of two-triggered approach in terms of how we identify  
17 this if we really do want to target primary care for the  
18 reasons that have been discussed.

19           This clearly does not recognize some of the other  
20 workforce issues we have. I practice critical care. You  
21 can't find critical care doctors now to do the kind of work  
22 that's really critical, and sort of the generalist who

1 manages a critical care unit. And the same is true with  
2 general surgeons, as Karen would point out if she were here.

3 But I think we need to address those issues in a  
4 different place, perhaps. I think we're on the right track  
5 with this recommendation.

6 The RUC process has been talked about a lot as why  
7 are we where we are when we've just had a five-year review.  
8 One of the issues I have seen with that is when CMS went  
9 back and did the 10 percent neutrality adjustment after the  
10 five-year review was completed, the 10 percent plus  
11 reduction was applied it to the RVUs themselves, not to the  
12 conversion factor, which did make a difference to primary  
13 care reimbursement.

14 And it also made it impossibly difficult to manage  
15 that inside of a group practice. So that's kind of a detail  
16 below the 60,000 foot level but I wish we could ask CMS to  
17 change how they did that.

18 And then as far as the medical home goes, I think  
19 that there are some additional infrastructure skill sets  
20 that would be important. One is what you might call  
21 population management, where registries are created in these  
22 practices related to the patients who get enrolled with

1 their chronic diseases. So that you have a known  
2 denominator that you can manage to. And that does involve  
3 IT. There's no question about it, and clinical decision  
4 support.

5 I think the e-prescribing aspect of this could be  
6 an important early tool that could be important.

7 And then I know that the American College of  
8 Physicians has proposed some tiering in how they're thinking  
9 about medical home where some patients who are, relatively  
10 speaking, healthier receive coordination of care, preventive  
11 care, that sort of thing. And then the patients with the  
12 chronic diseases, there might be a payment per member per  
13 month that's at a different level. And we might think about  
14 that.

15 I do worry about what the amount of payment might  
16 need to be if we're asking for an infrastructure to  
17 carefully manage patients. And also, it needs to be said, a  
18 lot of the work of managing these multiple chronic disease  
19 payments really requires mid-level support so that you have  
20 nurses and others helping manage the patient between visits.  
21 And so that's another cost that somehow has to be looked at  
22 depending on the enrollment types of patients who go into

1 the medical home.

2 DR. DEAN: Obviously, this is a topic that is  
3 pretty near and dear to my heart. I guess anything that  
4 obviously supports or encourages primary care is something  
5 that I would see appealing.

6 Having said that, I have some skepticism about the  
7 approach of the modifier.

8 I think maybe we have some semantic issues. I  
9 think the thing that primary care, the value that primary  
10 care brings is care coordination. If that's the case -- I  
11 think I said earlier -- that really doesn't lend itself very  
12 well to a CPT structure. It's just hard to fit it into a  
13 CPT box. And so I think we may well need a different  
14 mechanism to recognize that.

15 I guess I would say, just as a picky point, it  
16 says that primary care is at risk of being undervalued. I  
17 think we've established pretty categorically, it is  
18 undervalued, and I'd like to see stronger language there.

19 And I think that one of the values of a care  
20 coordination payment that has not been mentioned, that you  
21 did bring up nicely in the paper, is the fact that a lot of  
22 these services do not require face to face contacts. In

1 fact, a lot of them it's a waste of time of both the  
2 physician and the patient to have a face-to-face contact.  
3 And yet that, given the current structure, is the only way  
4 that there's any reimbursement. And so I think that we need  
5 to look at ways to recognize services.

6 But at the same time I fully understand why that  
7 requirement is there, because you have to somehow verify  
8 that there really was a service provided.

9 MR. HACKBARTH: And this is one of the reasons,  
10 Tom, that I don't see these approaches as mutually  
11 exclusive. See, I see the medical home as the more direct  
12 approach to dealing with the care coordination and the  
13 importance of activities that currently don't have codes.

14 As Nancy has pointed out, another tact you can  
15 take is to expand the codes and offer billing opportunities  
16 for different services. But I worry that often those  
17 services just don't lend themselves to the fee-for-service  
18 mentality. They are best paid for on a per patient per  
19 month basis. Building all of the code infrastructure may  
20 not be the way to go.

21 So again, you've laid out the reasons why I think  
22 these are complementary approaches as opposed to mutually

1 exclusive approaches.

2 DR. DEAN: The issue with all the pipeline issue,  
3 I think certainly this would be a small step in the right  
4 direction. I think drawing people into primary care is a  
5 much more complex issue and it does have to do -- money is  
6 an issue. But we have major educational structure  
7 influences. We have perceptions of where does the primary  
8 care doc fit in the hierarchy of medical decision-making?  
9 Are we really just the kind of ones that take along after  
10 the specialists have made the decisions -- which I think is  
11 really not the case. And yet that's the perception.

12 We also have the perception that is frequently  
13 given to medical students that to be a family doc you have  
14 to know everything. And nobody can know everything and so  
15 you're foolish to try. Well, in fact, that's obviously not  
16 true. And yet we see that thinking evolving.

17 The University of South Dakota is, in their  
18 mission, a family practice oriented medical school. Well,  
19 everybody that comes in says they want to go into family  
20 practice. I mean, they're not stupid, they know what they  
21 have to do to get in.

22 [Laughter.]

1 DR. DEAN: And yet we see that commitment eroding  
2 as they move through the specialties.

3 We hear it from the specialists that say well, I  
4 know that what family docs do is good but I'm not smart  
5 enough to be a family doctor because I can't know all that  
6 stuff. And I want to deal with an area that I can really  
7 get my hands around and feel be comfortable with. And so we  
8 see that happening.

9 Plus, certainly money is an issue. There's no  
10 question about that.

11 But also, the ability to really have an active  
12 role in patient decision-making, I think, and to have some  
13 credibility within the whole medical hierarchy, is something  
14 that is a concern because people want to have the sense that  
15 what they're doing has some value.

16 So I think there's a lot of cultural issues.  
17 There's a lot of fear issues in terms of that I'm going to  
18 get in over my head and not able to do what needs to be  
19 done. It's a very complex issue.

20 Just a comment on the issue of access to  
21 specialists, which is a complicated issue. But it seemed to  
22 me that there would be a way to structure some financial

1 incentives that would allow the people that buy into the  
2 idea of entering a medical home would accept at least the  
3 fact that they would have to consult their primary care doc  
4 in order -- and not necessarily the primary care doc  
5 necessarily has to sign off on it.

6 But at least if we know that it happens -- and  
7 frequently they don't. They just go off and we find out  
8 later that they want to see the specialist for reasons that  
9 really made no sense at all. If we just had a chance at  
10 having some input, because I think we really do have to be  
11 afraid of the gatekeeper concept because that really got  
12 some negative press or some negative reception.

13 Finally, the last concern I have about the medical  
14 home from a rural point of view is that the criteria -- I  
15 think what we do in our little practice, we meet most of  
16 these criteria without half of those requirements for the  
17 extra personnel, and the extra things. And we can largely  
18 handle it because we're little.

19 And so I worry that, in fact, we're providing that  
20 service but we're not going to be able to meet the criteria  
21 that are set out for certification. And so I'm not sure  
22 what the solution is.



1           I think, Nick, you said there is a proposal for  
2 different tiers of medical homes and maybe that's a start.  
3 But I think that the issue, in the final analysis, is are  
4 you providing the service, not so much what the structure  
5 should be. But I don't know.

6           MR. BERTKO: So I'm going to say I'm a bigger  
7 supporter of the second part, the medical home case  
8 management fee type.

9           The first comment would be the good news here is  
10 this doesn't need to follow the other one. We've got, I  
11 think Cristina said but John didn't, what, 10 or 15 years in  
12 practice or something like this in Medicaid, as well as  
13 newer things out there. So if one were just to grab out  
14 that experience you could probably design one that would  
15 work reasonably well. It's not as if we're going off into  
16 the dark.

17           The stuff we're doing in the first alternative is  
18 new stuff.

19           Secondly, to address the incentives here, Tom  
20 mentioned it in one direction. I will tell you that from a  
21 lot of experience with plan design, as you might imagine,  
22 Part B premium reductions are nearly invisible. So I would

1 go in a different direction and I would keep it extremely  
2 simple. You can still go to a specialist that's not  
3 referred, but there's a \$20 copay for regular people and a  
4 \$5 copay for low income. And the \$5 co-pay is just about  
5 the same size as the \$3 brand copay, or \$3.50, whatever it  
6 is in 2008. So it's a really simple type of mechanism.

7           And believe me, copays in that sense work really  
8 well. This would be separate from anything that would  
9 happened with Medigap. You could have a Medigap policy that  
10 pays everything, but if you go to a specialist that's not  
11 referred or not connected the way Tom suggested, you pay the  
12 \$20 up front.

13           MR. HACKBARTH: So in effect what you've done is  
14 create a special flavor of Medigap for --

15           MR. BERTKO: No, I haven't changed any Medigap.  
16 You can have all the A through K --

17           MR. HACKBARTH: Well, to the extent that you're  
18 saying that copays can't be covered --

19           MR. BERTKO: Copay cannot be covered. That's all  
20 I'm saying.

21           MR. HACKBARTH: So there's special supplemental  
22 coverage rules for people who elect to enroll in the medical

1 home.

2 MR. BERTKO: So here comes the next part of it.  
3 Again, we need to have this happen as much as possible. So  
4 I would follow the Part B enrollment. Let it be an opt-out  
5 enrollment. You're in. You get several notices. Your  
6 physician, who is inferred, gets several notices. And you  
7 can leave anytime. You don't have to worry about a lock-in.  
8 But you would be into it until and unless you opt out of it.

9 The next point here is I particularly agree with,  
10 I think it was Tom, your point about -- maybe it was Nick's  
11 -- the budget impact here. Almost all of the research says  
12 greater use of primary care physicians leads to budget  
13 savings no matter what utilization says. It was a recent  
14 JAMA article I mentioned at lunch.

15 And then the very last one is we ought to be  
16 candid. The first alternative does promote primary care but  
17 it really says fix the RUC, and do it by specialty. Avoid  
18 the other crazy things that are happening with some  
19 specialists who still need this. Fix it as it should have  
20 been fixed for the last 15 years and compile all of that.

21 Sorry, you've heard that sermon before.

22 DR. KANE: First, I'm supportive of both proposals

1 and I'm hoping some practices can do both to start to make  
2 up for the financial disadvantages that primary care is at.

3 But I just wondered if we could explore a little  
4 bit how CMS or the fiscal intermediaries could support the  
5 medical home a little bit. So for instance, in hearing John  
6 talk about how hard it's been to get the data together for  
7 the pilot, it needs to be very clear that medical homes  
8 could really use some support from the fiscal intermediaries  
9 around the total package of services or the out-of-referral  
10 use, whatever we want to call it.

11 As Tom said, you don't know until afterwards, and  
12 sometimes you still don't know, that your beneficiary has  
13 gone outside of your circle of care.

14 So I think there's a real need for a really timely  
15 way to feed back what your beneficiary's use is across the  
16 whole episode or time period that you're caring for them.

17 The only place I can think of who can do that for  
18 you as the fiscal intermediary, unless you're in some kind  
19 of managed care arrangement.

20 I think the other piece of information that  
21 medical homes could really probably use to the benefit of  
22 Medicare generally is if we start to bundle A and B

1 payments. So you've got a patient you want to refer to a  
2 hospital for a blah, blah, blah. It might be really helpful  
3 to know where the Part A/B bundles are the most effective  
4 and best quality, rather than having the primary care guy  
5 try to guess. Have the primary people -- empower them with  
6 some of the information to manage his care better.

7           Then that goes to my point of it would be great to  
8 be able to reward the medical home not just for care  
9 coordination and for what they do themselves but for how  
10 well they manage the whole package. Certainly not capitulating  
11 them, but sharing savings if they manage to refer  
12 appropriately for inpatient care or follow up.

13           Across the whole episode of care, the primary care  
14 physician can have a huge impact. I know my group makes a  
15 lot of money just by avoiding ER use. And there should be  
16 some way to reward them for that, not just for what they do  
17 on the primary care side.

18           So I'm just saying try to empower them. I with  
19 all of us who think this is great, let's make it stronger.

20           But I think there's a lot that CMS and the fiscal  
21 interviews could do to make that a much more powerful  
22 experience so that we're not chasing after the information

1 without any way to do that.

2 MS. HANSEN: Probably three areas, and one of them  
3 will be related to a context.

4 I am supportive of the recommendations, the two  
5 segments of it, but with some substance that some people  
6 have identified.

7 One of the things, in terms of just going to page  
8 16 with the medical home component of it -- let me just  
9 backtrack.

10 The first recommendations are -- I guess Arnie's  
11 comment is put on the tourniquet. So I do see that as the  
12 first fix, per se. But the medical home is where I think  
13 the total promise may come in relative to some of these  
14 items here that maybe could be -- it's implied but maybe  
15 some further drill down, because I think we had some earlier  
16 conversation as to really what are we defining as primary  
17 care from the prevention kinds of things to the care  
18 coordination aspect.

19 And just to talk about a picky thing, I just  
20 wondered if the third bullet could be conducted care  
21 management rather than case management?

22 But with that whole piece of doing the medical

1 home, the budget neutrality component that I think Nick  
2 brought up, I also want to say that perhaps between the  
3 studies about primary care but whether or not, when you  
4 start a whole method that's somewhat different, it will cost  
5 more in the beginning. It's just like any kind of ROI.  
6 That it would perhaps not be forevermore but maybe just the  
7 commitment that in the beginning there would be some  
8 increased costs that we would expect in order to eventually  
9 get to that kind of efficiency.

10           So I don't know what the time factor is but I  
11 don't want to go in right off the bat saying it has to be  
12 budget neutral which oftentimes, in demos kind of kills the  
13 demo when they haven't had the time to really prove their  
14 effectiveness.

15           The other thing is two elements that I think  
16 about, and maybe this is implied in the health technology.  
17 It's just that pharmacology is such a big part of this,  
18 relative to the medical home. Because again, we're talking  
19 about complex individuals. We're not talking about the  
20 simple care management folks with one or two things of  
21 prevention. But when it comes to the complex areas that  
22 really the big dollars go with, the ability to make sure

1 that there is almost some geropharmacology that's built into  
2 that whole component of the medical home.

3 MS. BOCCUTI: Are you suggesting perhaps requiring  
4 like an annual medication review? Or are you saying to have  
5 somebody on staff that specializes in that?

6 MS. HANSEN: I think a medication review and  
7 reconciliation would be very helpful, since that's  
8 oftentimes what gets people in trouble relative to the  
9 issues of going into the ER, going into hospital care.

10 And then finally, the other element of medical  
11 home -- and maybe again it's implied but I think it needs to  
12 be maybe strengthened. All of the research that's been  
13 going on about care transitions, like post-hospital care,  
14 needs to be built into the accountability of a medical home.  
15 Because I think our data is that about one out of five  
16 Medicare beneficiaries per year enter a hospital.

17 So if that's the case, just knowing the odds of  
18 care transition issues will come up. And that's where the  
19 whole rehospitalization stuff comes in. So if the medical  
20 home is to really be truly effective as to what gets  
21 "bundled" into the medical home, but it's really about the  
22 managing of care, having a primary system. We're not



1 talking about what physicians they are or advanced nurse  
2 practitioners. So I'm not going there.

3 But it's just that this is the work that has to be  
4 done to really have an effective product of a medical home.  
5 And investing in it in the front end will cost more.

6 And then finally, another dimension of this that  
7 doesn't easily get reflected, just the complexity of  
8 cognitively impaired individuals. I brought that up before.

9 I don't know quite how to pinpoint it. I just  
10 know it's one of these things that kind of is an extra  
11 appendage hanging out there but has a real component of care  
12 coordination issues, cost issues, just the ability to figure  
13 out some way to do that.

14 My last point, which is something that -- I've  
15 started to learn that you've got to say things about six  
16 times, Nancy.

17 One of the things that strikes me with this, as we  
18 talk about medical home, let me bring it back to the patient  
19 or the consumer. Whether or not there is a way to -- in  
20 long-term care there's the example I've given -- there's the  
21 concept now that states' Medicaid have picked up relative to  
22 money follows the person.

1           So it's the idea of when you think of the  
2 chronicity of the individual, when they're not real frail  
3 they need prevention. But then, when they get really  
4 complex, there's a bundle of money that's like this little  
5 balloon traveling with this older person moving along.

6           If there's a way to figure out the cost of care  
7 over a period of time, depending on the kind of complexity  
8 they go into, whether they have a stroke suddenly, what's  
9 the added factor of cognition, for example, or mental  
10 illness? These are things that really drive up costs as  
11 well as coordination.

12           So I don't know if there's a way to track this of  
13 money follows the person, regardless of institutional  
14 structures. This has come up with some of the long-term  
15 care rehab facilities where when we looked at geographical  
16 maps in the past some places don't have that. But home  
17 health agencies still deal with it. So it's not the  
18 structure but it's really the profile of the individual.

19           So I don't know if there's any longitudinal way  
20 that we can follow the person clinically over time and just  
21 make sure that the money goes with them and that the medical  
22 home will do a lot more care coordination and geropharma

1 watching in a complex patients.

2 So it's a third thought that I have that's off the  
3 table but it's another way to do it other than thinking  
4 about these chunks because they're just bigger silos.

5 Thank you.

6 DR. CASTELLANOS: Most of the comments I wanted to  
7 make have already been made.

8 One is everybody's talking from the primary care  
9 doctor, how he feels about having patients seen by a  
10 specialist. Let me give you a specialist viewpoint, which I  
11 am. You saw on the slide, about 22 percent of my practice  
12 is primary care.

13 Quite honestly, of those 22 percent, a good 80 to  
14 90 percent of that could adequately be taken care of by a  
15 primary care doctor. What this does to my schedule, it  
16 busies my schedule up and it doesn't allow me to provide the  
17 urology care that I need to within my specialty. But a lot  
18 of times I see these patients because nobody else is  
19 available.

20 So I think from a specialty viewpoint sure, some  
21 of the specialists may get a little bent out of shape out of  
22 it. But I would rather have Tom call me, tell me what's

1 going on with the patient, let me evaluate it, and then send  
2 it back to Tom to manage. I think that's the appropriate  
3 way, and that's the cost-saving way of taking care of the  
4 patient.

5 As far as the recommendations go, I think we're  
6 going in the right direction and I really like that. And I  
7 support the recommendations or the directions we're going.

8 There's no question the medical home, in my  
9 opinion, is finally paying the primary care doctor for what  
10 he does. He's doing it already now. He's doing the  
11 coordination of care. He's doing the rectification of the  
12 medications. He's looking at the patient. He's looking at  
13 the social issues of the patient. He's dealing on all of  
14 these issues where, under our E&M codes, he's really unable  
15 to code for that.

16 And finally, on the medical home, I think he's  
17 finally able to do it. But it's also elevating him to a  
18 very prominent position within the medical community. He's  
19 a vital cog in the wheel. He really is. And without him,  
20 it doesn't work.

21 As we saw in our papers today, 95 percent of our  
22 patients want a primary care doctor or somebody who is going

1 to be captain of the ship.

2 As far as education, I really want to stress this  
3 again. We've talked about the pipeline. We've talked about  
4 education. In the papers that were given to me, on page  
5 three and page 12, there was some mention of it.

6 Again, you're focus is in the postgraduate  
7 training, which I think is important. But the decision to  
8 go into a specialty by the physician in medical school is  
9 done in the second or third year of medical school. So if  
10 you're going to waste your money and time talking about  
11 trying to get people into that field after their medical  
12 school graduation, you're going to miss the bus.

13 So you really have to stress this. This is part  
14 of the same thing, as we've talked about it. Right from the  
15 get-go, right in the beginning of medical school, stress  
16 some of the important issues that we're trying to talk about  
17 here.

18 I could spend a lot of time doing that, but I've  
19 said so much about it before.

20 And the final thing is paying this out of -- I  
21 think we ought to think about how we're going to pay for  
22 this. Obviously, the buzz word in Washington is budget

1 neutral, and everybody agrees it's easier to do it that way.  
2 But what this does, it doesn't provide the new money that's  
3 necessary to establish these medical homes.

4           There's going to be some savings. Perhaps it can  
5 be paid out of savings. Perhaps it can be paid out of new  
6 money. By doing it in a budget neutral basis, you're going  
7 to get a little bit of a backlash from the other non-primary  
8 care doctors. And what you're going to find out is  
9 everybody's going to want to be defined as a primary care  
10 doctor now. The OB/GYNs already say they're primary care  
11 for the female. The urologists, they say they're primary  
12 care for the male.

13           So I think we're going to have to really look at  
14 how we're paying for this and not always just consider  
15 taking out budget neutrality.

16           MR. HACKBARTH: We're going to have to move ahead,  
17 Arnie. I just want to quickly touch on two things.

18           The first is the budget neutrality issue. As I  
19 recall the papers, the first option, the conversion factor  
20 bonus, was explicitly presented as a budget neutral option.  
21 My recollection is that the medical home option was not  
22 presented as budget neutral.

1 MS. BOCCUTI: As a pilot.

2 MR. HACKBARTH: Right. And let me just briefly  
3 talk through the reasoning there.

4 The conversion factor bonus, as I said, can be  
5 presented with different rationales. The paper focused on  
6 making up for the passive devaluation that's happened in the  
7 past. So it's making up for deficiencies in the RUC  
8 process. We all agree the RUC process needs to be fixed  
9 going forward. But the fact is there's been under payment  
10 in the past and that could be how you set the value of the  
11 conversion factor.

12 If you're making up for chronic under valuation of  
13 primary care through the RUC process, I think it's a logical  
14 step to say well, that money ought to be financed by the  
15 people who were overpaid through the RUC process. So I  
16 think there's a plausible budget neutrality rationale there.  
17 We can discuss it further but that was, I think, the  
18 thinking here.

19 As for the medical home, this is a pilot. There  
20 are going to be certain up front type costs, for example for  
21 the lump some payments, that are clearly going to add money.  
22 They are payments over and above the existing fee schedule.

1 Now what you're testing in the pilot is whether, in fact,  
2 that money will be offset by savings and specialty consults  
3 and unnecessary hospitalizations avoided, et cetera. Don't  
4 know the outcome, but that's what you're testing.

5           So there, I think, it is plausible to incur some  
6 up front costs as part of the task of exploring a new  
7 option.

8           Now one of the things that we'd have to grapple  
9 with for next time on a final recommendation is how much up  
10 front costs we contemplate. Because one of the things that  
11 will happen with this is that CBO will score it if it  
12 becomes a legislative proposal. It would be helpful for us  
13 to not just throw it out there and say score it whatever you  
14 think but try to give them more concrete parameters on what  
15 we think we are undertaking. So there will be more on the  
16 cost of the pilot next time.

17           Last issue, before we move on. In this discussion  
18 we haven't talked about pilot versus demo at all. That came  
19 up this morning in the context of bundling.

20           There's been some turnover in the audience. So  
21 for the benefit of the audience, I just want to say a word  
22 about why this is characterized as a pilot, as opposed to a



1 demo, especially inasmuch as there is now a demo mandated by  
2 statute now under development in CMS. People may say why  
3 are they even talking about a medical home pilot.

4           The use of the term pilot signifies, for me at  
5 least, a couple of things. One is a statement about scale.  
6 A pilot, to me, connotes a larger scale than a demo.  
7 Although, as Bill pointed out this morning, there are some  
8 demos that involve a great deal of money these days. But  
9 that's part of the statement, pilot, large scale.

10           The reason I think that is important or the  
11 Commission may want to consider that, is large enough scale  
12 to find results quickly. Whether they are results for  
13 better or for worse, I think we need to accelerate the  
14 process by which we test ideas -- seemingly good ideas --  
15 and decide whether they can contribute to the program.

16           The second part of a pilot is that lay out  
17 parameters in advance of what constitutes success and be  
18 real concrete about those. And if the pilot is successful,  
19 allow the Department to go ahead and implement, in this  
20 case, the medical home idea as a regular part of the program  
21 without going back through the legislative process.

22           So when I use pilot and we character this draft

1 recommendation as pilot, it's those two points that we're  
2 trying to drive home, scale and no need to go back through  
3 the legislative process if it works.

4 Now Bill laid out, as always, a series of well  
5 thought arguments about why you should be careful about  
6 going down the pilot approach. We don't have the time to go  
7 through all of that again this afternoon, but I wanted to be  
8 clear as to why we were characterizing this as a pilot.

9 DR. SCANLON: If I remember right though, in terms  
10 of scale there was a provision in the CHAMP Act to expand  
11 the scale of the medical demo without making it a pilot.

12 MR. HACKBARTH: Yes. In fact, the CHAMP Act,  
13 which of course was not enacted -- it passed the House but  
14 not the Senate -- provided for tripling the size of the  
15 TRHCA , at least in dollar terms, of \$100 billion to \$300  
16 million; correct?

17 MS. BOCCUTI: That's how it was scored. That  
18 wasn't, I don't think, in legislation to triple it. But as  
19 CBO looked at the way the designed CHAMP, it would have  
20 effectively -- that's how they determined that it would be  
21 implemented.

22 MR. HACKBARTH: Thanks.

1           Okay, we are going to move on now to Part D and  
2 performance measures.

3           Thank you all, Cristina, Kevin, John.

4           DR. SOKOLOVSKY: Good afternoon.

5           Drug plans provided benefits in 2007 to more than  
6 24 million Medicare beneficiaries at a cost of nearly \$50  
7 billion. But policymakers have limited information to  
8 evaluate how well the plans are performing.

9           In the period leading up to implementation of the  
10 drug benefit, the Commission conducted a number of studies  
11 to find out private payers managed and evaluated their drug  
12 benefits. As part of that process, we held an expert panel  
13 to see how experts in the field considered drug plan  
14 performance.

15           Last month, working with contractors from NORC and  
16 Georgetown University, we convened another expert panel to  
17 see how perspectives had changed over the last two years and  
18 identify ways to measure plan performance over time. The  
19 panel was composed of researchers, plan representatives,  
20 pharmacists, beneficiary counselors, and large private  
21 payers.

22           The panel didn't come to a consensus but discussed

1 the advantages and disadvantages of different measures.

2 We also conducted focus groups in three cities  
3 during the summer and at each site we met with groups of  
4 beneficiaries, groups of physicians, and pharmacists. In  
5 this presentation, we'd like to share the results of these  
6 efforts and have your ideas on how to evaluate Part D. We  
7 also have two draft recommendations for your consideration.

8 Our expert panel discussed the need for measures  
9 to evaluate how well plans meet costs, access, quality, and  
10 customer satisfaction objectives. Most of the measures  
11 discussed by the panel can be collected from data that the  
12 plans already submit to CMS. This is data that is either on  
13 the CMS plan finder website, in quarterly reports that plans  
14 submit to the agency, or in claims data. However, the panel  
15 had most difficulty conceptualizing performance measures  
16 that would adequately capture how well plans provide access  
17 to needed medications, and how well they meet clinical  
18 quality goals. In these areas, the panel had ideas but no  
19 real measures.

20 Physicians and pharmacists in our focus groups  
21 stressed that poor communication between plans, pharmacists,  
22 and physicians could result in delays before beneficiaries

1 receive needed medications. More standardized messaging  
2 between the plans and the pharmacists could reduce  
3 administrative costs for providers and improve beneficiary  
4 access.

5           The CMS plan finder contains lots of information  
6 for beneficiaries to use when selecting plans. It provides  
7 composite performance measures of drug pricing information,  
8 ease of using the drug benefit, and customer service. Plans  
9 received from one to five stars for each measure.

10           Panelists like the star format, but they had  
11 concerns about how well the measures were calculated. They  
12 felt that some of the composite measures did not capture the  
13 dimensions of access, quality, and customer satisfaction  
14 that were most important to consumers.

15           The website, by the way, has lots of other  
16 information. It includes plan premiums, network pharmacies,  
17 and estimated out-of-pocket costs for beneficiaries who have  
18 specific medical conditions or health status. Beneficiaries  
19 can also enter the names of the drugs they are currently  
20 taking and see which plans cover them.

21           Panelists believe that beneficiaries really need  
22 just a small number of easy to understand measures and that

1 would be most helpful in choosing a plan. But they did  
2 agree that a broader set of measures was necessary to help  
3 policymakers monitor plan performance.

4 A good measure should be validated to see that it  
5 actually measures the broader concept. It should be able to  
6 differentiate performance among plans. And finally, people  
7 should be able to understand how the measure was calculated.

8 Many measures discussed by the expert panel could  
9 be calculated from data already collected by CMS but the  
10 panel didn't believe that current data was sufficient to  
11 measure access and quality performance goals.

12 Beneficiaries in our focus group, as well as in  
13 the published literature, list cost as the most important  
14 factor in determining their choice of plans. They said that  
15 Part D has made prescription drugs more affordable and most  
16 report saving money. Some physicians also noted that their  
17 patients were more likely to fill prescriptions now that  
18 they have drug coverage.

19 Although plan premiums may not typically be  
20 considered as a performance measure, several of the  
21 panelists stated that the premium was the summary cost  
22 measure and was most relevant for beneficiaries and the

1 Medicare program to use in judging plan performance.

2           Other panelists thought that beneficiaries would  
3 find an estimate of typical out-of-pocket costs for people  
4 with specific medical conditions helpful. But they did  
5 caution that it would be difficult to construct such a  
6 measure. For most conditions there are a variety of drug  
7 regimens that a physician might prescribe. A particular  
8 regimen of drugs may be more expensive in one plan than  
9 another but a different drug regimen may lead to the  
10 opposite results.

11           We are continuing to think through a type of  
12 measure that could be developed and would appreciate any  
13 ideas you might have on this.

14           Panelists suggested that a measure of generic  
15 utilization was an important sign of the value that  
16 beneficiaries and taxpayers were receiving from their plans.  
17 Evidence indicates that most plans rapidly shift utilization  
18 from a branded drug when a generic variety becomes  
19 available. The Pharmacy Quality Alliance, an association of  
20 different stakeholders which is meeting to determine quality  
21 measures, found that measure of generic utilization was not  
22 a good performance measure because, in fact, the rate of

1 generic efficiency was very high and there was little  
2 variation among plans.

3           However, panelists pointed out that high levels of  
4 generic utilization may actually have unanticipated  
5 consequences for some beneficiaries. By law, beneficiary  
6 cost-sharing is set at an average of 25 percent of total  
7 costs. Plan representatives told us that plans with  
8 particularly high levels of generic utilization may have to  
9 raise copayments for more expensive branded drugs in order  
10 to meet statutory requirements. As a result, beneficiaries  
11 who require these drugs may end up actually with higher out-  
12 of-pocket costs. This is an issue that the Commission may  
13 wish to examine in greater detail in the future.

14           Panelists believe that it is very difficult to  
15 accurately measure access to needed drugs. For example, if  
16 you just count the number of drugs listed on a plan's  
17 formulary it won't really be a measure of access. It  
18 wouldn't tell you whether the drugs are readily available or  
19 if they're restricted by high cost-sharing or management  
20 techniques like prior authorization.

21           Some ideas for measuring access were discussed.  
22 One possibility is to measure the share of prescriptions



1 delayed at the point of sale. One plan representative noted  
2 that although plans do not currently submit this data to  
3 CMS, they could do so.

4 Some panelists thought that such a measure would  
5 have the potential to show variation in access among plans.  
6 However, they cautioned that this measure has to be able to  
7 distinguish between delays that are due to actual barriers  
8 and not things like beneficiaries failing to pick up a  
9 prescription.

10 Other measures of this type could include looking  
11 at what eventually happens at the point-of-sale. For  
12 example, is the prescription filled as it was written? Is  
13 it filled with an alternative drug? Is it paid for by the  
14 beneficiary out-of-pocket? Or never filled at all? Again,  
15 lots of ideas but no one really had an idea of how to do  
16 this, even though they essentially that this was one of the  
17 most important ways of measuring plans.

18 This leads to draft recommendation one. The  
19 Secretary should develop a measure of beneficiary access  
20 that calculates whether beneficiaries get a prescribed drug  
21 or its alternative without undue delay.

22 This recommendation we don't think would have

1 spending implications but we haven't yet been able to verify  
2 that. If plans are rated on this measure it may improve  
3 beneficiary access. Plan reporting costs may increase  
4 somewhat.

5           The implication here is that we need to have a  
6 much better way of knowing whether plans differ in providing  
7 access to beneficiaries for their needed medications. And  
8 if they do, why. We expect to continue working on this  
9 issue and would appreciate any suggestions you might have.

10           Many physicians in our focus groups said that Part  
11 D has affected their prescribing patterns. They were  
12 generally willing to prescribe generic drugs and prescribe  
13 drugs that they think are most likely to be covered by most  
14 plans. But if a drug is not approved by the plan, it can  
15 result in considerable time for the physician and the office  
16 staff, whether changing a prescription, filling out a prior  
17 authorization, or making the case for an exception. Many  
18 said that they will only do this when it would be clinically  
19 unjustified to substitute one drug for another. For  
20 example, physicians routinely told us they wouldn't switch a  
21 patient that's stabilized on one mental health drug for  
22 another drug.

1           So they try to learn from the pharmacist which  
2 drug will be approved without additional paperwork.  
3 However, the pharmacists told us that, in fact, plan  
4 messaging does not always identify alternative drugs or say  
5 why drug has been denied. One gastroenterologist in our  
6 focus group really give a very dramatic example of this. He  
7 said that there are five proton pump inhibitors that he  
8 prescribes, that he can give his patients with a particular  
9 kind of gastric problem. Each plan will have one of these  
10 drugs on their preferred list. So he has taken to writing  
11 five prescriptions for each patient and tells them to take  
12 it to the pharmacy and just keep submitting them until one  
13 is accepted.

14           When a plan does not provide needed information to  
15 the pharmacist, delays will result. The pharmacist may go  
16 back and forth with the plan and the physician submitting  
17 alternative drugs until one of them accepted. And sometimes  
18 the problem may not be that it's the wrong drug but that the  
19 plan feels that the quantity prescribed is too high.

20           Now our impression -- and of course there is no  
21 data on this -- our impression was that most plans do  
22 provide information. But when a plan doesn't provide it, it

1 takes a disproportionate amount of time to handle it.

2           Pharmacists tell us that even in the easiest  
3 situation, where the plan tells the pharmacist the approved  
4 drug and the doctor switches the prescription, the script is  
5 rarely dispensed on the same day. Most cases are resolved  
6 within a few days so the beneficiary has maybe a modest  
7 delay in getting his or her prescription filled. But in  
8 unresolved cases beneficiaries may pay full price or not get  
9 the drug at all.

10           So draft recommendation two says the Secretary  
11 should require plans to include information to pharmacists  
12 when they reject a prescription, telling them why the drug  
13 is not covered and if an alternative would be accepted.

14           This recommendation, again, we don't think should  
15 affect spending, but we have not confirmed this. It should  
16 increase the timeliness of beneficiary access and reduce  
17 administrative costs for both physicians and pharmacists.

18           E-prescribing may resolve many of these issues  
19 eventually but it's hard to estimate how much time it will  
20 take before e-prescribing becomes a regular part of clinical  
21 practice. And again, if the necessary information is not  
22 being transmitted to the pharmacist, it may not be

1 transmitted to the physician either.

2 CMS doesn't currently provide clinical quality  
3 performance measures for PDPs, and the development of such  
4 measures is still very much in a formative state. Finding  
5 meaningful measures to evaluate the quality of  
6 pharmaceutical care for Medicare beneficiaries is hampered  
7 in part because there are no evidence-based guidelines to  
8 evaluate drug regimens for older individuals with multiple  
9 comorbidities. If drug claims were linked to other Medicare  
10 claims data, we might in fact begin to construct an  
11 evidence-base for quality pharmaceutical care.

12 Panelists and quality organizations like the  
13 Pharmacy Quality Alliance favor measures that seem to focus  
14 on patient adherence to drug regimens. They note that --  
15 and this is the Pharmacy Quality Alliance. They say that  
16 for every 100 prescriptions, only 15 to 20 are refilled as  
17 prescribed.

18 Plan patient adherence activities could involve  
19 things like contacting patients taking drugs for chronic  
20 conditions who have not refilled their prescriptions and  
21 reminding them to do so. However, panels pointed out that  
22 incentives under Part D may be misaligned for PDPs to

1 encourage patient adherence. Plan administrative costs  
2 would increase if they contacted patients or their  
3 physicians and they would bear the risk of increased  
4 utilization. Further, unlike MA plans, they wouldn't  
5 benefit if increased endurance lead to reduced medical  
6 costs.

7           Lastly, CMS uses the CAHPS survey to assess  
8 overall beneficiary ratings of drug plans and how helpful  
9 the plans are when the beneficiary needs information. Panel  
10 participants found existing CAHPS rating measures difficult,  
11 since all of the national plans get the same two stars for  
12 overall customer satisfaction, which is unlikely to be  
13 useful to beneficiaries. And the plans told us they were  
14 concerned because they had no idea how these measures were  
15 calculated.

16           CMS also provides performance measures related to  
17 plan call centers. Current measures here rate beneficiary  
18 waiting times and the percentage of calls that are  
19 disconnected before the caller reaches a customer  
20 representative. Panelists believe that these were important  
21 measures for consumers.

22           CMS doesn't collect data on physician or

1 pharmacist satisfaction with particular plans. A survey of  
2 providers might be very useful in getting at some of these  
3 issues.

4 Now I await your comments, particularly on the  
5 draft recommendations.

6 MR. BERTKO: I've got a bunch of questions and  
7 comments. And Joan, please don't think I'm shooting the  
8 messenger on this one. When I read it, I said your focus  
9 groups are all over the place. So a couple of comments to  
10 start with.

11 Could you go back to your second recommendation,  
12 the messaging one? To the best of my recollection, and only  
13 from a couple of plans, the messaging that comes back to the  
14 pharmacist runs through the credit card VISA messaging  
15 system, and that is quite limited. So I forget the exact  
16 number of characters you can have, whether it's 20 or 40.  
17 It's like when you're sending a message off in a block to  
18 somebody when you have a response.

19 You may need to actually investigate a little bit  
20 more the size of this, whether most of the plans use it --  
21 which I think they do, because they use similar formats;  
22 whether there are standard codes, because that could

1 eliminate a whole bunch of it in terms of rejected because.  
2 And then what's left there to spit out the alternative  
3 drugs.

4 Comment number two, the GI example. I am stunned  
5 at that. I went to a little family practice plan. The guy  
6 pulled out his handheld and says oh, you're under the  
7 BlueCross formulary now. Dink. Here is what I can  
8 prescribe for you.

9 Writing five scripts seems -- this is not e-  
10 prescribing. This is you plug your handheld into your  
11 computer and it downloads the scripts you have. Did you  
12 guys cover anything like that?

13 DR. SOKOLOVSKY: Yes.

14 MR. BERTKO: What did they say?

15 DR. SOKOLOVSKY: First, I should say that there  
16 was another gastroenterologist in the same focus group and  
17 he said I wasn't going to say anything but I do the same  
18 thing.

19 MR. BERTKO: Write five scripts?

20 DR. SOKOLOVSKY: Yes.

21 MR. BERTKO: You're kidding.

22 DR. SOKOLOVSKY: But the other thing was that we



1 did have one physician -- and only one physician as I recall  
2 -- in any of the focus groups who was using Hippocrates.  
3 And he said it was not always accurate, that sometimes you  
4 had -- because plans consolidated, you would find the wrong  
5 PBM listed, the drug that they would list as being covered  
6 by that plan wasn't being covered by that plan.

7 MR. BERTKO: I'll ask maybe our physicians and see  
8 whether they use it or not.

9 Another separate point here, you made a statement  
10 which I think is true but not complete. And that was that  
11 the 25 percent coinsurance has to be balanced out. And that  
12 is a true statement for what I would describe as the defined  
13 standard plan.

14 However, you can avoid that just by calling an  
15 enhanced plan. Generally, the charge on it is a little bit  
16 different but sometimes not substantially more. And so if  
17 you wanted one with lots of cheap generics and a relatively  
18 low copay, something under the 25 percent, you can buy it  
19 for a couple of bucks more.

20 You find out by looking on the plan finder.

21 That's another thing here, which is my other  
22 comment, which is beneficiary responsibility. Access on

1 here from your write up and from what I think I heard today,  
2 is extremely hard to define. I don't think you had anybody  
3 define it.

4           And my comment also is that the beneficiary  
5 population is really heterogeneous. You've got people who  
6 use almost no drugs. You've got people that use the common  
7 drugs, the vast majority. And then you've got folks who  
8 have either high costs or need very specific drugs.

9           And so can you have a single one through five star  
10 mechanism that does that? I would find that impossible,  
11 perhaps, to determine but instead having a grid -- take  
12 common conditions, 10 conditions, and then what's the access  
13 for each of these conditions, for a diabetic, for a person  
14 with cardiac conditions, et cetera. Because otherwise you  
15 get this thing which doesn't seem to be able to work right  
16 for anybody.

17           Again, I'd go back there -- I'm not even sure that  
18 that's an answer to it, but defining access seems to be  
19 extremely difficult.

20           And you get back to, like somebody mentioned  
21 earlier, the USA Today article with people asking for drugs.  
22 Access to drugs they may not need shouldn't be conflated

1 with access to drugs they do need. And that one, I think,  
2 is extremely difficult to tear apart.

3 But it is something that when you're describing  
4 access, you shouldn't say this plan -- I'll take Jay's plan  
5 with a fairly tight formulary. Is this a bad plan because  
6 he doesn't serve the XYZ drug? I don't think so. Whereas  
7 I'm almost sure it's on the plan that I used to work with.

8 DR. MILLER: But John, that's exactly the point is  
9 when she held this expert panel the complaint among the  
10 plans were you look at Jay's plan and you say this is a bad  
11 plan because it doesn't offer a gazillion drugs, whereas the  
12 other plans have more drugs -- and Joan, I'll get all this  
13 wrong -- there's tiers, there is specialty tiers, there may  
14 be prior auth. And the actual plans were saying this isn't  
15 fair.

16 MR. BERTKO: Yes, that's right.

17 DR. MILLER: So I get your point that they were  
18 saying this is a problem, they didn't have a specific  
19 measure. But what they were asking us and asking CMS is to  
20 devote resources to try and break this concept down, I think  
21 is what Joan is up to here.

22 MR. BERTKO: I was trying to say that.

1           In fact, you prompted something else, which is the  
2 last part of access to drugs, which you kind of got to but  
3 I'm not sure you said specifically, is what are the  
4 utilization review limitations on various drugs? And  
5 different plans have different -- whether it's step therapy  
6 or quantity limits or prior authorization. I think you can  
7 get to three or four major categories and then it may need  
8 to become by drug.

9           I haven't looked at plan finder for a long time  
10 but supposedly some -- but probably not enough of that -- is  
11 there. And maybe that would be some useful comments.

12           MS. HANSEN: I think, Joan, you're asking us for  
13 some input. I actually still am, unfortunately, a little  
14 confused about this whole thing that when I just asked you  
15 for clarification about when there are no generics and you  
16 have to use a brand name and then the 25 percent is really  
17 significant, and that there's some discrepancies of the  
18 plans.

19           So I guess I just would appreciate some  
20 understanding better. And maybe I just didn't even get it  
21 when you were trying to explain that, too.

22           So I guess the bottom line is how do we get

1 through some of the inconsistencies, I guess, is the bottom  
2 line, that we can help address by this question?

3 DR. SOKOLOVSKY: I'm not sure I understand your  
4 question. Are you asking me to explain the tiering system  
5 and how it works?

6 MS. HANSEN: I think it's almost trying to figure  
7 out, from a beneficiary point of view, how do they get a  
8 solution for what they really need without an unfairness  
9 built in to the issue of the cost-sharing in some cases  
10 because of this artifact of generics, vis-a-vis the brand  
11 and the statutory issue that you brought up? How do we get  
12 a solution for the beneficiary that's more consistently  
13 fair?

14 DR. SOKOLOVSKY: I don't know if we have a real  
15 good answer to that. If somebody is capable of going  
16 through the plan finder and putting in their drugs, they can  
17 find the best solution that they can find.

18 When we did earlier work on this, we found that  
19 only 11 percent of beneficiaries either used it to  
20 themselves or had somebody helping them use the plan finder.  
21 This may change as more of the baby boom generation ages  
22 into Medicare. But right now it is a problem. And the

1 specialty tier, which now virtually all plans have, you  
2 can't put a drug on the specialty tier unless it's at least  
3 \$600. But if it is, then it's coinsurance, not a copay  
4 there. It can be 25 percent but we have seen instances of  
5 over 30 percent for coinsurance there.

6 And people who are taking those drugs, not all  
7 necessarily but many of them, may be people who are  
8 extremely ill and there is no alternative for them.

9 MR. EBELER: Thank you for the chapter and the  
10 presentation. I think the recommendations do go in the  
11 right way.

12 I think we have to take head-on this question that  
13 you alluded to in your presentation and mentioned in the  
14 chapter, where the comment is reporting on access and  
15 quality. And, in effect, using technology to reach out to  
16 beneficiaries to fill scripts is counter to the incentives  
17 of the plan. That is the reason why you have public  
18 reporting, not why you don't have public reporting.

19 It just strikes me that it is critical to get  
20 those kinds of data on the table. We clearly need a clearly  
21 defined access measure. But on the quality measures as  
22 well, it just strikes me the logic has to be reversed there.

1 You have public reporting to give you a mechanism to assess  
2 against whatever financial incentives you have.

3 And second, I just think that Part D only plans,  
4 as well as the MA plans, just need to sort of in this  
5 public-private partnership work with the public sector to  
6 reach out and create that kind of appropriate access, not  
7 fight against it. It just strikes me that's a critical  
8 reporting element.

9 DR. STUART: Thank you, Joan.

10 I read this with interest and I came to the  
11 recommendations, which actually were not in the chapter that  
12 we saw. So I'm seeing these for the first time.

13 I guess I'm not surprised that the expert panel  
14 was confused about this because they're looking for a way to  
15 link performance measures to the PDP scope of work. And the  
16 PDP scope of work is really narrow here.

17 I mean what you'd really like a drug plan to do --  
18 let's be honest. You'd want to make sure the beneficiaries  
19 get needed medications. You want to make sure that the  
20 medications are managed well. And you want to check to see  
21 whether you get the outcomes that you would expect to get  
22 from good medication management. And none of that is here.

1 And so you look at this.

2 Well all know how Part D came about -- well, maybe  
3 not. In a dark room.

4 But if you were to come into this particular  
5 session right now without having any background at all about  
6 Part D, and you look at these recommendations, you'd say  
7 boy, this is really thin gruel. I'd like to see something  
8 that goes a little bit beyond this.

9 I don't have the answer in terms of what the  
10 quality measure ought to be. But by golly, there should be  
11 a broad-based evaluation of Part D, and particularly of the  
12 standalone PDPs. I think the Commission ought to be behind  
13 that and say look, this is something that costs us \$40  
14 billion to \$50 billion a year now. And we're going to  
15 evaluate it by whether there's a transmission of rejected  
16 claims? We need something more than that. And I think we  
17 ought to go on record as having something more than that.

18 DR. CROSSON: Joan, thank you for your usual high  
19 quality work. I had one question and then I think a comment  
20 similar to Bruce's.

21 The question is in terms of the search for an  
22 access measure. One of the things I wondered was might not



1 the best or simplest way to do it anyway would be to just  
2 ask people? So that in the survey process -- I don't know  
3 all of the questions -- but I wonder if the focus group  
4 talked about simply asking and recording the frequency with  
5 which beneficiaries listed failure of access as a problem or  
6 as a reason to switch plans. So that would be the first  
7 question.

8 DR. SOKOLOVSKY: I would say that in every group  
9 we heard somebody had this issue but mostly people were  
10 satisfied. So if we had a group of 12 people, there was  
11 going to be at least one person, maybe two people, who had a  
12 problem of people who switched plans because of that kind of  
13 problem. But the others would not have had that problem.

14 DR. CROSSON: Right. But what I was saying was  
15 the question was there was no recommendation from the focus  
16 group as to how to measure access. So my question was could  
17 you not simply measure it by recording, in some way, the  
18 frequency for each plan, the frequency of individuals who  
19 listed failure of access and ranked the plans accordingly?

20 The second point, it's a little along the lines of  
21 Bruce's comment, and it has do with the issue of adherence.  
22 I just think that that's an issue that is so much more

1 important than many of us realize, that it's going to be an  
2 area that we would like to -- I don't know if we're ready a  
3 for recommendation on making that part of the quality  
4 assessment yet.

5           We had a very interesting experience and somewhat  
6 humbling experience in our Colorado region right after the  
7 rollout of our clinical information system. One of the  
8 service improvements that we thought we would get by this  
9 was to decrease patient waiting time in the pharmacy. So  
10 that as the physician records the prescription in the  
11 medical record, it automatically goes to the pharmacies --  
12 and ours are, for the most part, onsite. By the time the  
13 patient is finished with the visit, gets dressed, gets down  
14 to the pharmacy, the notion was the drug would be ready in a  
15 bag and they'd just pick it up and pop down their modest  
16 copayment and be off.

17           After about two weeks the pharmacy manager called  
18 up the medical director and said would you mind coming down  
19 here, I have something to show you. And in fact, there was  
20 an entire storeroom filled with bags that had not been  
21 picked up. And this is in the setting where the individual  
22 only had to walk downstairs in most cases, and in the face

1 of rather nominal copayments.

2           Within this problem of adherence and adherence to  
3 recommended refills, there's a range. If somebody decides  
4 that they'd rather not pay for a drug for their hay fever,  
5 that's one thing. But if people are not, in fact, picking  
6 up their antihypertensive agents and then coming back two  
7 months later with still elevated blood pressure and then put  
8 on a second prescription, you end up with rather  
9 dysfunctional care.

10           So we have a lot of work to do with this. I would  
11 suspect that since the nominal purpose of the Part D drug  
12 benefit was to try to add coverage for pharmaceuticals in  
13 order to provide a comprehensive package of benefits that  
14 would work together for the overall welfare of the  
15 beneficiaries, that leaving out or not addressing the  
16 question of whether, in fact, the people are actually taking  
17 the drugs for at least specified medical conditions where we  
18 know that the drug is effective and it has long-term health  
19 benefits and it has long-term impacts even on the cost for  
20 beneficiaries and for the Medicare plan would be a fruitful  
21 area of work.

22           MS. BEHROOZI: Joan, as complicated as a lot of

1 the stuff is that we've been talking about today, I feel  
2 like you got stuck with the hardest job because I feel like  
3 everything I want to say comes back down to it's such a  
4 fragmented delivery system. We're talking about quality  
5 when we're just talking about a payer when you're talking  
6 about PDPs, right? I mean, they're not really plans,  
7 they're just a way of covering the cost of drugs for  
8 beneficiaries. So what can our expectations be of them?

9 We should be able to have expectations about  
10 people's treatment; right? But holding each of these  
11 entities along the continuum separately responsible for the  
12 whole picture just doesn't work.

13 Anyway, thank you for the work you put into it.  
14 But I don't know what to say about the whole thing except to  
15 say obviously there are fundamental flaws with Part D and  
16 that's just one of the dimensions of those flaws, the  
17 fragmented nature of it and how it perpetuates misalignment  
18 of incentives and things like that.

19 I just wanted to say one thing about draft  
20 recommendation two. So we pay for people's drugs, both on  
21 the active employee side and on the retiree side. We're  
22 neither a PDP or an MA-PD. We receive the employer subsidy.

1 But we do that, we transmit -- well, we don't. Our PBM, we  
2 instruct our PBM to do the messaging to the pharmacist. The  
3 PBM says okay, we've done that. The members come to us and  
4 say how come I had to pay a copay for a drug that you said  
5 was free? So we go back to the PBM and we say what does  
6 your messaging say? And I don't know, John, enough about  
7 the technicalities of exactly how the message is  
8 transmitted. But they tell us this is what it says. It  
9 says you are covered in full for X drug.

10 The pharmacist isn't reading it off the screen to  
11 the beneficiary, to our beneficiary, to our member when  
12 they're standing there. That's not in all cases. Again, it  
13 highlights, I guess, the fragmented nature of it.

14 Just to have the plans or the PBMs they're using  
15 transmit the information to the pharmacies doesn't  
16 necessarily mean that the beneficiary or the physician gets  
17 the accurate information. It's certainly a good thing to  
18 have the plans do but maybe it's a little along the lines of  
19 what Bruce is saying. It doesn't quite go to the heart of  
20 it.

21 I'm not against it but for us it always gets  
22 screwed up at the point of the pharmacist reading the

1 message aloud to the beneficiary.

2 DR. STUART: I just wanted to follow up on the  
3 business about having a fragmented system. I think that's  
4 the whole point about having an evaluation, is if every PDP  
5 plan was successful according to these two draft  
6 recommendations and others that we were to come up with --  
7 it would be processed-based because that's all they do -- we  
8 could say well, these things work like a charm, they're  
9 great. And I think we need more than that.

10 And so knowing what the impact of a fragmented  
11 system is is really important to our business here as  
12 commissioners for Medicare.

13 MR. BERTKO: Let me only reiterate what Jennie  
14 said about half an hour ago. If we went to any kind of  
15 medical home and you had to download a Part D summary, which  
16 would be trivial to execute, you would have a great help  
17 with that. In fact, it could be in the PDP's interest to  
18 coordinate and manage the drugs as well as the Medicare fee-  
19 for-service.

20 DR. DEAN: I just wanted to make the same point I  
21 think I made once before, is that we need to have some  
22 mention of geographic access. In our setting -- and I think

1 there are some regulations relating to it, but they  
2 apparently don't have much teeth. I work with the only  
3 pharmacy in a 50-mile radius. And they have contracts with  
4 most of the Part D plans. But there's one major company  
5 that they felt they just couldn't abide by their payment  
6 levels and don't.

7 And so I have a fair number of patients who have  
8 to go 50 or 60 miles to get their prescriptions or wait for  
9 it to be sent by mail order. And it can be a real problem.

10 I remember one of the staff sent me some  
11 information about the geographic regulations but apparently  
12 they are not being very forcefully enforced or I can't  
13 remember how stringent they are. But it is a problem in our  
14 area.

15 So some measure of geographic access, I think,  
16 would be appropriate to try and work in there.

17 DR. REISCHAUER: Do people stay in those plans  
18 more than one year?

19 DR. DEAN: Yes, because they're cheap. It really  
20 boils down to whatever is the premium. That's what sells  
21 it. That's what sells it. And they put up with that.

22 DR. REISCHAUER: So they don't count gas.

1 DR. DEAN: You would be amazed at how far people  
2 will drive to save a quarter on a loaf of bread. It blows  
3 my mind. But they will do that. Talk about false economy,  
4 but it happens a lot.

5 I just mention that of the rural health care  
6 system, pharmacy services I think are one of the most  
7 threatened elements of the whole rural health care system.  
8 And Part D is a big element of that, that they have been so  
9 squeezed by the PBMs that we are beginning to have to look  
10 at what kinds of alternative structures we could use when  
11 the local corner drugstore isn't there anymore because that  
12 is very, very close to happening.

13 DR. SCANLON: John, doesn't this violate the  
14 geographic in terms of access? I thought that you had to  
15 have a pharmacy within a certain number of miles in urban  
16 areas and a certain number of miles within rural areas? And  
17 50 miles is not the number I remember.

18 MR. BERTKO: There is a requirement. I don't  
19 recall off the top of my head what it is. It could be that  
20 it's being interpreted on average for a state like Tom's. I  
21 don't know though.

22 DR. DEAN: [off microphone.] I don't know either



1 what the numbers are. I just know that this is what's  
2 happening in my own location.

3 MR. HACKBARTH: Okay, Joan, thank you. Well done,  
4 as always.

5 Our last session for today is on fee-for-service  
6 benefit design.

7 DR. SCHMIDT: So this afternoon we're continuing  
8 the discussion about fee-for-service benefit design that we  
9 started last December. We're looking at this topic in part  
10 because of the realization that policymakers will need to  
11 use a combination of approaches to improve the outlook for  
12 Medicare's long-term sustainability. The goal here is to  
13 think about whether changes to fee-for-service benefit  
14 design could encourage beneficiaries to use appropriate care  
15 when they have some discretion about it, be somewhat more  
16 sensitive to the cost of the care that they use, and seek  
17 care from more efficient providers.

18 Let's recap what we talked about last September.  
19 There are some key shortcomings in fee-for-service  
20 Medicare's benefit design that need addressing. First, it  
21 has no cap on beneficiaries' cost-sharing liability, and  
22 that risk of potentially large out-of-pocket spending, as

1 well as the difficulty beneficiaries have in predicting what  
2 they might owe out-of-pocket, leads most individuals to get  
3 supplemental coverage through retiree plans, Medigap  
4 policies, and Medicaid.

5           If policymakers were to make changes to fee-for-  
6 service benefits but didn't take supplemental coverage into  
7 account the benefit changes could be entirely ineffective.  
8 That's because supplemental coverage fills in some or all of  
9 Medicare's cost-sharing, so supplemental coverage could undo  
10 what the benefit change was intended to do.

11           If we rank Medicare beneficiaries by their total  
12 spending, the top 25 percent of beneficiaries account for  
13 more than 85 percent of total spending. So it's very  
14 concentrated, as we've talked about. This concentration has  
15 implications for how cost-sharing liability gets  
16 redistributed if policymakers redesign fee-for-service  
17 benefits.

18           All Medicare beneficiaries are facing pretty steep  
19 increases in costs for Medicare premiums, deductibles,  
20 coinsurance, and supplemental coverage. At the same time,  
21 as we've said, there are some underlying problems that need  
22 addressing in the benefit. But due to Medicare's problems

1 with long-term financing, if policymakers change the fee-  
2 for-service benefit they will probably want to do so in a  
3 budget neutral manner. So if they were to cap out-of-pocket  
4 spending for the smaller number of beneficiaries that  
5 account for most of the spending, that would probably  
6 involve redistributing the out-of-pocket burden around more  
7 evenly.

8           In September some of you debated what is in the  
9 research literature about how out-of-pocket spending affects  
10 use of services and health outcomes. This motivated us to  
11 go back and review the literature and then try to lay it out  
12 in a way that will help all of us think about what is most  
13 applicable to fee-for-service Medicare. So that's what  
14 we're going to do over the next few slides.

15           First, let's take a minute to remember what health  
16 insurance is supposed to do. One important function is to  
17 reduce an individual's exposure to financial risk and  
18 catastrophically high out-of-pocket spending. At the same  
19 time, insurance shields people from seeing the full cost of  
20 care. So insurers and payers believe that insurance should  
21 deter use of low value services by leaving some portion of  
22 covered services unreimbursed. And here by low value

1 services I mean that beneficiaries wouldn't have used them  
2 if they had had to pay for them themselves.

3           Some analysts think it's often a good thing to use  
4 different rates of cost-sharing for different kinds of  
5 services. The idea here is that a benefit should charge  
6 less cost-sharing for services when the beneficiary needs  
7 the most protection, for example, a surgery and  
8 hospitalization in a life-threatening situation. On the  
9 other hand, higher cost-sharing may be appropriate for  
10 services that are more discretionary. Ron had an example  
11 back in September that CMS now allows beneficiaries to pay  
12 the out-of-pocket to have vision correcting lenses implanted  
13 rather than traditional lenses during cataract surgery.

14           This all sounds straightforward but all of you  
15 know it can be difficult to draw the line between which  
16 services are of higher and lower value. One thing that  
17 would help draw these lines is a more solid body of evidence  
18 on which therapies are comparatively more effective than  
19 others, and for which subpopulations of patients they are  
20 most appropriate.

21           MS. MOORE: So now turning to the literature on  
22 cost-sharing, I'm going to mention some things to keep in

1 mind and then take you through the research.

2           So first, many of these studies don't use a  
3 randomized experimental design. Without this it can be  
4 difficult to control adequately for non-price factors that  
5 influence the use of services such as an individual's  
6 underlying health status or propensity to seek care.  
7 Specifically, it's hard to completely separate the effects  
8 of selection bias, which is the tendency of sicker  
9 individuals to seek insurance coverage more readily than  
10 healthier persons, from the pure response to a change in  
11 cost-sharing. The differences in the way researchers have  
12 controlled for these non-price factors have contributed to a  
13 wide range of results in the literature.

14           Other factors to consider include the time horizon  
15 of the analysis and the population studied. Some studies  
16 are over 30 years old and since then health care costs have  
17 grown more rapidly than the economy as a whole. Care that  
18 was once provided in the hospital is now routinely supplied  
19 on an outpatient basis. Medical technology now includes  
20 better diagnostic screening and minimally invasive surgery,  
21 and prescription drugs are a more widespread mode of  
22 therapy.

1           Another consideration is study duration, because  
2 the long-term response to a change in cost-sharing could be  
3 different from the short-term response. For our purposes,  
4 we also want to note that a lot of the literature on cost-  
5 sharing excludes the elderly.

6           So the type of insurance product being studied is  
7 also important. In managed care cost-sharing is often much  
8 lower than indemnity insurance and patients may be less free  
9 to use certain providers and technologies, and this could  
10 affect results.

11           In terms of outcomes, price changes can have  
12 effects beyond change in service use. Some studies consider  
13 health outcomes such as mortality rates but more look at a  
14 use of appropriate services or adherence rates for  
15 prescription drugs with the implication that a reduction in  
16 either of these could have a negative impact on health.

17           Of course, guidelines for appropriate care may not  
18 have been developed specifically with the elderly in mind.

19           Other researchers, including our own Bruce Stuart,  
20 have looked at offsets such as whether increasing cost-  
21 sharing for prescription drug expenditures increases overall  
22 medical expenditures.

1           So now we're going to start with the familiar  
2 first. As many of you know, the Federal government funded  
3 the RAND Health Insurance Experiment -- which I'm going to  
4 refer to as HIE -- in the mid-1970s to examine how people  
5 respond to cost-sharing. Results from this experiment  
6 suggest moderate sensitivity to cost-sharing. So a 10  
7 percent increase in price leads to about a 2 percent decline  
8 in the use of services.

9           To put this in perspective, this response is lower  
10 than estimates of price sensitivity for gasoline and new car  
11 purchases that were studied at about the same time.

12           HIE also found that individuals were less  
13 responsive to cost-sharing for hospital care and more  
14 responsive for well care with acute and chronic outpatient  
15 care falling in between. The main effect of higher cost-  
16 sharing was that people initiated medical care less. Once  
17 they were under medical care, their costs were only slightly  
18 lower. So to put it another way, there were fewer episodes  
19 of care but costs per episode were only slightly lower.

20           They also looked at response to cost-sharing by  
21 health status and found that the sick were no less likely to  
22 reduce their use of medical care than the healthy. And this

1 is somewhat unexpected because medical services for the sick  
2 are generally thought to be less discretionary than medical  
3 services for the healthy.

4           Averaged across all participants, higher cost-  
5 sharing did not affect health outcomes adversely. One  
6 exception was participants with both low incomes and poor  
7 health who had some better health outcomes under free care  
8 than cost-sharing.

9           HIE remains the most comprehensive study on  
10 response to cost-sharing, particularly because of its  
11 ability to control for selection bias. In terms of  
12 relevance to the Medicare program, the HIE looked at  
13 indemnity insurance and approximately 80 percent of Medicare  
14 beneficiaries are covered under fee-for-service, which is  
15 indemnity. On the other hand, the study excluded the  
16 elderly and was conducted over 30 years ago.

17           We also looked at literature on supplemental  
18 insurance. Researchers agree that Medicare beneficiaries  
19 with Medigap or retiree health coverage have higher use of  
20 services and spending on average than those with no  
21 supplemental coverage. There are two main explanations for  
22 this higher spending.



1           The first is that supplemental insurance shields  
2 people from most or all out-of-pocket spending at the point  
3 of service and so people use more than they might otherwise  
4 would. The second explanation concerns selection bias.  
5 That is the tendency for people who anticipate using more  
6 medical care to seek out supplemental insurance more readily  
7 than people who don't anticipate needing care.

8           So to figure out the effect of out-of-pocket  
9 spending, studies make an attempt to control for selection  
10 bias but there's disagreement because after controlling for  
11 selection bias some researchers say that spending by those  
12 with supplemental insurance is 25 percent higher. This  
13 result is generally consistent with HIE. But a whole  
14 another group of researchers find that the higher spending  
15 disappears after controlling.

16           We're now going to look at literature on  
17 prescription drug use among the elderly. It's important to  
18 note that most of these studies were carried out within the  
19 context of managed pharmacy benefits. This literature  
20 suggests that the elderly are moderately sensitive to cost-  
21 sharing for drugs. Higher copays and capped benefits are  
22 associated with lower drug spending. The responses in the

1 literature range from levels found in the HIE to levels  
2 three times as large.

3 We also find a correlation between increased cost-  
4 sharing and lower drug adherence. For some elderly, such as  
5 those in poor health or with specific chronic conditions,  
6 this lower drug adherence has been found to increase overall  
7 spending or result in negative health outcomes. But there  
8 is no evidence that this is the case for all elderly.

9 And I want to really quickly mention a recent  
10 elderly-specific study that's noteworthy because it was a  
11 natural experiment and can control a little bit better for  
12 selection bias, and looked at an increase in cost-sharing in  
13 both drugs and physician visits.

14 The results indicate there were reductions in  
15 service use greater than those found under HIE. But there  
16 were also offsets in the form of increased hospital use.  
17 Both the response to cost-sharing and the hospital offset  
18 were more dramatic for those with chronic conditions or high  
19 medical spending.

20 DR. SCHMIDT: So we were looking to the literature  
21 to help us think about an issue that John raised last  
22 September, whether our estimates for how much more

1 beneficiaries spend when they have coverage that wraps are  
2 on Medicare are too low.

3           The literature suggest that beneficiaries are  
4 moderately sensitive to price and even relatively modest  
5 price sensitivity can have big dollar implications when  
6 we're talking about a program as large as Medicare.

7           We also saw that in one specific area of the  
8 literature people that have supplemental coverage to  
9 Medicare spend on the order of 25 percent more than people  
10 with similar health status and no supplemental coverage.  
11 But as you just heard, there is some disagreement among  
12 analysts as to how large that effect would be after you  
13 control for the fact that sicker people tend to seek out  
14 more coverage.

15           So this matters because if this insurance effect,  
16 the pure effect of a change in cost-sharing, is larger than  
17 what we estimated in September, that would free up resources  
18 that would allow us to do other things such as introduce  
19 catastrophic protection within the fee-for-service benefit.

20           The specific option that raised this issue was a  
21 case that would prohibit Medigaps and retiree plans from  
22 covering the Part A and Part B deductibles. Supplemental

1 plans could cover all of the rest of Medicare cost-sharing  
2 if they wanted to, but not the deductibles.

3 Back in September our contractor, Actuarial  
4 Research Corporation, estimated that this would lower  
5 Medicare fee-for-service spending by about \$2 billion in  
6 2007 or less than 1 percent per year. ARC's assumptions  
7 about the effects of insurance on spending are generally  
8 lower than what you would get using results from the health  
9 insurance experiment.

10 We asked ARC to use higher assumptions consist  
11 with the HIE and this time they estimated that fee-for-  
12 service spending would be about \$10 billion lower in 2007,  
13 or about 5 percent lower per year. So clearly this  
14 assumption makes a big difference.

15 In response to John, after reviewing the  
16 literature, we take your point. We think the preponderance  
17 of evidence suggests that supplemental coverage does lead to  
18 somewhat higher Medicare spending. But also, given the  
19 disagreement in the literature, we think it would be  
20 important for us to show some sensitivity to that by using  
21 some lower assumptions, as well

22 Now let's move on to a different question that

1 Nancy Kane raised in September. You may remember this slide  
2 before, which shows how concentrated Medicare spending is.  
3 You can look at the two right-hand columns, in particular,  
4 for an overall sense of things.

5 So the top 25 percent of beneficiaries when ranked  
6 by their spending account for something on the order of 85  
7 percent of total spending. Nancy asked, given this degree  
8 of concentration in spending, whether it makes sense to  
9 change benefit design for all fee-for-service beneficiaries?

10 So maybe a better approach would be to change  
11 provider incentives for those who are caring for the sickest  
12 beneficiaries, for example getting those providers to  
13 coordinate their care, sending those sickest beneficiaries  
14 to efficient providers, and those who deliver particularly  
15 high quality care, those types of steps.

16 I think the answer to her point is yes, that makes  
17 sense to the extent that you can identify who is likely to  
18 be among the highest spending group. And then, in turn,  
19 depends on whether people are persistently high spenders  
20 over time.

21 So here's some evidence we put together several  
22 years ago for the Commission on that particular question.

1 On the left you see the data for the top 25 percent of  
2 beneficiaries when they are ranked by their Medicare  
3 spending. And among this group, 50 to 60 percent of those  
4 beneficiaries remain among the top 25 percent in subsequent  
5 years. So you can see year one, two, three and so on.

6 I think this degree of persistence in spending is  
7 what has given rise to initiatives for disease management  
8 and care coordination within Medicare. However, we need to  
9 remember that there isn't yet strong evidence that these  
10 kind of initiatives lead to savings.

11 Also, I should point out that it's hard to predict  
12 who will be among the very highest spenders in a given year  
13 because there is more year-to-year turnover and mortality  
14 affecting these higher ranking groups. On the right-hand  
15 side you can see the same sort of slides for beneficiaries  
16 who were ranked among the top 1 percent of all beneficiaries  
17 in terms of their spending. In subsequent years about 30  
18 percent remained in the top 1 percent one year out but that  
19 number drops off over time.

20 There are still other reasons policymakers may  
21 want to change fee-for-service benefit design for everyone.  
22 Even if the other three-quarters of all beneficiaries only

1 account for 15 percent -- so I'm using the inverse of the 25  
2 percent accounting for 85 percent here -- 15 percent of  
3 total Medicare spending is still a significant amount of  
4 money. And using fee-for-service cost-sharing to steer all  
5 beneficiaries towards higher quality or more efficient  
6 providers could help change the way providers care for  
7 everybody, including the sickest beneficiaries. Or  
8 policymakers may want to change fee-for-service benefit  
9 design on grounds of equity, to reduce out-of-pocket  
10 liability for the sickest beneficiaries and spread cost-  
11 sharing around more evenly.

12 Now let's move on to a question that Jay raised in  
13 September about the redistributive effects of the  
14 illustrative cases that we looked at. And by that I mean  
15 what share of beneficiaries would gain or lose relative to  
16 what they pay out of pocket in fee-for-service Medicare  
17 today.

18 Remember that our contractor estimated these  
19 effects using a simulation model that we described in the  
20 fall and we aimed to keep Medicare program spending budget  
21 neutral.

22 This slide shows you that illustrative case, and

1 it has a lot of moving parts you can see on the slide. It's  
2 got combined deductible and a catastrophic cap and it keeps  
3 Medigaps and retiree plans from covering the deductible. It  
4 would use 20 percent coinsurance on all services except for  
5 hospice.

6 So beneficiaries that have a hospitalization would  
7 have much higher cost-sharing on average because they would  
8 be paying 20 percent of covered charges rather than the Part  
9 A deductible.

10 On the other hand, beneficiaries who now pay say  
11 50 percent of allowable costs for outpatient mental health  
12 visits or those who are paying on the order of 40 percent  
13 for services in hospital outpatient departments would see  
14 some relief from cost-sharing.

15 Now let me warn you that this slide is somewhat  
16 different from what is in your mailing materials because for  
17 this slide we used a higher assumption about how  
18 supplemental coverage leads to higher Medicare spending  
19 consistent with what we talked about a few slides ago. And  
20 so that, in turn, affect the district of financial outcomes  
21 in this pie.

22 You can see that for the combination of out-of-



1 pocket spending plus our crude estimates of how the scenario  
2 would change Medigap and retiree premiums nearly half of  
3 fee-for-service beneficiaries would have lower combined  
4 costs and about a quarter would have higher combined costs.

5 Jay had asked for more detail about the size of  
6 those higher and lower costs to get a sense of the intensity  
7 of the pain or relief that beneficiaries might feel. This  
8 is a version of the same distribution of beneficiaries but a  
9 little bit more detail about the size of the spending  
10 changes.

11 You can see that there are three blue pieces of  
12 the pie, and those are the beneficiaries whose net spending  
13 for out-of-pocket cost-sharing and supplemental premiums is  
14 higher. Those three pieces add up to 23 percent of the pie  
15 you saw on the last slide. Among these people who had net  
16 higher spending, most would pay \$100 to \$250 more for the  
17 year.

18 Similarly, the three yellow piece of the pie are  
19 individuals whose net spending is lower, the 48 percent from  
20 the previous slide. You can see that the majority of these  
21 people have net financial gains of between \$50 and \$500 for  
22 the year.

1           We want to leave you with a few questions to  
2 discuss. For example, which features of the fee-for-service  
3 benefit design are most in need of changing? How do you  
4 feel about the issue that we talked about with respect to  
5 beneficiaries' response to higher cost-sharing? Should we  
6 be more consistent with the Health Insurance Experiment?  
7 Should changes to cost-sharing for all fee-for-service  
8 beneficiaries be paired with better incentives for providers  
9 who care for the sickest individuals? And how might we  
10 phase in changes to benefit design over time?

11           Next month we'll continue this look at fee-for-  
12 service benefit design with a discussion of other goals for  
13 using cost-sharing. Arnie articulated some of these ideas  
14 last fall. For example, policymakers might want to steer  
15 beneficiaries towards providers with better track records of  
16 quality and efficiency.

17           John talked about also maybe using it to encourage  
18 primary care. Or we might want to use it to move  
19 beneficiaries towards therapies where there's a more solid  
20 evidence of comparative effectiveness.

21           MR. BERTKO: Just a quick comment. First, thanks  
22 to both of you guys for doing all this extra work. It's one

1 thing to have my suspicions validated as to actuarial rules  
2 of thumb.

3           The one comment that I would add here that might  
4 be of some value is your comment about trying to balance the  
5 two estimates with the effects of selection. I would point  
6 out that much of this is under Medigap, which has very  
7 defined open enrollment rules. There's a window of six  
8 months in which people can choose to join in. I think plan  
9 C is the exemption from that. But for all of the other  
10 plans you have to think about it when you're 65 and go in or  
11 not.

12           That doesn't say selection is missing but it also  
13 means that you can't choose the richest plan when you're  
14 actually much sicker at say age 74 or age 82. So there will  
15 be some selection but I would put it on the lower end of the  
16 scale as opposed to the greater end of the scale.

17           DR. REISCHAUER: You can switch plans. Once  
18 you've made an option to go in at age 65 then you're free to  
19 switch and still be under --

20           MR. BERTKO: Right, but the big option is do you  
21 have Medigap or not? When you look at the main coverage  
22 issues, Part A and Part B cost-sharing, they're virtually

1 the same. There's not that much cost difference between  
2 them. The extra benefits you get from -- most people are  
3 enrolled in I think three of the 10 options. Yes, you can  
4 switch, but so what?

5 DR. REISCHAUER: Now you can switch into one with  
6 a catastrophic cap, too.

7 Let me make sure I'm understanding these charts  
8 right and then ask you a question. Slide 10, when the bars  
9 get smaller, it's because people are dying; right?

10 DR. SCHMIDT: That's right.

11 DR. REISCHAUER: So there's missing people.

12 DR. SCHMIDT: The difference in the height from  
13 one year to the next is mortality.

14 MR. BERTKO: I'm actually on the old MedPAC side  
15 of this responsiveness and not on John's for several  
16 reasons. One is when we're talking about people at the high  
17 end of the spending, there's a big chunk of them for who  
18 this is the last year of life. I think cost-sharing is not  
19 the first thing that they have on their minds.

20 Secondly, there are a certain fraction of them  
21 that are duals; right? And they don't face any cost-  
22 sharing. And there's another chunk who are persistent here

1 who, if they are in these high spending categories several  
2 years in a row, they will be duals. You can age into the  
3 situation.

4 And so I think, going to the RAND study, the  
5 under-65 is not necessarily a right way to go to get these  
6 parameters.

7 I also wondered, we talk about these people like  
8 there's the top spenders and us, or the rest. I know CBO  
9 did some of this and we had a consultant do some work here.  
10 But I just wondered if anybody has looked at over your  
11 lifetime on Medicare how many people spend zero years in the  
12 top quintile, one year, two years, three years, like this.  
13 Is it that the vast majority of people at some time or  
14 another do fall into this top category, whatever you want to  
15 choose it to be?

16 If that's the case, I think you look at this a lot  
17 differently and you sell it to people a lot differently than  
18 sort of like you're 65, but do you want to buy this extra  
19 protection for catastrophic rather than you're going to need  
20 it -- it's highly likely that you're going to need it some  
21 time?

22 DR. SCHMIDT: I'm aware of studies that have

1 looked over the entire lifetime but maybe someone else  
2 around the table. Bruce?

3 DR. STUART: I was just going to say I think what  
4 Bob is saying is he'd like to see it turned around. In  
5 other words, he'd like to see at what leads up to cost-  
6 sharing being a high spender.

7 And I don't think that study has been done yet.  
8 Although, you've got the data. You could turn it around.

9 DR. KANE: Aren't there information like you have  
10 a one in five chance of needing long-term care, which  
11 usually means you're going to --

12 DR. STUART: Sure, there's that. But what you  
13 really want to know is you want to know not just what those  
14 bars look like leading up to high spenders. But you also  
15 want to know what triggers it. But that's not a cost-  
16 sharing issue. That's really kind of a care management  
17 issue.

18 DR. KANE: What we want to know is what chance do  
19 you have of being in the top 25 percent? What's your  
20 lifetime chance? If you know what it is for long-term care  
21 but we don't know what it is in your top 25? I think we  
22 must know that somewhere.

1 DR. SCHMIDT: We know some things like on the  
2 order of a quarter of total spending is for people in the  
3 last year of life, statistics like that.

4 DR. KANE: [off microphone.] But a lot of people  
5 never spend and die.

6 DR. SCHMIDT: That's true.

7 If I could make one comment about your comment  
8 about duals. For the purposes of our modeling, I think it's  
9 useful to remember that we did not apply rules about what  
10 Medicaid could fill in to dual beneficiaries. So they paid  
11 no cost-sharing or there were no changes to their cost-  
12 sharing in our simulation model.

13 DR. REISCHAUER: I was just saying that when we're  
14 thinking about the responsiveness to higher copayments, why  
15 Medicare might be different from the rest is there's a chunk  
16 of people who tend to be high spenders who face no cost-  
17 sharing.

18 MR. EBELER: This is very well done. This issue  
19 has been with us since the beginning of the program in many  
20 ways. The difficulty here is as you walk down the road to  
21 policy options, sort of the option that says -- and I do not  
22 dispute the data. I am not going to -- the actuaries and

1 economists have determined that elderly people can't insure  
2 against the deductible is a pretty tough option, even though  
3 it may make sense.

4           That's a tough nut to crack. There's always been  
5 a discussion of coming up with some actuarial estimate of  
6 what the cost is, in effect charging the Medigap carriers a  
7 surcharge to make the Trust Fund whole, in effect, for their  
8 extra utilization. But it's a tough option.

9           Particularly in the context of the evolving  
10 Medicare Advantage program, and a lot of plans there that  
11 have no particular capacity to manage care, but which are  
12 paid pretty generously. If we set up a system where the  
13 only way the elderly can get their deductible covered is to  
14 go in that direction, and we're paying the wrong way in that  
15 direction, we're going to save 10 percent over here and  
16 spend 12 percent over here.

17           So I just think you really have to think about  
18 moving from the analysis to the policy instrument here  
19 because it's a very difficult policy instrument. I've never  
20 quite figured out how to pull the trigger on the policy  
21 instrument.

22           DR. MILSTEIN: I think that all things considered,



1 we're going to get more yield from incentivizing providers  
2 than incentivizing seniors. That's my view.

3 But that if we are going to consider incentivizing  
4 beneficiaries, I think it's important that we, in keeping  
5 with our theme of encouraging value, shy away from blunt  
6 instruments and begin to -- however imperfect our measures  
7 may be -- use beneficiary cost-sharing to encourage use of  
8 better performing providers. And even though the cupboard  
9 is relatively bare, better performing treatment options, if  
10 I can stretch the metaphor a little bit.

11 So that's my view. We have places to start. For  
12 example, a modest beginning might be to encourage through  
13 lower beneficiary cost-sharing for those who actually do  
14 have cost sharing, or some kind of a rebate for those who  
15 are dual eligibles tilting toward providers that may be  
16 initially are participating in and scoring well in our P4P  
17 programs. And perhaps time to sort of synchronize with the  
18 point at which our P4P programs incorporate not just quality  
19 but also efficiency. Because that's the only way that you  
20 could begin to hypothesize impact on Medicare spending trend  
21 while lifting quality.

22 Since it would take -- since we started out with

1 P4P reporting only and then quality and then we hope phase  
2 three is quality and efficiency, maybe we might dovetail  
3 such an incentivization of beneficiaries to encourage  
4 selection of higher value options with the advent of  
5 information on relative provider value and relative  
6 treatment option value.

7 DR. SCANLON: In response to a number of comments,  
8 I look at this more from the perspective of how do we get  
9 catastrophic coverage into Medicare? We're talking about  
10 pretty poor insurance when you don't have catastrophic  
11 coverage. And for some people we're talking about \$5,000 or  
12 \$10,000 in out-of-pocket expenses on incomes of maybe  
13 \$15,000 or \$20,000.

14 To Bob's point about the duals, the good news may  
15 be you're on Medicaid. The bad news is how you got there.  
16 You bankrupted yourself to get there.

17 And then compounding the bad news is the fact that  
18 states don't all pay the copays. And so therefore you may  
19 then have an access problem to deal with as well.

20 To Jack's point, I guess the other thing is that  
21 we shouldn't only be thinking about providing the  
22 catastrophic coverage, but let's look at the deductibles and

1 whether or not the deductible -- you can get insurance for  
2 the deductible becomes a different issue if it's unified  
3 deductible of say \$250 as opposed to the way it's structured  
4 now with a very large hospital deductible which a lot of  
5 people say doesn't make sense because that's one of the  
6 least discretionary services that you're going to use.

7           And then if we say that you shouldn't have  
8 insurance for that, it's maybe potentially more reasonable.  
9 But when you start to think about it, if it's a reasonable  
10 deductible do I want to pay somebody 40 cents to write a  
11 check for a dollar? That's what it comes down to with the  
12 supplemental plan, roughly. The loss-ratio requirement is  
13 either 55 or 65 percent and we used to have to do analyses  
14 to see that they were meeting those loss-ratio requirements.  
15 They weren't that far off.

16           Partly it's individually marketed. So you end up  
17 do having a very high load on those. So there's a question  
18 here about we may be doing beneficiaries big favors from a  
19 number of perspectives in terms of a better insurance policy  
20 and not buying something that has a very high cost for the  
21 value that you're getting.

22           DR. CASTELLANOS: I'd like to carry Arnie's point

1 just a little bit, and I want to be very, very careful how I  
2 say this. We've looked at all the Medicare providers. We  
3 want all the providers to have appropriateness of care,  
4 efficiency, quality, and resource use.

5           The other end of the equation is the beneficiary.  
6 And with cost-sharing, not saying we're doing it but we're  
7 pushing them towards appropriateness of care, resource use,  
8 quality, and efficiency. So I don't see anything wrong in  
9 going in that direction if it's done correctly. And I want  
10 to be very careful about that.

11           DR. REISCHAUER: If you thought about providing  
12 catastrophic coverage through Medicare, and now that we have  
13 a drug benefit, the package for middle class kind of people  
14 is more or less than adequate package not too dissimilar  
15 from the average employer-sponsored package. You could see  
16 the participation in Medigap begin to decline, I would  
17 think. And that would have salutary impacts in a voluntary  
18 kind of way.

19           MR. HACKBARTH: People weren't really buying a lot  
20 of drug coverage through Medigap, is my recollection. I  
21 thought you were saying that because they have it now  
22 they're not going to buy Medigap.

1 DR. SCHMIDT: Isn't he referring to that if you  
2 added catastrophic protection?

3 DR. REISCHAUER: Right.

4 MR. HACKBARTH: Oh, I see. You may not have to  
5 force it. Okay.

6 Others?

7 DR. STUART: This is just a quickie. One of your  
8 questions was do you want to use your assumptions here  
9 consistent with the HIE.

10 And I agree with Bob. I think that it's not only  
11 old and it doesn't deal with the old, but there was a  
12 special feature of that experiment that made it possible to  
13 conduct, which was everybody was held harmless. So that if  
14 you had people that had high out-of-pocket spending, they  
15 knew that they were going to get something back. And so  
16 that would lower the estimated effect of cost-sharing. So  
17 that's one reason that I would be very careful about that.

18 The second is that the new studies that have been  
19 done in the last decade or so are just better studies than  
20 the older secondary data analyses. There are just better  
21 techniques out there.

22 And the fact that you find different measures of

1 price sensitivity, in large part I think is due to the fact  
2 that you've got different populations. You've got some  
3 heterogeneity under there. And trying to understand that  
4 heterogeneity may be important to the policy decision about  
5 what you do with deductibles, depending on who's going to be  
6 subject to those deductibles.

7 So I think that part really does bear some  
8 additional analysis. And for that you're going to have to  
9 use secondary data. You can't go back to the HIE for that.

10 DR. SCHMIDT: The newer study, the newer  
11 literatures that you're discussing, are mostly on drug  
12 benefits; right?

13 DR. STUART: I'm talking about all of the studies.  
14 It's not just drug benefits. It's looking at responsiveness  
15 to other services, as well.

16 DR. SCHMIDT: One thing we raised in the paper is  
17 that an issue with newer studies is that many of those are  
18 taking place in the context of managed care. And could it  
19 be that the price sensitivities in that context are maybe  
20 somewhat different from those in an indemnity --

21 DR. STUART: I think that gets to the  
22 heterogeneity, in part. And the reason that many of these

1 studies have focused on managed care is because there are  
2 all of these little natural experiments. One of the things  
3 that managed care plans do is that they frequently change  
4 their coinsurance policies and so you've got that piece that  
5 you can analyze.

6 But that's what you're trying to do here, too, is  
7 that you're looking at something that's going to change and  
8 you want to know how people's behavior is going to change in  
9 response to that change.

10 DR. MILLER: So we'll do some sensitivity  
11 analysis, is how we're going to navigate this problem.  
12 Thank god Joe Newhouse wasn't here when you said that about  
13 HIE. There would have been a scrap on the table.

14 MS. HANSEN: This is more of an observation. As  
15 we've been looking at coverage for the uninsured and some of  
16 the state plans that have moved ahead, and they do have  
17 catastrophic coverage, one thing that became so palpably  
18 visible that there is no comparable when you talk about the  
19 Medicare population because some of the state plans are  
20 saying there's a maximum spend that we have. But then the  
21 Medicare plan is wide open, which obviously then potentially  
22 leads to -- as you were saying, Bob -- the fact that people

1 could spend until they get to being a dual eligible.

2           So I guess that becomes this catastrophic  
3 coverage, per se. But it's not a built-in part of the  
4 policy side of it. But the policy design now of many of the  
5 plans for the states that are trying to cover their  
6 uninsured, they actually have a catastrophic top there.

7           DR. REISCHAUER: There is an experiment to be done  
8 comparing FEHBP retirees with Medicare, the people who are  
9 not covered by Medicare.

10           DR. SCHMIDT: Can you lay that out a little more  
11 for me? I'm sorry. Can you lay out what you mean a little  
12 more?

13           DR. REISCHAUER: There are retired Federal  
14 employees who have BlueCross BlueShield plan and no  
15 Medicare. And so they're under a different cost-sharing  
16 than somebody in Medicare with a supplemental policy.

17           DR. SCANLON: It depends on the individual because  
18 they had the option of being in Medicare and a lot of them  
19 had been in Medicare when the Part B medium was low. Now  
20 that it's means tested, maybe more of them are not going to  
21 sign up for Medicare. But BlueCross is an example of one of  
22 the major FEHBP plans. They will operate as a supplemental



1 for you so that you have zero cost-sharing when you have  
2 opted for B under Medicare. So some people might qualify  
3 for the experiment and others won't.

4 DR. REISCHAUER: I know.

5 MR. HACKBARTH: Last word, Jay.

6 DR. CROSSON: I'm trying to sort out sort of where  
7 we are with this question. So I'm going to be a little  
8 reductionist here.

9 But it sounds to me like we started out saying  
10 isn't there something we could do in the area of  
11 catastrophic coverage to prevent people from being  
12 bankrupted within Medicare and improve the quality of the  
13 insurance policy, if you will.

14 It sounds like what we said was that one way to  
15 pay for that is through an uninsurable deductible, which is  
16 about \$172. Is that right?

17 DR. SCHMIDT: Yes, using the higher assumptions.

18 DR. CROSSON: Okay, so using the higher  
19 assumptions.

20 And with that, and with people then not having to  
21 pay for that through Medigap premiums, about 75 percent of  
22 people would either save money in the end or have a trivial

1 increase, less than \$50. So tell where I'm wrong here. For  
2 \$172 up front and a 75 percent chance of coming out  
3 virtually even or not, you then get protected against  
4 catastrophic loss?

5 MR. BERTKO: Correct.

6 DR. CROSSON: Assuming the pricing. Then we  
7 wondered whether this is politically salable or not. It  
8 seems to me like it might be. Because it sounds like a  
9 pretty good deal. Isn't that something that we could test  
10 in some way to see what the waters --

11 MR. HACKBARTH: We'll send you out.

12 [Laughter.]

13 DR. CROSSON: I still have two years to go. You  
14 wouldn't want to lose me this early, would you?

15 So what am I missing here?

16 DR. MILLER: I think some of the things that maybe  
17 Jack was referring to and others of us who have probably  
18 some scar tissue to show on this -- and I think it's too bad  
19 that Anne Mutti isn't still here.

20 But you might be surprised -- in fact I'll say you  
21 will be surprised -- by how people's reaction to not being  
22 able to insure against first dollar coverage, regardless of

1 the amount, plays in the policy process. It's quite  
2 remarkable.

3 And then also, the other thing that happens in  
4 these kind of situations, you're right, you look at these  
5 kinds of things and you think look, on net most people are  
6 coming out better and the dollar amounts are prepared. But  
7 you're also, in that light blue one, a bunch of people just  
8 took a hit. And that won't be missed.

9 And so I hear you, and what you said is exactly  
10 what we're driving at. I think that is where we're headed  
11 with all of this work. Rachel, is that correct?

12 But I just don't underestimate, there's a whole  
13 industry built around insuring first dollar coverage and  
14 it's not small.

15 MR. HACKBARTH: What can we say about the people  
16 that are in the blue? What are the characteristics that  
17 people who end up losing under this reconfiguration?

18 DR. SCHMIDT: I think it's going to be people for  
19 example who have a hospitalization where they're paying 20  
20 percent coinsurance on covered charges, and that's typically  
21 a lot higher than just paying the Part A deductible. But  
22 maybe not as high as the \$3,100 cap on out-of-pocket

1 spending. It's that type of a person.

2 MR. HACKBARTH: And so potentially it's people who  
3 are quite sympathetic and it leads to this is a sick tax,  
4 people wanted to insure against it so that they didn't have  
5 this burden.

6 DR. REISCHAUER: That was my original point, which  
7 was over a lifetime maybe you're in the yellow, 98 percent  
8 are in the yellow a sufficiently long time. So the fact  
9 that they're in the blue for three years, they're still net  
10 better off big time. And without being able to show that...

11 DR. KANE: Wouldn't the people who no longer  
12 provide first dollar coverage be able to provide  
13 catastrophic coverage?

14 MR. BERTKO: No. there would be no policy.  
15 That's part of Medicare fee-for-service.

16 DR. KANE: I see.

17 MR. HACKBARTH: You're making a private purchase.

18 But I think that there is still something worth  
19 maybe pursuing here. I agree with Jack's political  
20 assessment. This has been discussed in various ways over  
21 the years. It's never an easy sell but I'm not quite ready  
22 to say it's not worth pursuing.

1 DR. REISCHAUER: I want you to stake your  
2 chairmanship on it.

3 MR. EBELER: I did not mean to imply that we  
4 shouldn't pursue it because we need catastrophic coverage in  
5 this program and we need to revise the front end cost-  
6 sharing.

7 But this mechanism where you preclude people from  
8 buying an insurance product that they have opted to buy for  
9 many years is a very difficult mechanism to implement. The  
10 question is are there other ways to get there.

11 Bob may be right. If you make Medicare a decent  
12 enough benefit package, over time the market erodes of its  
13 own -- it's just not worth it. But it's a difficult place  
14 to get to.

15 MR. HACKBARTH: There are two political  
16 constituencies here. One is the beneficiaries and how it's  
17 received by them. The other is the insurance industry and  
18 how it's received by them. So even if you could persuade  
19 the beneficiaries this is a good deal, you still have the  
20 other hurdle to deal with. But we'll be back to this.

21 Thank you. Good work, Rachel and Megan.

22 Okay, we are down to our public comment period.

1 Please keep your comments to no more than a couple of  
2 minutes. Begin by identifying yourself and your  
3 organization. And if you see this red light go off, that  
4 means it's time to complete your comment.

5 DR. GREENO: Thank you. I'm Dr. Ron Greeno. I'm  
6 representing the Society for Hospital Medicine. We're the  
7 organization that represents the nation's 22,000  
8 hospitalists.

9 We were unable to comment after the session this  
10 morning but I did want to clarify something that was  
11 presented in the PowerPoint presentation this morning. And  
12 that was the comment that -- there was a comment that the  
13 most common model for compensating hospitalists was  
14 basically a reward for volume, a fee-for-service model. I  
15 would agree that that's true.

16 The conclusion, though, was that paying based on  
17 volume increases incentives for admissions and that is where  
18 I would like to make a point of clarifications.

19 Hospitalist programs do not generate admissions.  
20 Hospitalists, by far and away the majority of hospitalist  
21 programs all over the country only see patients after they  
22 have been admitted to the hospital. In other words, they

1 only see a patient after some other physician -- either an  
2 emergency room physician or a primary care physician in  
3 their office -- has decided that that patient needs to be  
4 admitted.

5           And so whether you incent -- we agree that the  
6 best way to incent hospitalists is not to pay them on an  
7 RVU-type basis. Unfortunately, that is still the vast  
8 majority of how the variable portion of their compensation  
9 is paid. We agree that there are better ways to do that,  
10 including quality and patient satisfaction.

11           And there is a very rapid movement, quite frankly,  
12 in the hospitalist field to move towards those kinds of  
13 compensation measures. But I would disagree that paying by  
14 RVU increases admissions, because it just doesn't.

15           We don't control who gets admitted to a  
16 hospitalist service any more than an emergency room  
17 physician controls who walks into their emergency room. We  
18 see who we're asked to see and care for them from that point  
19 on.

20           I just wanted to clarify that for the hospitalists  
21 that we represent.

22           Thank you.

1 MS. McILRATH: I'm Sharon McIlrath with the AMA.

2 First, I'd like to thank the Commission for  
3 recommending the positive update.

4 Then I would like to remind you that, though I  
5 didn't hear the word once today, we do still have the SGR,  
6 that the latest prediction is that there will be 16 percent  
7 cuts between now and January, maybe in two steps or maybe in  
8 one step.

9 And then to suggest that in some of the chapters  
10 that you might want to acknowledge the role that the SGR may  
11 be playing in terms of driving volume and some of the other  
12 issues that you were discussing.

13 Then I would like to respond to the several  
14 comments that were made about the inequities of the RUC  
15 process. I think it would be useful to go back and review  
16 the history of the several five-year reviews. The first  
17 five-year review, the RUC recommended significant increases  
18 in the E&M codes. Then HCFA did not accept all of the  
19 increases that were recommended. They gave those services a  
20 lower increase.

21 In the second five-year review the primary care  
22 specialties, in part because they felt that since HCFA had



1 not accepted the earlier recommendations of the RUC, did not  
2 attempt to have an increase.

3           And the third review, the rationale for raising  
4 those services again was because they were never valued  
5 appropriately in the first place, and going back to the  
6 original RUC recommendation. I mean there were other  
7 arguments made but that was the one on which the  
8 recommendations were based.

9           So I don't think that -- maybe it was an  
10 unintentional implication, but there was an implication I  
11 think in the discussion that it was the RUC that prevented  
12 primary care from getting increases. I just think it would  
13 be appropriate to remember that there were a lot of other  
14 people that were involved in the process and that there are  
15 practice expense values that you might want to be thinking  
16 about in addition to the work values. It's not all about  
17 work.

18           That the RUC is now looking at -- they have  
19 several screens that they've put in place and they have  
20 identified codes. They are working through them. It is not  
21 going to be an easy process. But trying to identify and  
22 make some recommendations to CMS on some of the overvalued

1 codes. So the RUC is trying to change.

2 But all of that being said, then I think that  
3 let's go back to the recommendation that you had for  
4 changing the conversion factor for everyone in order to  
5 finance an increase for primary care services, however those  
6 end up getting defined. I think it would be useful to have  
7 the staff put together some simulations for you on what  
8 would happen if you gave certain sizes of increases to  
9 primary care. How much would you have to cut the conversion  
10 factor for everyone else to do that?

11 And then if you did it and the SGR was still in  
12 place and you had -- let's say it was this year or last year  
13 when they did the five year review. It ended up being a 5  
14 percent across-the-board reduction for almost everyone. So  
15 let's say it was something similar to that.

16 So you have a 16 percent cut for most of -- for  
17 everybody. Then you have 5 percent on top of that for all  
18 services except whatever E&M services that you identify.  
19 And then you have say it was an 8 percent, which was similar  
20 to what they got. You have now 21 percent minus 18 percent,  
21 you still have even primary care sitting there with a very  
22 significant reduction.

1           So as long as the SGR is in place, you can do a  
2 lot of things but you're not going to get to the bottom of  
3 the problem that everybody is having.

4           Just also to note that the 55 percent of what the  
5 internists do, according to this table, are other services.  
6 So you're cutting them on 55 percent of their services and  
7 raising them on 45 percent. So where do you end up then?

8           I just think it just would be -- if you're going  
9 to do this, to do it in a budget neutral manner does not  
10 make sense. As someone said, particularly when if there are  
11 savings from these things, they're likely to be over on the  
12 hospital side. I just think you need to look a little  
13 longer at how you might fund it.

14           MS. DODERO: Denise Dodero with the Association of  
15 American Medical Colleges. We represent U.S. and Canadian  
16 medical schools and major teaching hospitals.

17           My comment relates to your earlier discussion this  
18 afternoon around physicians and financial relationships with  
19 other entities, and particularly an observation that was  
20 made about the fact that during a physicians' formative  
21 years they may be influenced in terms on their thinking on  
22 this whole topic.

1           I wanted to just inform you that the AAMC, over  
2 the past several years, has convened a variety of task  
3 forces and expert panels and produced a number of documents  
4 and guiding principles on this topic. We would be happy to  
5 provide those to you or give you access to our staff and  
6 member experts.

7           I would additionally add that, as timing would  
8 have it, if you were to go to our homepage -- at least as of  
9 last night -- the top topic on there is around conflicts of  
10 interest and some recent work by the AAMC. So I would offer  
11 that materials or information for your use if it would be  
12 helpful.

13           Thank you.

14           MR. HACKBARTH: Okay, we'll reconvene tomorrow at  
15 9:00 a.m.

16           [Whereupon, at 5:26 p.m., the meeting was  
17 recessed, to reconvene at 9:00 a.m. on Thursday, March 6,  
18 2008.]

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1 MEDICARE PAYMENT ADVISORY COMMISSION

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PUBLIC MEETING

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The Horizon Ballroom

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Ronald Reagan Building

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International Trade Center

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1300 Pennsylvania Avenue, N.W.

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Washington, D.C.

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Thursday, March 6, 2008

9:04 a.m.

COMMISSIONERS PRESENT:

- GLENN M. HACKBARTH, J.D., Chair
- ROBERT D. REISCHAUER, Ph.D., Vice Chair
- MITRA BEHROOZI, J.D.
- JOHN M. BERTKO, F.S.A., M.A.A.A.
- KAREN R. BORMAN, M.D.
- RONALD D. CASTELLANOS, M.D.
- FRANCIS J. CROSSON, M.D.
- THOMAS M. DEAN, M.D.
- NANCY-ANN DePARLE, J.D.
- DAVID F. DURENBERGER, J.D.
- JACK M. EBELER, M.P.A.
- JENNIE CHIN HANSEN, R.N., M.S.N., F.A.A.N
- NANCY M. KANE, D.B.A.
- ARNOLD MILSTEIN, M.D., M.P.H.
- WILLIAM J. SCANLON, Ph.D.
- BRUCE STUART, PH.D.

1 NICHOLAS J. WOLTER, M.D.

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

2 MR. HACKBARTH: We have two sessions scheduled for  
3 today. The first is on refining the payment system for  
4 skilled nursing facilities.

5 Carol, will you lead the way and introduce our  
6 guests?

7 DR. MILLER: Actually, I'm going to do that  
8 quickly.

9 I just want to acknowledge and introduce Bo  
10 Garrett and Doug Wissoker from the Urban Institute.

11 They here today, they have done the work in  
12 developing the models that we are going to go through and  
13 the simulations that you are going to hear about.

14 Often our conversations go in kind of policy  
15 directions but they're here to deal with the technical  
16 questions of the analysis.

17 I just want to acknowledge them because if we go  
18 off in the policy direction and they don't get a lot of play  
19 here, it's important to know that we couldn't be having this  
20 conversation without their work. And going forward, if you  
21 pick up these ideas, they will pay play an instrument role  
22 with us and the staff educating the rest of the world about

1 what the underlying structure here is.

2 So I just want to acknowledge the work of the two  
3 of them before we get going.

4 DR. CARTER: Over the past several years, we have  
5 discussed two widely acknowledged problems with Medicare's  
6 PPS for SNFs. First, it does not adequately adjust payments  
7 to accurately reflect the cost for nontherapy ancillary  
8 services. These are things like IV medications, respiratory  
9 care, and drugs.

10 Nursing costs are used as a proxy to adjust  
11 payments but they're a poor proxy. NTA costs don't always  
12 vary with nursing costs and they are much more variable. So  
13 while SNF payments in the aggregate are more than adequate,  
14 they are not sufficiently targeted.

15 The second key problem with the PPS is that  
16 payments vary with the amount of therapy delivered, creating  
17 an incentive to provide therapy for financial reasons.  
18 We've reported that the share of beneficiaries receiving  
19 therapy and the amount that they receive have both continued  
20 to increase.

21 Another omission of the PPS is that it does not  
22 include an outlier policy to defray the cost for

1 exceptionally costly care. Over the years we've seen  
2 evidence of these problems. Patients who need expensive  
3 IVs, antibiotics or expensive drugs or ventilator care are  
4 harder to place than other patients. You have raised  
5 concerns about the large differences in the financial  
6 performance between hospital-based and freestanding SNFs and  
7 between nonprofits and for-profit facilities.

8 I just want to give you a brief overview of what  
9 we're going to talk about today. We're going to go over the  
10 designs to pay for NTA and therapy services. We're going to  
11 describe an example outlier policy. Then we're going to  
12 walk through our simulations of the impacts on payments.  
13 And then I want to raise some data concerns that we have  
14 about the limitations and what we could do to improve the  
15 data that are available.

16 There are two draft recommendations for your  
17 consideration.

18 Just a quick overview and reminder, the SNF  
19 payment system consists of three components that get added  
20 together. There's a nursing component, a therapy one, and  
21 an other, which is a room and board. Those get added  
22 together. There are 53 case-mix groups that are used to

1 adjust payments. The key here is that therapy minutes are  
2 used to establish payments.

3 In our proposed design, you can see that the  
4 nursing component would stay the same. We are going to  
5 revise the therapy component with a completely different  
6 design. We are going to add a new NTA component, and so now  
7 you're going to add four components together instead of  
8 three. And then on top of that, for the stays that qualify,  
9 there would be outlier payments.

10 In designing the PPSs, the components that  
11 establish the NTA and therapy components use a variety of  
12 patient and state characteristics, and you can see those on  
13 the slide. Under the broad stay classification, the therapy  
14 component uses an indicator of whether the patient received  
15 more than the minimum amount of therapy required to get  
16 grouped into a rehabilitation RUG. Payments don't increase  
17 as a function of the amount of service that's provided  
18 beyond this minimum, but rather as a function of the patient  
19 and stay characters of the patient, such as was the patient  
20 recovering from a stroke or a hip fracture?

21 We explore different designs for each component  
22 and then use the one that was the best at predicting NTA and

1 therapy costs to model how payments would change under a  
2 revised PPS. I'm not going to go through the details of the  
3 modeling but Doug and Bo are here to answer any questions  
4 that you have.

5           These results we presented back in November so  
6 they should be fairly familiar to you. Under the NTA new  
7 component, the new component explains the differences in  
8 costs of NTA services per day much better than the current  
9 design. You can see the comparison at the state level is 23  
10 percent compared to 5 percent and at the facility level 31  
11 percent compared to 13 percent.

12           One measure that I want to spend a little time on  
13 is to assess the accuracy we also used something called the  
14 CMI coefficient. This measures the costliness of the  
15 facility's mix of patients captured by the payment design.  
16 We look for a coefficient of one, which would indicate that  
17 payments are perfectly proportional to costs.

18           In the current design, you can see that the CMI  
19 coefficient is well above one, it's 2.34, indicating that  
20 facilities with above average NTA case-mix are underpaid for  
21 the services they provide, and facilities with below average  
22 NTA costs are being overpaid.

1           In the new component, you can see that the CMI,  
2 while not perfectly proportional to costs, is a lot better  
3 than the current PPS design. The component would distribute  
4 payments for NTA services much more in line with their costs  
5 and thereby reduce the incentives to avoid such cases.

6           Now we're going to turn our attention to the  
7 redesign of the therapy component. And here, comparing the  
8 first three measures, you can see that the revised design is  
9 essentially as accurate as the current one. Where they are  
10 really different is in the last line.

11           The redesign would result in payments that are  
12 much more proportional to cost than the current design. The  
13 current design tends to overpay facilities with above  
14 average therapy costs and underpay facilities with below  
15 average therapy costs.

16           In contrast, the redesign has the CMI coefficient  
17 that's much closer to one, so payments will be much more  
18 proportional to their costs and there will be much less  
19 financial incentive for providers to adjust their mix of  
20 cases for financial gain.

21           As in any PPS, we need to be mindful of the  
22 incentive to under furnish therapy services. CMS will need

1 to monitor the provision of therapy and patient outcomes,  
2 underlining the need to assess patients at admission and  
3 discharge, which the Commission has repeatedly recommended.

4 CMS could also lower the risk of stinting on  
5 services by adopting a pay for performance based payment  
6 using quality measures which we recently recommended. And  
7 they could use changes in functional status as one of the  
8 measures.

9 Now I want to turn to the design of the outlier  
10 policy. Although outlier policies typically consider total  
11 costs, we designed one focused on ancillary costs, which  
12 include NTA and therapy costs. Ancillary costs are highly  
13 variable and they vary due to differences in patients. A  
14 total ancillary cost outlier policy will provide equal  
15 consideration to patients with exceptionally high therapy or  
16 NTA costs. The policy focuses on per stay, not per day  
17 costs because of the financial risk to an institution is the  
18 costs incurred over the stay, not on any given day.

19 The example outlier policy that we modeled is a  
20 \$3,000 fixed loss on ancillary costs. SNFs would have to  
21 incur losses about equal to the average ancillary cost per  
22 stay and then they would qualify for an outlier payment.

1 This created an outlier pool of 1.7 percent of payments.

2           With the best models predicting NTA and therapy  
3 costs and the outlier policy, we estimated the impact that  
4 the redesigns would have on total payments. The three  
5 policies together shift payments in the directions that we  
6 anticipated. The revised PPS would redistribute payments  
7 from freestanding and for-profit SNFs to hospital-based SNFs  
8 and nonprofit SNFs. Payments to hospital-based facilities  
9 would increase 20 percent while payments to freestanding  
10 facilities would decline slightly, 2 percent.

11           By ownership, payments to nonprofits would  
12 increase 7 percent while payments to for-profits would  
13 decline 3 percent. In aggregate, payments to rural and  
14 urban facilities would remain unchanged.

15           As expected, we found that the revised PPS design  
16 would shift payments across facilities based on their mix of  
17 patients. It would redirect payments towards patients with  
18 high NTA care needs and away from therapy care that is not  
19 related to patient characteristics.

20           Payments to SNFs with high shares of rehab RUG  
21 stays would decrease 6 percent in aggregate, compared to  
22 current payments. Payments to SNFs with high shares of



1 extensive services stays -- these are patients needing IV  
2 medications, tracheostomy care, or ventilator support --  
3 would increase 15 percent.

4           Because SNFs vary considerably, their impacts are  
5 not uniform. Here I'm showing you just what would happen,  
6 who in the distribution experiences large and small changes  
7 in their payments. For example, the first row shows the  
8 impact on hospital-based SNFs. Although payments to almost  
9 three-quarters of hospital based SNFs would increase at  
10 least 10 percent, there was won percent of SNFs that would  
11 experience a 10 percent decline in their payments.

12           Looking by patient mix, over one-quarter of SNFs  
13 with high shares of rehab only stays would see their  
14 payments decrease by at least 10 percent, but 6 percent of  
15 facilities would see their payments increase by 10 percent.  
16 So it's just trying to give you a sense that there is a  
17 distribution out there. Not all of the facilities in one  
18 category gain payments or lose payments.

19           We examined the Medicare margins of SNFs that  
20 would experience the largest and smallest changes in their  
21 payments. I want to note that there was a mistake in your  
22 mailing materials. In this table the last two headers are

1 switched, and that's on page 26.

2 Under the revisions to the PPS, the vast majority,  
3 that is 83 percent of SNFs would experience the largest  
4 declines in payments had Medicare margins that were at least  
5 10 percent in 2003. Conversely, 70 percent of SNFs that  
6 would see their payments increase by more than 10 percent  
7 had Medicare margins of negative 10 percent or lower.

8 As a result, the widely divergent financial  
9 performances are going to narrow. Aggregate margins would  
10 change the most for hospital-based SNFs. Despite the large  
11 increases in payments for most hospital-based SNFs, most  
12 would continue to have negative margins. This is because  
13 the revisions only affect ancillary payments and those make  
14 up just over half of the daily payment.

15 Their very high routine and overhead costs at many  
16 hospital-based facilities would still affect these  
17 facilities' financial performance.

18 Now I want to look a little bit at what the impact  
19 of the outlier payments had on facilities. The outlier  
20 policy that we modeled affected 2.6 percent of stays and  
21 were distributed very broadly over 60 percent of SNFs. A  
22 slightly higher share of hospital-based SNFs would receive

1 outlier payments. Although a majority of facilities would  
2 receive an outlier payment, only a subset of them would, on  
3 net, benefit from the outlier policy. That is, the outlier  
4 payments that they would receive from the pool would exceed  
5 what they had paid into it. And an even smaller group, 7  
6 percent of SNFs, would see their payments increase by more  
7 than 5 percent. So it's a fairly targeted outlier policy  
8 that we modeled.

9           So a summary slide here, our analysis indicates  
10 that compared to the current system the revised PPS would  
11 more accurately pay for NTA services, pay as accurately for  
12 therapy services using patient and stay characteristics, and  
13 offer some SNFs financial protection against extraordinarily  
14 high cost cases. Because payments would be more accurate,  
15 access would improve for beneficiaries who require expensive  
16 NTA services.

17           I would like to point out that this revised PPS  
18 does not require any new data but the designs are slightly  
19 more accurate when they include hospital diagnostic  
20 information. We think this information should be  
21 communicated between hospitals and SNFs but note that this  
22 would require coordination between providers.

1           In view of our findings, we propose the following  
2 recommendation: that Congress should required the Secretary  
3 to revise the SNF prospective payment system by adding a  
4 separate nontherapy ancillary component, replacing the  
5 therapy component with one that establishes payments based  
6 on predicted patient care needs, and adopting an outlier  
7 policy.

8           These revisions would be implemented in a budget  
9 neutral way so there would be no impact on program spending.  
10 Payments would be more accurate and would increase to some  
11 SNFs and decrease to others, and they would improve access  
12 for beneficiaries with high NTA care needs. To implement  
13 these revisions, CMS would need to make many changes that  
14 are consistent with those it makes when implementing or  
15 revising the PPS.

16           In doing this work, we identified several areas  
17 where better data would make payments more accurate and  
18 allow us to link payments and costs to outcomes. Currently,  
19 the SNF diagnosis data is very poor. SNF claims have fields  
20 for recording this information but the data are not required  
21 for payment. SNF claims also do not include the dates when  
22 individual services are provided. Dates would help predict

1 daily costs more accurately, evaluate utilization throughout  
2 a stay, and allow costs to be linked to patient assessment  
3 information.

4           The current patient assessment tool requires SNFs  
5 to report on services provided during the past 14 days.  
6 This look back period makes it impossible to distinguish  
7 between services furnished by the SNF from those furnished  
8 during the prior hospital stay. The look back periods may  
9 they also generate higher than necessary payments, since  
10 services provided during the preceding hospital stay can  
11 qualify patients for higher paying RUGs.

12           And last, the SNF cost report does not require  
13 facilities to split out nursing costs from routine costs.  
14 While not a substitute for patient level information, this  
15 facility level nursing cost information would allow us to  
16 examine the relationships between case-mix, cost, quality,  
17 and staffing. Many Medicaid cost reports already require  
18 this information.

19           This leads us to our second draft recommendation.  
20 The Secretary should direct SNFs to report diagnosis  
21 information and dates of service on their claims, services  
22 they furnish separately on the patient assessment, and their

1 nursing costs separately from routine costs on the Medicare  
2 cost report.

3 And now we look forward to your discussion.

4 MR. HACKBARTH: Well done, Carol, Bo, Doug.

5 Thank you very much.

6 A quick question just for clarification, Carol.

7 Would you put up slide 11?

8 This, as I understand it, does not include the  
9 effect of the outlier piece? This is just --

10 DR. CARTER: It does include the outlier. It  
11 includes everything.

12 MR. HACKBARTH: What's the downside on this?

13 DR. CARTER: I do think we need to be mindful that  
14 providers, given that you're paying them now a prospective  
15 rate, we want to make sure that beneficiaries continue to  
16 receive services that they require. And that's where using  
17 a pay for performance policy would really help to make sure  
18 that patient care isn't eroding under a prospective payment  
19 system. It's identical to any PPS, where you pay a set rate  
20 and you have to worry about the care that patients get after  
21 that.

22 MR. HACKBARTH: Questions, comments?

1 DR. SCANLON: I think there's only upsides here  
2 and I really want to congratulate you on getting us to this  
3 point. It's been only about 10 years that we've know that  
4 we've had these problems and we now have a way of trying to  
5 address them.

6 It's interesting that Mark made the comment about  
7 technical versus policy, because I was thinking of this as  
8 we're not really changing policy. We set out to have a PPS  
9 and if were going to do a PPS right from the beginning we  
10 would've done these things. And so again, thankfully we're  
11 here.

12 The downside that Carol mentioned, I do think  
13 there's more than perhaps waiting for pay for performance  
14 that we can think about. And maybe we should be thinking  
15 about in terms of a policy prescription is that when we know  
16 there's a risky incentive that we have in a system that we  
17 need to take actions ahead of time, as opposed to waiting  
18 for problems to happen and then respond to it.

19 I guess in the context of therapies, the risk is  
20 of under provision. And the question is whether we can  
21 borrow something from the home health PPS, which is the  
22 utilization adjustment, which is to say we're going to

1 project the amount of therapy we think you need. But if you  
2 go so far below that then we're going to adjust the payment.  
3 And it could be in terms of a percentage of the therapy  
4 that's received over the course of the entire stay, as  
5 opposed to anything on a per day basis.

6 That was one seemingly risky incentive that seemed  
7 to be in the system.

8 The other one, I guess, was not so much the  
9 patients that were at risk but kind of the financial  
10 integrity was you raised the issue of the outlier and how  
11 maybe it should be adjusted for length of stay. I think it  
12 probably should be adjusted for length of stay and we need  
13 to think about how to do that, as opposed to waiting for  
14 something to happen which would be that we would suddenly  
15 discover we have all longer lengths of stay, which might get  
16 people into outliers.

17 This PPS is vulnerable to that because it is a per  
18 day PPS, unlike the others.

19 DR. CARTER: I just want to clarify. You're  
20 talking about paying a lower marginal cost after say the  
21 median length of stay?

22 DR. SCANLON: Yes. And maybe even having some



1 variation in that percentage that you pay. This is  
2 something to be thought about, but I think pointing in that  
3 direction. Again, the principle is if we've got a risky  
4 incentive, let's address it from the beginning as opposed to  
5 seeing if we have a problem ex poste, because then it's  
6 harder to make changes.

7           The other policy principle maybe should be that  
8 there should be no embarrassment about asking for  
9 information when we're paying this much money. One, it's  
10 the information coming out of the facilities and they have  
11 that.

12           This idea that there has to be some communication  
13 between the providers, I have also no problem with and  
14 particularly because of this case. People do not enter SNFs  
15 through the SNFs emergency department because they don't  
16 have them. What happens is you have to apply to a SNF and  
17 explain what services you're going to need before you're  
18 admitted. So there's already a communication going on. The  
19 question is we should make sure that it's done in a way that  
20 we know what's happening and that we know that there's an  
21 adequate amount of information that's being transmitted back  
22 and forth.

1           If we want it in the policy I think that's fine,  
2 but that's the policy that I would push, that we really  
3 shouldn't be embarrassed about asking for information to  
4 improve our payment and our understanding of what we're  
5 getting and in the process we're protecting beneficiaries.

6           DR. STUART: I agree with Bill. I think these are  
7 excellent recommendations and long overdue. And it's a slam  
8 dunk. We ought to do them.

9           Having said that, I wonder about, even though  
10 there are relatively few facilities that are going to take a  
11 big hit -- 10 percent or less -- I'd be interested in  
12 knowing a little bit more about those. In particular,  
13 quality of care in nursing homes has been a big issue in the  
14 press recently. It's been around for a long time. CMS has  
15 a list of poor performing facilities. I'd be wondering  
16 whether there's any correlation between gains and losses and  
17 whether the facilities are on that list or what they look  
18 like according to other quality criterion.

19           And then I'd also wonder about whether you would  
20 suggest that there be some kind of a phase-in period for  
21 this and whether there would be special quality monitoring  
22 for firms that would be losing funds under it because those

1 are the ones that you're probably most concerned about.

2 DR. CARTER: We talk about a phase-in period in  
3 the paper. PPSs and revisions to PPSs sometimes are done  
4 with a phase-in period and some are not.

5 I think if there is a transition it should be  
6 short because right now we've got a big mismatch in payments  
7 and so the shorter time period that we can make changes to  
8 make payments more accurate, I think the better. But I  
9 think a two or three-year transition would be okay.

10 About your other point, we haven't looked at the  
11 quality measures. I will say that we did look at the  
12 financial performance of the SNFs that would take the  
13 largest reductions in payments, and they are the high-  
14 performing SNFs. They are the SNFs with margins that were  
15 at least 10 percent or higher.

16 So at least we know something about their  
17 financial performance but we haven't looked at the quality  
18 measures. But that is something that I think CMS should be  
19 looking at. And we, of course, have made recommendations to  
20 improve their quality measures.

21 DR. SCANLON: I would just comment that it's very  
22 hard to look at the quality of SNFs across the country. The

1 special focus facilities that Bruce mentioned, it's a  
2 program where each state is to target a few very limited  
3 number, probably under five. And they're potentially among  
4 the worst in that state. But each state is doing it, so  
5 it's not consistent across the country in terms of what  
6 might be wrong with those.

7           And then as you do look at the data across the  
8 country from the nursing home surveys, there are such great  
9 difference that no one really believes that they're  
10 consistently measured, that we have very large proportions  
11 of facilities in some states where we have found  
12 deficiencies of actual harm and very small numbers in other  
13 states. Nobody can believe that the underlying differences  
14 among those homes in those states reflects that.

15           MR. HACKBARTH: It would be interesting to look  
16 with our two new proposed measures of discharge to the  
17 community and readmission to the hospital, how to the  
18 different groups of SNFs look on those of quality measures  
19 to see if there are any interesting patterns.

20           Arnie, did you have a comment on this particular  
21 point?

22           DR. MILSTEIN: No, on the presentation. Not on

1 this point.

2 MR. HACKBARTH: I have you on my list. Let me get  
3 to some others.

4 MS. HANSEN: I just want to thank you. This is  
5 elegant work done relative to the two recommendations and  
6 how you came about it. I think one of the things relative  
7 to quality and prevention, I think, Bill, your point about  
8 knowing where the stinting could possibly occur and putting  
9 in basically a stop or basically a marker for seeking out  
10 whether or not that kind of risk could be mitigated. At  
11 least that would be highlighted and people would know it in  
12 advance so it would be fair.

13 The second thing is I really appreciate the aspect  
14 of asking for data because, in fact, I think, Glenn, I was  
15 going to say that the fact that we're going to be looking at  
16 the readmission issue on the other side, that without that  
17 kind of data we really won't know. And I know there are  
18 just a lot of finger-pointing kinds of issues sometimes that  
19 inadvertently occurs to issues of quality of say decubitus  
20 ulcers, as to where they start. So I think the ability to  
21 really have those data elements measured early.

22 And then finally, I appreciate the fact that one

1 of your subsets is relative to the staffing component.  
2 We've brought that up before. That's important to make sure  
3 that we have the qualified staff as one of the metrics  
4 there.

5 So again, I just really thank you, the ability to  
6 target this appropriately is the right thing to do.

7 And just the access issue that was concerned -- I  
8 guess this is more of a CMS element, but how we keep an eye  
9 on that as to what impact that might have for beneficiaries.  
10 Because right now there actually is a reverse discrimination  
11 already, I know some nursing homes won't take people just  
12 because they know they have high NTAs and they don't want  
13 them. So that actually has precluded access. So if  
14 anything, I think this might open the door better if they're  
15 paid appropriately.

16 Thank you.

17 MR. EBELER: It gets a little repetitive. I also  
18 think these are very good directions to go and support the  
19 directions.

20 Bill and Jennie captured the data idea. We  
21 shouldn't be embarrassed about asking for this. We need it  
22 for making sure the program is operating properly for the

1 beneficiary and the hospital to nursing home data is just  
2 the classic handoff where you just need to make sure that  
3 that is accompanied by the right clinical information for  
4 the next care team. So that strikes me as very logical.

5           Again, getting to -- we're flipping the incentives  
6 for therapies basically in this proposal, as I read this.  
7 Are there or can there be developed clinical and functional  
8 criteria for when that's appropriate? Because it strikes me  
9 that the stronger the professional criteria of the need for  
10 the service, the easier it is to monitor and understand  
11 what's going on. If the criteria are soft, you really need  
12 to worry more about the overuse and then the flip fast under  
13 use.

14           I don't know whether the criteria are clear now.

15           DR. CARTER: There are slowly being developed sort  
16 of clinical pathways and sort of the right -- how much  
17 therapy a typical stroke patient needs. They tend to be  
18 fairly general. The ones that I have seen tend not to focus  
19 on the elderly population. But that's an area that we  
20 should look at.

21           I did want to point out that this payment system  
22 does use patient characteristics to project the amount of

1 therapy somebody is needing. So a patient that is  
2 recovering from a stroke or a hip fracture is going to get a  
3 higher payment.

4 MR. EBELER: I don't dispute that. It's just if  
5 the criteria are soft, it just seems to me you lean more  
6 towards Bill's argument of building in mechanisms and  
7 measures so that you can really know what's happening there.

8 I think this is a great way to go.

9 DR. MILSTEIN: I'm also supportive of this  
10 direction and my comments are just a slight variant on  
11 Jack's.

12 Glenn asked whether what are the potential flies  
13 in the ointment. Essentially, what we've done here is we've  
14 built a better fitting model by, among other things,  
15 allowing into our predictor variable how much clinical  
16 activity is going on, things like that. How many patient  
17 assessments are done and whether respiratory care is, for  
18 some patients, initiated or not.

19 So if you say what's the down side of that, in  
20 order to achieve a better fitting model we have  
21 inadvertently tilted slightly in the direction of paying  
22 more for more services. That's the essence of this model.



1           Having said that, I think it's the right direction  
2 to go and I think that some kind of anticipation that there  
3 will be a small subset of revenue maximizers who may be  
4 inclined at the margin to look at these opportunities for  
5 actually changing the course of care, maybe through a  
6 medical director of the facility that's managing a lot of  
7 the patients and writing some of the orders and/or very  
8 simple such as -- I don't know whether there's such a thing  
9 as potential for broad stay classification creep. I don't  
10 know whether that's completely impossible or not. But those  
11 are the kinds of things that I would want to think about  
12 putting tripwires in place to monitor.

13           That said, I believe this is a favorable  
14 direction. The better fitting models intuitively appeal to  
15 me as a positive direction.

16           MR. HACKBARTH: In the case of the therapy  
17 payment, actually what we've done is move away from a system  
18 that ties payment very closely to the amount of therapy used  
19 or expected to be used to one that ties it more to the  
20 characteristics of the patients. So we've moved away from  
21 the use payment link.

22           DR. MILSTEIN: In that category but toward it in

1 nontherapy ancillaries.

2 MR. HACKBARTH: Right.

3 DR. MILLER: I'm not sure I would characterize it  
4 like that. On the nontherapy ancillary, it's also true that  
5 it's based on the patient characteristics predicted.

6 DR. CARTER: Right.

7 DR. MILSTEIN: But not only on the patient  
8 characteristics.

9 DR. MILLER: On nontherapy ancillaries?

10 DR. MILSTEIN: The models I looked at has both  
11 patient characteristics and stay characteristics.

12 DR. CARTER: They have both, right, they do. I  
13 guess I wanted to say one thing that wasn't I don't think  
14 quite accurate, and I'm going to turn to these guys.

15 As the stays get longer, the payments actually get  
16 less because they're reflecting longer stay and the stays  
17 tend to be less intensive. So I just wanted to make sure  
18 that you understood the directions of those.

19 DR. KANE: I'm along the same lines of Arnie. I  
20 think this is great and I guess -- although this isn't my  
21 main question -- one question is why wasn't this done 10  
22 years ago? Is there something new and different going on?

1 None of this looks like it was not available that long ago.

2           The more specific question is the prior nursing  
3 home resident characteristic. I do feel that could be  
4 manipulable, depending on what that means. So could you  
5 just clarify does that mean any time in the last five years?  
6 Any time in the last week? Anytime in the last -- is it  
7 related to this particular reason that they're in the  
8 nursing home this time?

9           Because I am a little concerned that somebody  
10 might get readmitted to the hospital and then --

11           DR. CARTER: It's within the last six months.

12           DR. KANE: So this is going back to what Arnie was  
13 saying, there is a little bit of a risk that an unscrupulous  
14 nursing home would have somebody readmitted and then come  
15 back out. Would that be considered a prior nursing home  
16 stay then, even though they were sort of put in to fix the  
17 pneumonia or the infection and then brought back out again?  
18 Or would that be considered -- I don't know.

19           I just wouldn't want it to be something that  
20 somebody could manipulate along the lines of what Arnie was  
21 worried about. Or if it was how we would put safeguards in  
22 to be sure that there was no extra churning.

1 DR. CARTER: It's a non-PPS nursing home stay.

2 Does that help you understand that?

3 DR. KANE: No, actually that makes me even a  
4 little more worried because they're on Medicaid that means.

5 DR. CARTER: Or something else.

6 DR. KANE: So there's a lot of incentive to put  
7 them back in the hospital and put them into a potentially  
8 even higher in Medicare. Is there some way to protect -- am  
9 I wrong in thinking that could be a problem? And if I'm  
10 right, what should we do to prevent that kind of churning  
11 possibility?

12 MR. GARRETT: It happens that the weight on the  
13 prior nursing home variable is negative, so it actually  
14 suggests that there are lower expects costs for those  
15 patients.

16 DR. CARTER: Because they are lower intensity  
17 patients. Because those are really reflecting long stay  
18 patients with much lower level care needs.

19 DR. MILLER: What I would also say is we've heard  
20 you guys. Remember, this is the beauty of going through it  
21 twice, March and April. We've heard you guys on okay, are  
22 there any particular elements inside the model where we

1 might be exposed? And then we start thinking through some  
2 of the stuff that Bill is saying. Do you put an inlier in?  
3 Or do you put some -- to use a word somebody said -- a  
4 tripwire to try and look at this? And we've definitely  
5 heard you guys on there's some elements we'll look a little  
6 tighter at and see if there's anything to put in just to  
7 backstop this problem.

8           But I'm hearing the parameter estimate works a  
9 little bit against the gaming. But nonetheless, we have  
10 heard you and we've heard that there's at least two or three  
11 other things you want us to look carefully at. And we'll  
12 come back and make sure that we've wired that for the next  
13 time.

14           DR. WOLTER: I'm obviously very pleased to see  
15 this, also. And just wanted to point out a couple of the  
16 contextual issues, at least as I see them.

17           In past discussions, we have seen some data that  
18 the product in a hospital-based SNF is different than in a  
19 freestanding SNF. When I was part of the LTCH visits we did  
20 a few years ago, in some communities we heard loud and clear  
21 that, as hospital-based SNFs closed, freestanding SNFs  
22 really didn't have the capability to take care of some of

1 the patients that go into the LTCHs. And about a third of  
2 hospital-based SNFs have closed in the last four or five  
3 years, maybe more than that.

4 And so I think that trying to devise a payment  
5 system that better captures the clinical conditions that we  
6 are treating hopefully will have providers looking at how to  
7 provide the capacity to do that.

8 I know in the past, also, we've talked about there  
9 remains overlap between patients who might go particularly  
10 to hospital-based SNFs, rehab units, or LTCHs. And could we  
11 devise a classification system that looked at ultimately a  
12 payment system that would focus on the patient, regardless  
13 of the setting that they went into?

14 At least a few years ago we talked about that as  
15 an ideal. Seeing how long it takes to do something like  
16 this makes me wonder if we can get to the other. But it  
17 would be still a nice goal to look at how could we focus the  
18 payment on the patient characteristics regardless of whether  
19 they're in a hospital-based SNF, an LTCH, in a rehab unit,  
20 for example. Because not all communities have a lot of  
21 choice in regard to those services.

22 So maybe that's something we can keep our eye on

1 as this unfolds.

2 MR. HACKBARTH: Carol, could you update us on --  
3 as I recall Congress, asked CMS to set up a demonstration  
4 project that focused on identifying patient characteristics  
5 and needs and was neutral in terms of the type of facility.  
6 What's the status on that project?

7 DR. CARTER: This is a demonstration to use a  
8 common patient assessment tool starting at hospital  
9 discharge. And it's being implemented in, I guess, all of  
10 the post-acute settings. The tool has been piloted and I  
11 think the pilot was done in Chicago. The first market is  
12 being implemented I think in March and it's going to be  
13 tested in seven other markets, sort of rolled out over the  
14 summer.

15 The results of that demonstration, I think a  
16 report is due to Congress in 2011.

17 MR. HACKBARTH: Is the demo just focused on the  
18 new patient assessment instrument? Or there also a payment?

19 DR. CARTER: They're collecting cost information,  
20 as well.

21 MR. HACKBARTH: So they can compare for comparable  
22 patients.

1 DR. CARTER: CMS, in the long run, is headed  
2 exactly where Nick talked about.

3 DR. DEAN: I just wanted to tag on to Bill's last  
4 comment, and I think Jack mentioned it too, about the  
5 importance of clinical data being transferred -- and it's  
6 probably beyond the scope of what you're doing.

7 I am on the receiving end of a lot of transfers to  
8 a skilled nursing facility in our local critical access  
9 hospital that come from a long distance away where they've  
10 had surgery in Sioux Falls, which is 125 miles away. And I  
11 don't have any day-to-day contact with what's happened.

12 It's like pulling teeth to get the information  
13 that we need sometimes. We made a rule that there has to be  
14 direct physician to physician communication in order for us  
15 to accept these patients. And you would have that we were  
16 asking for -- I don't know what. It's just a constant  
17 battle.

18 Patients come back -- fortunately, they're usually  
19 patients that I know, so that's a big help. But they will  
20 be on antibiotics or they'll be on a bunch of new drugs.  
21 And the information that we get just doesn't justify those  
22 things. And so we have to struggle.



1           Like I say, I'm sure it's beyond the scope of what  
2 you're doing, but it's a frustration I couldn't avoid  
3 bringing up. I don't know what the answer is but it's an  
4 ongoing problem.

5           MR. HACKBARTH: Any others?

6           Okay, well done. Terrific work.

7           And the final session is on hospice cost and  
8 payment. Jim, you can start when ready.

9           DR. MATHEWS: Good morning. I'll say up front, I  
10 hope this presentation engenders a little more discussion  
11 than the last time I was up here. I think I got a courtesy  
12 question. I could start with a few jokes, if that helps.  
13 Maybe not

14           Today I will be talking about the third in our  
15 series of presentations on hospice that we began in the fall  
16 of last year. I will talk largely about two things today.  
17 The first is the effect of hospice on Medicare spending at  
18 the end of life relative to non-hospice care. The second is  
19 an analysis of Medicare payments for hospice relative to  
20 providers' cost.

21           We have discussed specific details of the hospice  
22 benefit previously, so I won't cover those again. But I do

1 want to make a couple of key points by way of preface to the  
2 substantive part of this discussion.

3 First, the Medicare hospice benefit was  
4 established to give beneficiaries an alternative to  
5 conventional medical treatment for terminal conditions at  
6 the end of life. Hospice provides an enhanced benefit  
7 package that is consistent with the preferences of those who  
8 do not want aggressive end-of-life care.

9 Second, the passage of this benefit as part of  
10 TEFRA was conditioned on the premise that it would be less  
11 expensive than conventional medical treatment at the end of  
12 life. Arnie, you and other commissioners asked about this  
13 when we discussed hospice in November.

14 In response, we conducted a comprehensive  
15 literature review of analyses of the cost of hospice  
16 relative to conventional end-of-life care. These range from  
17 evaluations of the National Hospice Study in the early  
18 1980s, to studies published just last year.

19 In evaluating these data, I would recommend not  
20 getting too caught up in the specific dollar amounts.  
21 Rather, it's more constructive to focus on the overall  
22 trends as they pertain to potential changes in Medicare's

1 hospice payment system. Such changes are warranted, given  
2 that Medicare spending for hospice exceeded \$10 billion in  
3 2007, more than the program spent on inpatient rehab  
4 inpatient facilities, critical access hospitals, long-term  
5 care hospitals, CORFs, psychiatric hospitals, ambulatory  
6 surgical centers, or clinical lab services. It is no longer  
7 a niche benefit.

8           However, that payment system has not been  
9 fundamentally updated since its inception 25 years ago. We  
10 believe that the payment system embodies conflicting  
11 incentives that create substantial tensions that undermine  
12 the long-term stability of the hospice benefit.

13           There are a few common points that can be  
14 extrapolated from the literature on the effect of hospice on  
15 Medicare end-of-life spending. First, beneficiaries who  
16 elect hospice incur less absolute spending in the last two  
17 months of life than beneficiaries who did not elect hospice.  
18 This spending differential is achieved largely via the  
19 substitution of less costly hospice care for more costly  
20 inpatient services. So a beneficiary in hospice may incur  
21 \$4,000 in Medicare spending in their last two months life  
22 while a comparable beneficiary who does not elect hospice

1 may incur twice that amount of spending.

2 Medicare spending for beneficiaries electing  
3 hospice may be lower than non-hospice enrollees in the third  
4 or fourth months before death, but maybe not. Patient-  
5 specific or other factors may affect the cost relationship  
6 in these months. In rough terms, spending levels are  
7 comparable for hospice and non-hospice beneficiaries in  
8 these months.

9 The cost of patients enrolled in hospice is higher  
10 than the cost for patients not enrolled beginning as early  
11 as the fourth month before death if not sooner, but  
12 definitively so by the sixth month before death.

13 The magnitude of the spending reduction in months  
14 one and two is so large, however, that hospice enrollment  
15 may still produce lower net spending through five to seven  
16 months.

17 The literature also suggests that over the course  
18 of the last year of life hospice has either no effect on  
19 Medicare spending relative to beneficiaries who do not elect  
20 hospice, or it can even result in higher spending.

21 So in general, the effect of hospice in lowering  
22 Medicare spending at the end of life is a function of the

1 length of hospice enrollment. The patient's terminal  
2 disease also plays a role. As I mentioned a moment ago,  
3 hospice use results in a reduction in Medicare end-of-life  
4 spending by reducing Part A utilization, largely inpatient  
5 hospital admissions. So in addition to length of stay,  
6 hospice's ability to result in lower Medicare spending  
7 relative to conventional end-of-life care depends on the  
8 amount of Part A utilization associated with the last six  
9 months of life for a given terminal disease.

10 To summarize the first part of this presentation  
11 then, hospice results in lower Medicare spending relative to  
12 conventional end-of-life care in absolute terms only in the  
13 last two months of life. Net lower spending can persist to  
14 roughly six months. These estimates again can vary by  
15 patient characteristics such as terminal disease. You have  
16 a great deal more information on this point in your paper  
17 and we can discuss it at length if you prefer.

18 As we noted earlier, the hospice benefit was  
19 established based in part on the presumption that it would  
20 result in lower Medicare spending relative to conventional  
21 end-of-life care. Since that time, Medicare spending on  
22 hospice has grown considerably. Hospice spending tripled

1 between 2000 and 2007, reaching \$10 billion in that year.  
2 As we've discussed previously, its growth is fueled by more  
3 beneficiaries electing hospice and growth in spending per  
4 hospice enrollee.

5 The number of providers has grown along with  
6 spending, but what is interesting is that nearly 90 percent  
7 of the growth over this time has been in for-profit  
8 hospices, which have grown at a rate of about 12.5 percent a  
9 year over this time. For-profit hospices can either be  
10 associated with one of about five large national chains or  
11 they can be independent entities. Very few nonprofit  
12 hospices began participating in Medicare during this period.

13 Since Medicare pays for hospice on a per diem  
14 basis, spending per enrollee is largely a function of the  
15 length of time a patient is enrolled. Between 2000 and 2005  
16 mean hospice length of stay increased by over 30 percent.  
17 This increase is driven by the increase in long hospice  
18 stays, as stays at the median have remained largely stable  
19 over this time.

20 As we have discussed previously, length of stay is  
21 generally correlated with the hospice patient's terminal  
22 diagnosis. Some diagnoses, such as Alzheimer's disease and

1 chronic ischemic heart disease, have relatively longer  
2 lengths of stay, while patients presenting with diagnoses of  
3 renal failure or sepsis have much shorter lengths of stay.

4           But we found that diagnosis doesn't explain all of  
5 the variation in length of stay that we see among different  
6 hospice providers. You may recall our discussion in the  
7 fall of hospices affected by the aggregate per beneficiary  
8 payment limit, or the cap. Cap hospices had mean lengths of  
9 stay double that of non-cap hospices, and over 40 percent of  
10 episodes at cap hospices exceeded 180 days, compared to 15  
11 percent of episodes at non-cap hospices.

12           We hypothesized that cap hospices may be treating  
13 a disproportionate number of patients with conditions that  
14 typically have longer lengths of stay. This turned out to  
15 be true, but it was also the case that cap hospices had  
16 uniformly longer lengths of stay for all patients. So  
17 patient mix alone didn't explain the differences that we  
18 saw.

19           Given that CMS and its intermediaries generally  
20 issue the same guidance to hospice is regarding  
21 characteristics of patients suitable for hospice admission,  
22 we speculated that other nonclinical factors may be

1 influencing the growth in the length of stay.

2           In particular, we wanted to see if profitability  
3 could be a factor in explaining the increase. In the fall  
4 of last year we presented a hypothetical model illustrating  
5 this hypothesis in which margins increased with longer  
6 lengths of stay. This is because hospice episodes are  
7 nonlinear in cost. They are more expensive at the beginning  
8 and end of the episode, but Medicare's payments are  
9 generally linear. Therefore, a hospice would be able to  
10 increase its profitability by lengthening the relatively  
11 more profitable interim days to offset the less profitable  
12 days at the beginning and end of an episode.

13           We saw some oblique evidence of this possibility  
14 in the relationship between hospice's ownership status and  
15 length of stay. The lengthening of hospice episodes since  
16 2000 coincides with the large influx of for-profit hospitals  
17 participating in Medicare.

18           To evaluate this hypothesis, as well as to  
19 evaluate hospice financial performance overall, we needed a  
20 systematic analysis of hospice payments and costs. This had  
21 not been done previously. A number of commissioners  
22 expressed interest in hospice margins when we last discussed



1 the topic in November.

2 We therefore constructed an analytic database  
3 using hospice cost reports, claims, and provider data for  
4 2001 through 2005. We found that data quality was an issue  
5 and applied a number of edits and screens to cull aberrant  
6 data, resulting in a loss of slightly more than 20 percent  
7 of providers in each year. We then calculated the margins  
8 according to standard MedPAC protocols and checked our  
9 results against the few available point sources of  
10 information on hospice profitability. These included  
11 historical data from a survey by the National Hospice and  
12 Palliative Care Organization that included financial data,  
13 estimates of margins in the health services research  
14 literature, and financial analysis of the large publicly  
15 traded for-profit hospice chains.

16 Overall, we found that hospice aggregate margins  
17 tend to be in the low single digits across all years that we  
18 looked at, but with a couple of noteworthy modalities.  
19 Freestanding hospices have higher margins than provider-  
20 based hospices, which had negative aggregate margins in all  
21 years. Freestanding hospice's Medicare margins were 6.3  
22 percent in 2005, compared to negative 5.6 percent for

1 provider-based hospices. On average, margins are about 15  
2 percentage points apart for the two groups across these  
3 years.

4 Provider-based hospices had higher costs per day  
5 than freestanding hospices, in part because of overhead  
6 costs allocated from their parent provider, be it a  
7 hospital, home health agency, or SNF. There may be other  
8 factors that could explain part of this differential, such  
9 as differences in the intensity of hospice care or  
10 differences in staffing mix but data to do yet exist to  
11 assess these factors.

12 Nonprofit hospices had negative aggregate margins  
13 in all years, averaging about 17 percent lower than for-  
14 profit hospices margins across the years. As we note in  
15 your paper, other revenues for nonprofits can be  
16 significant. For-profit hospices have strongly positive  
17 margins in all years, ending up at nearly 12 percent in  
18 2005. Again, there is some interesting variation within the  
19 margins of for-profit hospices.

20 Looking at margins for urban and rural hospices,  
21 we found that there was about a 3 percentage point  
22 difference between urban and rural hospice margins for all

1 years except 2005, when they converged. When we examined  
2 our provider of services data, we found that the number of  
3 rural for-profit hospices increased by 25 percent in 2005,  
4 which might explain why the gap narrowed in that year.

5 We also calculated margins for hospices affected  
6 by the cap versus other hospices and found that margins for  
7 cap providers were substantially higher than others. These  
8 margins do include the overpayments that must be returned to  
9 the Medicare program, but we'll come back to that shortly.

10 We observed an interesting pattern in which  
11 margins rose from a low in 2001, peaked in 2003, and then  
12 declined a bit through 2005. We observed this trend across  
13 almost all hospice groups. We do not yet have an  
14 explanation for it, but now that the information is public  
15 we anticipate working with CMS and the hospice community to  
16 assess why this might be the case.

17 We also examined margins by Medicare participation  
18 date. We wanted to look at this aspect because we had heard  
19 that many new entrants into the program were in essence  
20 required to admit patients with longer lengths of stay and  
21 thus incurred a greater exposure to the Medicare hospice  
22 payment cap. According to the conventional wisdom, this was

1 because of existing referral relationships between more  
2 established hospices in a market and other elements of the  
3 local health care community.

4           As you can see in this slide, in each year from  
5 2001 to 2005 hospices that began participating in Medicare  
6 after January 1st of 2000 had consistently higher margins  
7 than those that began participating in the program before  
8 2000. This trend is consistent with the majority of  
9 hospices coming into the program after 2000 being for-profit  
10 entities.

11           So what drives this distribution of margins?  
12 Again, recall the hypothesis that longer stays are more  
13 profitable. We saw implicit evidence of this in the  
14 previous slide which showed margins for hospices affected by  
15 the cap. These hospices tend to have much longer lengths of  
16 stay than non-cap hospices, yet they are also the most  
17 profitable, putting aside the question of overpayment for a  
18 moment.

19           We wanted to test the hypothesis explicitly,  
20 however, and thus looked at hospices' margins as a function  
21 of length of stay.

22           In each year from 2001 to 2005, we grouped

1 hospices into length of stay deciles and compared their  
2 Medicare margins. We found that there was a nearly linear  
3 relationship between length of stay and hospices' margins.  
4 In all years hospices in the lowest length of stay decile  
5 had the lowest margins. In all years except 2005 hospices  
6 in the highest length of stay decile had the highest  
7 margins.

8           We're not sure if the explanation for the dip in  
9 hospice margins for the highest decile in 2005 but we see a  
10 similar dip in the EBITDA margins for one of the large  
11 publicly traded hospice chains. We will try and have a  
12 little more resolution of this issue by the next meeting.

13           Again, we analyzed the margins for cap hospices in  
14 detail and we found that there is considerable variation  
15 within these margins within each year. In 2005 one-quarter  
16 of cap hospices had Medicare margins of 4.7 percent or less  
17 while a quarter had margins of 28 percent or more.

18           We also note that so not that much of the cap  
19 hospices' margin is attributable to the overpayments.  
20 Subtracting the overpayments considerably erodes the  
21 profitability of these hospices. While the hospices in our  
22 database that exceeded the cap had an aggregate margin of 19

1 percent in 2005, subtracting those overpayments results in  
2 an aggregate margin of negative 2.9 percent.

3           The extent to which returning the overpayment  
4 affects hospices' Medicare profitability depends in part on  
5 the providers' cap liability and any subsequent behavioral  
6 response. There can be differences in hospices' response to  
7 a cap assessment. For example, when we reviewed the SEC  
8 filings for two large hospice providers, we found that in  
9 general when their cap liability reached a certain threshold  
10 in a given year they reported taking action that resulted in  
11 a lower liability the following year.

12           Mitra, you had asked about this point the last  
13 time we met and we can discuss this further.

14           By contrast, other providers that exceed the cap  
15 in one year do so again by a larger amount in the next. The  
16 average cap liability, expressed as a percentage of total  
17 payment represented by overpayments, increased from about 19  
18 percent in 2002 to 24 percent in 2005. So the aggregate  
19 liability is growing. Again, the interquartile range here  
20 is large. In 2005 the cap liability for the lowest quartile  
21 was 9 percent but was over 35 percent for the highest  
22 quartile.

1           Similarly, there are differences among hospice  
2 providers in their response as indicated by the number of  
3 hospices that reached the cap in multiple years. Glenn, you  
4 asked about this in November.

5           We found that many hospices that reached the cap  
6 in a given year did so in subsequent years as well. For  
7 example, of the hospices in our analysis that reached the  
8 cap in 2002, almost 41 percent subsequently exceeded the cap  
9 in 2003, 2004, and 2005. Of the hospices that reached the  
10 cap in 2004, two-thirds did so again in 2005.

11           To sum up this part of the presentation then there  
12 are a couple of key points that relate to the incentives in  
13 Medicare's hospice payment system from the providers'  
14 perspective. First, because of the nonlinearity of hospice  
15 episode costs, short episodes can be unprofitable. Episode  
16 costs are higher at the beginning and end of an episode  
17 while Medicare's reimbursement is generally steady.

18 Therefore, hospices have less opportunity to make up the  
19 higher beginning and end of episode costs in short episodes.  
20 Additionally, costs of certain types of short stay patients  
21 may also negatively affect hospices' financial performance.

22           Second, a corollary to the first point, under the

1 current reimbursement system profitability increases almost  
2 linearly with length of stay. The cap serves as a check on  
3 the hospice length of stay and thus profitability. Hospice  
4 providers are differentially able to deal with the effects  
5 of the cap.

6 Overall then, Medicare's payment system for  
7 hospice embodies two conflicting incentives. From a strict  
8 Medicare financing perspective, Medicare spending is lowest  
9 for hospice decedents compared to non-hospice decedents in  
10 the last two months of life. Therefore, the program's  
11 strict financial interests are in short hospice episodes.  
12 Longer episodes can increase spending relative to the cost  
13 of end-of-life care absent the hospice benefit.

14 By contrast, the incentives from the providers'  
15 financial perspective are very different. Short episodes  
16 are the least desirable in that they are the least  
17 profitable. Hospice profitability increases with length to  
18 stay. Any fundamental reforms of the payment system will  
19 involve reconciling these two contradictory incentives. I  
20 think this can be done.

21 It will also be necessary to take into account  
22 beneficiary considerations in reforming the payment system.



1 There is no doubt that many beneficiaries, if not most  
2 beneficiaries, who elect hospice at the end-of-life receive  
3 great benefit from it, especially if they have no other  
4 source of health care maintenance at this critical juncture.

5 But information on the quality care of care or  
6 even the types of care they receive is minimal. CMS's data  
7 collection that will begin this summer will be an essential  
8 first step towards obtaining such information. In the  
9 meantime, we will present what information does exist on  
10 hospice quality and content at the April meeting. At that  
11 point, we'll have covered the majority of the major issues  
12 surrounding Medicare's hospice benefit and can begin to deal  
13 with a number of specific policy considerations.

14 With that I will in conclude and try to facilitate  
15 your discussion in any way that I can.

16 MR. HACKBARTH: Thank you, Jim.

17 MS. DePARLE: Thanks. Jim, thanks.

18 I think you've done a great job of really delving  
19 into a lot of the questions, while raising new questions  
20 that we didn't even have when we talked about this last  
21 summer at our retreat. It really does feel like I'm peeling  
22 an onion here. But 25 years after this benefit was created,

1 it seems quite appropriate that we're spending the time  
2 trying to do that.

3 On the data collection that you just mentioned  
4 that CMS is doing, I think the last time you presented it,  
5 either here or separately you and I talked about that. Can  
6 you talk a little bit more about what it is they're going to  
7 be collecting? Because I've talked to some people in the  
8 industry who are concerned that they won't be collecting the  
9 kind of data that we and they might need to answer some of  
10 these questions.

11 DR. MATHEWS: Sure, I can talk about that.

12 Effective in July of this year CMS will begin  
13 requiring hospices to report information on the services  
14 that they provide and the specific practitioner who provides  
15 that service. CMS's initial effort is going to be limited  
16 in a couple of different ways. First, they have limited the  
17 scope of the kinds of practitioners who will be required to  
18 be identified on the claims. It will start with nurses,  
19 RNs, LPNs, home health aides, physicians, and nurse  
20 practitioners who are serving in the capacity of the  
21 enrollee's primary care physician.

22 So one concern from the hospice community is that

1 that limited range of practitioners identified as the first  
2 step of the data collection instrument does not fully  
3 reflect all of the care hospices provide.

4 CMS responds by saying those are the services for  
5 which they have revenue codes ready to go that can be  
6 immediately put into place, and that given that this is only  
7 the first phase of their data collection they would  
8 anticipate expanding this later.

9 MS. DePARLE: What are the other practitioners  
10 that the hospices think should be collected data from?

11 DR. MATHEWS: They basically say therapists should  
12 be included, counselors should be included, pastoral care  
13 should be included. They also provide a number of other  
14 types of visits during the course of a hospice episode, such  
15 a supervisory visits to the patient's home to make sure that  
16 everything is going according to the plan. I'm not sure  
17 what the position is with respect to those kinds of  
18 management functions.

19 There are a couple of other concerns that the  
20 industry has raised. One is that the initial CMS effort  
21 will not ask providers to report time increments for these  
22 visits. So that while we will have -- and this is essential

1 in my perspective -- information on the number of visits  
2 provided, and we do not have that information at all, we  
3 won't be able to qualitatively say or differentiate a 15  
4 minute visit from a two-hour visit.

5           Again, I've talked about this with CMS as well and  
6 they would like to do that in the future. They simply do  
7 not have the claims processing structure in place to collect  
8 that information now.

9           Again, I think that is a legitimate concern, both  
10 from the providers' perspective as well as from an oversight  
11 perspective, but it's one that CMS recognizes and is trying  
12 to deal with.

13           A third concern that the provider community has  
14 raised is, I believe CMS is requiring hospices to associate  
15 charges with each of the visit types, which is something  
16 they have no experience with up to this point in time. The  
17 community is worried that by putting charges on these line  
18 items that they might run afoul of the False Claims Act,  
19 given the fact that they are not used for reimbursement.  
20 CMS has issued a change to their requirement, their program  
21 memoranda requiring this data collection, specifically  
22 stating that False Claims Act considerations will not come

1 into play here.

2 MS. DePARLE: So I hope you will just keep track  
3 of where the data is going. It sounds like you're going to.

4 Secondly, I know you've personally spent time -- I  
5 know Glenn has and Mark and others probably -- with hospices  
6 who have come to Washington. I think I said this last time,  
7 I do think it would be useful for the Commission to hear  
8 from some clinicians. I don't know what the best way to do  
9 that is but Nick Wolters was alluding this morning to the  
10 trips he made to LTCHs when we were trying to understand  
11 what the service was. I think that would be useful to us as  
12 we're taking the time to really figure out what's going on  
13 in this benefit.

14 DR. KANE: I'm on the same boat. I understand the  
15 hospice benefit in the context of cancer care and how it  
16 might differ from conventional treatment. But I think as we  
17 get into the other diseases, particularly Alzheimer's or  
18 some of the diseases, I don't really understand whether  
19 there ever was a big inpatient end-of-life component to  
20 that.

21 Is there something even written about how hospice  
22 care is different from the conventional care for each of the

1 major disease types? Because the only one I can visualize  
2 clearly is the cancer differences. Just to help understand  
3 because just describing in terms of costs incurred is kind  
4 of hard to say -- it might be perfectly fine that they're  
5 the same for months six, five and four as conventional  
6 because it's conventional treatment. At what point does it  
7 deviate from conventional treatment? And why?

8 I'm having trouble imagining it from non-cancer  
9 diagnoses. So I just wondered if there was even something  
10 written clinically about these differences so we could just  
11 get a better handle on what the theory is at least?

12 DR. MATHEWS: To the best of my knowledge there is  
13 virtually nothing written on the content of hospice episodes  
14 differentiated by patients' terminal diagnosis. You would  
15 have to go back to the results of the National Hospice Study  
16 evaluation, which did have a few insights on to the  
17 differences in intensity of care stratified by cancer  
18 patients versus other patients.

19 Again, I may not have completely covered the  
20 waterfront here, but I have not seen anything elucidating  
21 differences in the intensity or content of care by  
22 diagnosis.

1 DR. KANE: But one of the issues might be whether  
2 there is conventional care hospice differences for some of  
3 these classes of patients, I guess. Maybe there never was  
4 one.

5 MR. HACKBARTH: I think this is a good question.  
6 Looking at the data that you've presented though, it seems  
7 to me that it implies that there are a variety of different  
8 patterns of care among hospices for at least broad  
9 categories of patients. It's not like there's a uniform  
10 hospice standard out there. We see a lot of variability, at  
11 least in use in financial performance based on the type of  
12 hospice.

13 DR. MATHEWS: That is true. But again these are  
14 very aggregate financial data and we do not have much of an  
15 understanding at all about what is driving some of the  
16 results that we see.

17 So for example, I mentioned the difference between  
18 margins and costs for provider-based versus freestanding  
19 facilities, and I mentioned that the provider-based  
20 facilities do have higher costs. In part, some of that  
21 might be allocated overhead from the parent provider, but  
22 there could be other things as well.

1           Skill mix, we have zero information about that.  
2 Intensity of care, are provider-based entities providing  
3 more care during the course of a week, more visits per week  
4 than freestanding facilities? No information.

5           We know there are differences in the mix of  
6 patients stratified by freestanding versus provider-based  
7 where provider-based facilities treat more cancer patients  
8 than freestandings. Arguably that confers some benefit in  
9 that their exposure to the cap is lower. But we've also  
10 heard anecdotally from a number of hospice providers that  
11 since the hospice is obliged to cover the cost of say  
12 chemotherapy or other types of expensive drugs used for  
13 palliative purposes that these patients are becoming more  
14 and more expensive and -- given the fact that they are the  
15 shorter term patients -- arguably they might be having an  
16 effect on the bottom line for the provider-based hospices.

17           Again, zero quantitative information for us to  
18 start digging in and better understanding the aggregate  
19 trends that we see here. And again, I think that's why the  
20 CMS data collection effort, even though it's not complete,  
21 has some significant gaps. I think it needs to get going.

22           MR. HACKBARTH: That's helpful.



1 MR. EBELER: Just a follow up on two things.

2 First, on the data side, when will we have data  
3 based on CMS's first round of data -- when will we know more  
4 based on that first round? And then when will they get to  
5 what sounds like the needed second phase of data collection  
6 to produce more robust data? But when will we know more?

7 DR. MATHEWS: Based on precedent, given CMS's  
8 timeline required to produce final standard analytical files  
9 that can be used for the kinds of work that we do, I am  
10 guessing it would be next June at the earliest before we  
11 would have claims reflecting this second half year's  
12 experience with coding the additional information. I don't  
13 have a specific timeline from CMS with respect to  
14 development of the next phase.

15 MR. EBELER: The reason I ask is we need to  
16 analytically figure out what's going on here and what the  
17 actual services are. I do think there is a countervailing  
18 pressure that, as things are heading in ways that don't  
19 quite sound right, we risk an extraordinarily valuable  
20 benefit can become discredited in some ways.

21 As we think about policy tools, we may need to  
22 think about blunter instruments for slowing growth until we

1 have the more sophisticated information to deal with this in  
2 a more appropriate way.

3 MS. BEHROOZI: Thanks. It's such interesting  
4 stuff, Jim, and it's so thorough.

5 So I again hesitate to ask you for one more thing  
6 but I had expressed earlier a concern about the fact that  
7 the cap is not adjusted by the wage index adjustment, as the  
8 payments are. As it becomes a more expensive benefit and  
9 more utilized in some places, I guess, more than others I'm  
10 concerned about the differential access implications that we  
11 will start producing.

12 I think we had talked at your first presentation  
13 about the fact that there were so few hospices hitting the  
14 cap that you couldn't really do enough of an analysis to --  
15 you couldn't see an impact yet on either providers leaving  
16 the market or entrants into the market or whatever. But  
17 that's going to get worse. It's growing so fast it's going  
18 to get worse quickly.

19 So I wonder if we could slice the margin analysis  
20 to somehow examine the impact of the wage index, because if  
21 you're talking about the claw back really impacting the  
22 margins, and you're talking about not-for-profit providers

1 already being significantly lower than for-profit providers,  
2 I'm really concerned about the presence of not-for-profit  
3 providers in the high wage index areas and whether they're  
4 just going to leave the market if it becomes too challenging  
5 for them. And so people in the high wage index areas will  
6 just end up with a different hospice benefit or kind of  
7 access than others.

8           And I think what Nancy brought up about what the  
9 conventional care would be for some of these other  
10 conditions, I guess with Alzheimer's it would be maybe a  
11 nursing home, maybe custodial home care. People would be on  
12 Medicaid otherwise, so I guess this is shifting kind of --  
13 again, I think you raised this in your first presentation.  
14 Is it becoming sort of a long-term care benefit around the  
15 back way? Maybe if there's a way to examine where these  
16 people would otherwise be, we can get at that a little bit.

17           Thanks.

18           DR. MILSTEIN: I agree with Jack. I can sort of  
19 anticipate where this is heading, a need to accept a short-  
20 term blunter fix aimed at what appears to be a problem area,  
21 the longer stays but doing everything we can to make that at  
22 least blunt as possible.

1           Also, I thought this was a wonderfully clear  
2 presentation. Thank you for that.

3           A couple of questions aimed at giving us the best  
4 possible information to minimize the bluntness of any tool  
5 that we need to move to. Is there any information on the  
6 relationship between either patient or family experience of  
7 care and either length of stay or diagnostic category? At  
8 the end of the day you can see these longer lengths of stay  
9 that are the cost added to the Medicare program, and that is  
10 a cost that we might all readily want to pay if the  
11 incremental value were there. I suspect when you're  
12 evaluating quality of care for hospice care that we would  
13 want to differentially weight family and patient experience  
14 relative to some of the more technical measures of quality,  
15 which would not be unimportant but just less heavily  
16 emphasized.

17           I'm guessing that in the annals of American health  
18 services research that there have been some studies on  
19 patient and/or family experience of hospice care. The  
20 question is have any of those studies examined the impact  
21 between patient experience and either diagnostic categories  
22 -- especially these newer diagnostic categories -- and/or

1 length of stay? So that's an area of examination, number  
2 one.

3           Maybe before I ask my second question I'll give  
4 you a chance to -- are you aware of any such studies?

5           DR. MATHEWS: None that make that distinction but  
6 I do anticipate presenting information on quality and  
7 content next month. And I can make sure to highlight any  
8 such aspects of studies that pertain to differentiation by  
9 length of stay or diagnosis.

10           DR. MILSTEIN: Thank you.

11           My second, if there is any information available,  
12 I think it would help us again make our corrective action  
13 less blunt is could you share with us -- not at this moment  
14 but when you have an opportunity -- the answer to the  
15 question how good are current predictive modeling tools at  
16 predicting longevity for patients enrolled in hospice  
17 programs? Are they horribly inaccurate? Are they  
18 reasonably good? Where do they fall in the spectrum of  
19 predictive power?

20           DR. MATHEWS: The short answer is it varies by  
21 patient diagnosis. There are some terminal disease  
22 trajectories that are very, very predictable. Sepsis, once

1 a patient starts to go bad the end is usually pretty quick.  
2 Cancer patients can generally have fairly well-defined  
3 terminal disease trajectories and some hospice providers and  
4 their corresponding referral bases have taken that to a fair  
5 degree of art or science, as the case may be, in terms of  
6 identifying a patient who is appropriate for hospice  
7 admission.

8           Some of the other diseases, the debility,  
9 dementia, adult failure to thrive, it's much less clear.  
10 And it's not necessarily that the guidance is unclear but  
11 rather the trajectory of any given patient is so uncertain  
12 that you can look at a patient with debility on day one and  
13 say this patient is categorically eligible. You can look at  
14 that same patient 180 days later and say this patient is  
15 categorically eligible. So that's where the tightness of  
16 the criteria tends to fall apart.

17           DR. MILSTEIN: Do I infer from your answer that  
18 this is not an area in which predictive modeling tools have  
19 been very widely applied, as opposed to clinician's  
20 guesstimates?

21           DR. MATHEWS: I don't know if I would go that far.  
22 There have been some attempts to identify characteristics of

1 patients say with Alzheimer's, a particular stage in the  
2 disease where they are no longer taking solid nutrition,  
3 that sort of thing, that from a clinical indication or from  
4 a clinical perspective would indicate that this patient is  
5 in the terminal disease state.

6 But we've heard anecdotally of something called  
7 the hospice effect, where you can take a patient who looks  
8 like they are going bad, get them admitted into hospice,  
9 they start providing palliative care, take them off all of  
10 their meds and the patient starts to improve. So that's  
11 also a confounding factor here.

12 DR. SCANLON: I think it's kind of interesting to  
13 have the two presentations this morning, and when you  
14 contrast them. With SNFs we had a problem, we had an  
15 incredible amount of data and it took us 10 years to get to  
16 a good point in terms of a potential solution.

17 And in the discussion this morning with say we  
18 haven't looked at hospice in essentially 25 years. We're  
19 asking all kinds of questions and basically we have very  
20 little information to try to address those questions. We're  
21 talking about a CMS data strategy that could take how long?

22 So I'm very much where Jack and Arnie are in terms

1 of needing to do something in the shorter term. I'll call  
2 it an interim step as opposed to blunt. Blunt doesn't sound  
3 like you're being thoughtful enough.

4 I would go to your margins chart on page 10  
5 because that's where I think we have a least one opportunity  
6 for the bluntness. Part of our concern here is not just not  
7 having looked at this in 25 years but the fact that we've  
8 had suddenly this rapid transformation of an industry and of  
9 utilization. The transformation in the industry has been  
10 this influx of for-profit organizations comprising now the  
11 majority of hospices.

12 If you look at the margin in 2005 with the 11 or  
13 almost 12 percent versus the minus 2 percent, we're talking  
14 about a huge difference. Those are averages. So what we've  
15 got is a distribution around that.

16 I guess I would posit as a policy position that  
17 it's unreasonable for someone to be making 20 or 25 percent  
18 on this kind of a benefit from the Medicare program. And  
19 that as an interim step we need to think about -- and I  
20 think it will have the effect of changing the rate of  
21 transformation -- thinking about what kinds of limits we  
22 should put on profits from hospices. Because the kinds of



1 discussion we're having here today, we are a good five years  
2 away from talking about how do we design a policy related to  
3 the types of services that we want provided and a policy  
4 that we can establish accountability for those services, and  
5 we can make sure that we're paying for them right.

6           If you take the last five years and project it  
7 forward for five more, we are in a very different situation  
8 in terms of spending, in terms of industry composition, and  
9 in a very much more difficult position in terms of trying to  
10 change things.

11           So I agree with the idea of bluntness or interim,  
12 whatever word you want to use to describe it.

13           MR. HACKBARTH: It seems to me that these data  
14 suggest that things are headed on a path and moving rapidly  
15 down a path that is troubling, particularly looking at the  
16 change in the composition of the industry and the new  
17 entrants. Clearly people see an opportunity, a financial  
18 opportunity here. And so, like you, I'm worried about  
19 allowing people to race down that path too long.

20           Bill, in other contexts you have proposed that  
21 there be, at the high end of the distribution -- in this  
22 case the high end of the profit distribution -- some sort of

1 sharing as a way of limiting very high profit opportunities.

2 I assume that's what you're talking about here?

3 DR. SCANLON: Since nobody bit on my suggestion  
4 before, I didn't want to use the same words. But yes,  
5 that's exactly what I'm suggesting is the idea that -- and  
6 there's a point at where the sharing could stop.

7 MR. HACKBARTH: Why don't you just say a couple of  
8 sentences about what you've argued.

9 DR. SCANLON: I've been trying to think about how  
10 can I recharacterize so I can get more proponents. Today I  
11 was thinking about using the outlier example, basically as  
12 we have an outlier this time it would be in terms of  
13 profits, that we actually say that we're going to share  
14 those profits, that the Medicare program is going to take  
15 back some of that money. You can say that, using that 12  
16 percent, that you can earn up to a 15 percent profit and  
17 keep it. And beyond 15 percent, between 15 and 25 percent  
18 we're going to share it 50-50. And beyond that we're going  
19 to take it all back.

20 And those numbers are gross. Since the way we've  
21 talked about other provider types, we have zero update  
22 recommendations with respect to provider margins that are in

1 the 5 percent to 6 percent range. So we could scale those  
2 parameters which I just gave you back considerably.

3 MR. HACKBARTH: I'm going to refrain from  
4 endorsing Bill's idea, at least until he comes up with a  
5 better marketing plan.

6 [Laughter.]

7 MR. HACKBARTH: But setting aside that, the  
8 program as designed has a blunt tool in it, namely the cap.  
9 There are issues about where that falls and how that falls.

10 What this conversation with Jack, Arnie, and Bill  
11 says to me is we may need a long-term strategy and a longer-  
12 term strategy and, for lack of a better term, the shorter  
13 term strategy may use some blunter tools, perhaps along the  
14 line that Bill described. And that might be a reasonable  
15 trade-off for doing something around the cap. Just doing  
16 something around the cap without doing anything else I find  
17 very unappealing based on the data that have been presented  
18 here.

19 MS. DePARLE: I raised the cap -- I guess I'm in a  
20 very different place than you are, Bill, because I raised  
21 the cap originally months ago because I was concerned about  
22 hospices who were serving appropriate patients under the

1 hospice benefit in an appropriate way and, through no fault  
2 of their own, were being hit with you owe us money back  
3 because those people happened to live longer than had been  
4 anticipated, just to put it very simplistically. This is a  
5 complex issue, but that's how I saw it as simple.

6           We're peeling back the onion here and seeing a lot  
7 more complexity to it. But as uncomfortable as I am with  
8 that cap, I'm thinking that it is not consistent with what  
9 Congress, I think, intended. I'm even more uncomfortable  
10 with what you're talking about, a kind of a cap on profits.  
11 I don't know that we've ever gone there in Medicare, and I  
12 wouldn't be comfortable supporting that, for hospice or for  
13 anything.

14           DR. SCANLON: We actually used to be there  
15 entirely in Medicare, in terms of a reasonable cost payment  
16 system, in retrospective reasonable cost payment systems, in  
17 that we said we were going to pay your costs, we're not  
18 going to give you profits. And we moved into PPS with the  
19 idea that we wanted to try and encourage efficiency. So we  
20 went to the economists and we borrowed this idea that if we  
21 create an incentive people are going to be more efficient.

22           But what we didn't do was we didn't ask ourselves

1 what do the economists say about the way markets work  
2 completely? The way the economists describe a market more  
3 completely would be to say that when there is really sort of  
4 great profits to be made, they are going to be competed  
5 away. The price is going to drop because people are going  
6 to say gee, you can make 25 percent on doing this. I'll  
7 provide it for less and people come and buy it from me as  
8 opposed to someone else.

9           When you've got administered pricing, it's hard to  
10 take advantage of that competition. So the issue is if you  
11 have administered pricing, what do you need to do? And I  
12 would argue what you need to do is to say let's take the  
13 market signals. The market signal here is that we've got  
14 this very large increase in the number of agencies or number  
15 of hospices and we also have this distribution of profits.  
16 And therefore, our administered price here is wrong. It  
17 needs to be something that is closer to the cost of  
18 delivering services.

19           As an interim step here, it's important to  
20 remember we're not talking about taking a service away from  
21 anyone. The agencies here, if we only operative on the  
22 profit side, the agencies can continue to provide the same

1 services that they were providing yesterday.

2 MS. DePARLE: I don't disagree with working on the  
3 administered pricing. I'm just saying that, to use Arnie's  
4 B word, what you're proposing, if it's a cap on profits at  
5 least as I heard it, is an even blunter instrument than the  
6 one he talked about.

7 DR. SCANLON: But in administered pricing I guess  
8 the question is where do we go to get guidance in terms of  
9 how to set administered prices? In utility pricing this is  
10 exactly what they do. The issue is that they look at what  
11 it is that's reasonable in terms of some kind of rate of  
12 return and then they set a price accordingly.

13 That's all we're saying here. Part of our problem  
14 here -- and hospice is one case, home health is another --  
15 is we have such an ill-defined or undefined product or  
16 service that it's possible to come in and say yes, I am  
17 providing it. And maybe five years from now we'll be able  
18 to say this. If we really understood it we would be able to  
19 say no, you're not. And if we get to that point then you  
20 don't need to think about things like profit controls.

21 If you knew that you were buying exactly what you  
22 were supposed to, then you would be comfortable not having

1 some kind of a limit on profit. But at this point in time,  
2 with this undefined benefit, we're stuck. I understand, it  
3 seems like it's un-American to say we're going to limit  
4 profits. But --

5 MS. DePARLE: I wasn't going to use that word.

6 DR. SCANLON: But people will. The reality is  
7 that this is a part about administered pricing and we're  
8 stuck in this situation.

9 DR. REISCHAUER: I'm not going to endorse profit  
10 limitations just yet.

11 I came down from Mars and I listened to this  
12 conversation in the context of the other conversations we've  
13 had. Jim has told us that on average, looked at over an  
14 entire episode, this service seems to save money, save  
15 Medicare money. And it's growing great guns. And you  
16 wonder what are we struggling here for? Every other meeting  
17 we have the reverse is true.

18 And so there's sort of two issues it strikes me,  
19 and one is the one we've already talked about here which is  
20 what is the service and how well is it being delivered? We  
21 don't seem to know and we think maybe it could be done a  
22 whole lot better.

1           Competition in this area sort of really is never  
2 going to work, Bill, because you only buy it once, in a  
3 sense, and the family isn't a particularly good judge of  
4 this either.

5           I was wondering, do we have trend data for people  
6 dropping out? You can sign up for hospice and then decide  
7 you don't want it. And that could provide some indication,  
8 although I don't think many people know what to expect. And  
9 there's a whole lot of familial and social change that's  
10 going on here that could confound things.

11           The second issue really is could we refine the  
12 payment system to better pay for appropriate care and  
13 provide the right kinds of incentives and maybe save some  
14 money. Given what you have laid out, it strikes me that  
15 there are probably some pretty easy ways to change the  
16 payment system. It could take five years to get down to  
17 them.

18           DR. MATHEWS: Even on what's been characterized as  
19 sort of a blunt and interim basis, and not even going into  
20 profit-sharing types of arrangements, there are probably  
21 some things you can do to switch the current incentives.  
22 MedPAC, in the past, has expressed concerns about these



1 extremely short stay patients. We see potential evidence of  
2 unprofitability of short stay patients for hospice  
3 providers. At the same time, we see the long length of stay  
4 being driven by the payment system.

5 I think there's probably a way, even in a very  
6 simple interim basis --

7 DR. REISCHAUER: A crude kind of way. Yes, right.

8 DR. MATHEWS: -- that would switch those  
9 incentives. And if you did it right you could do away with  
10 the cap altogether. And I think that can be done.

11 DR. REISCHAUER: Getting to the cap, your data  
12 shows that 9 percent of the providers hit the cap in 2005.  
13 There seems to be a very high recidivism rate in a sense.  
14 And you ask yourself how is this possible. And I hate to  
15 ask you to do more slicing and dicing, the way Mitra also  
16 was reluctant to do, but do we know whether the repeat cap  
17 hitters are provider-sponsored ones? Disproportionate  
18 numbers of them? Because then you can get into this  
19 overhead problem that somebody mentioned. Is the cost  
20 really done right?

21 DR. MILLER: Jim, I thought you did have some  
22 information on this in this discussion. Actually, this is

1 another point I wanted to draw out a little bit.

2 In our conversations, there is decidedly hit the  
3 cap and keep going types. But also, Jim -- and make sure  
4 that I'm doing this correctly -- you've also talked about  
5 the notion that there are for-profit providers who hit the  
6 cap and then manage themselves back out from under.

7 DR. REISCHAUER: I was going to ask you if we had  
8 the breakdown of the post-payback margins for the for-profit  
9 people who hit the cap and the not-for-profit ones? Because  
10 that would tell you a whole lot.

11 DR. MILLER: Jim, the people who are hitting the  
12 cap, that's dominated by for-profit providers.

13 DR. MATHEWS: That is correct.

14 DR. MILLER: And dominated by independent for-  
15 profit?

16 DR. MATHEWS: I don't know if I could go that far.  
17 It is dominated by for-profits, dominated by freestanding.  
18 So I think the provider based issue, I can explore that for  
19 you.

20 DR. REISCHAUER: But the real question is what is  
21 their post-payback margin, not whether they hit the cap or  
22 not?

1 DR. SCANLON: It's 9 percent as a total. So they  
2 don't affect much of the distribution above them.

3 MR. DURENBERGER: I'll just do this quickly  
4 because I'm not an economist. I don't sit on the board of  
5 any hospice company or any of that sort of thing.

6 But I'm sensitive to the fact you're going up on  
7 the Hill next week to hearings and things like that. And I  
8 really didn't want you to go up there with anything that  
9 might look like a consensus on this Commission that we're  
10 for capping corporate profits. It just isn't it time to do  
11 that.

12 Nor does it make a lot of sense if we're trying to  
13 -- I mean, I'm waiting for the time that this will be  
14 available to me and maybe I will have some choices and  
15 things like that. And I don't mind a little competition in  
16 the market or whatever there may be, a little variety. I  
17 don't mind people being creative about how to improve my  
18 benefit.

19 I just can't tell yet, as Jim is helping us  
20 understand, exactly what to anticipate or how to make those  
21 choices or any of that sort of thing.

22 But I do think there ought to be a potential in

1 the community in which I live and other communities to be  
2 able eventually to make those, or for my family to help me  
3 make those choices. And when I see that data like we see  
4 there, I see someone's taking advantage of creating those  
5 opportunities. That's a presumption. I can't prove it at  
6 all. We have all kinds of precedent for these other  
7 providers that would say maybe that doesn't happen.

8 But with regard to this one, in particular, I  
9 associate myself with all those who are asking the more  
10 appropriate questions, I guess. But I just wanted to say  
11 that in the context of the other weight you're going to  
12 carry over the next few months in that comment.

13 DR. KANE: I was just enjoying Bill's comment  
14 about limiting the profit. You know, back in the 1970s, in  
15 the dark ages, when we did have administered prices, there  
16 was a lot of time spent on utility pricing and how to create  
17 the right amount of profit. I wouldn't just apply it to  
18 this situation, though. I think if we're going to talk  
19 about what's the right amount of profit, going back through  
20 those models and saying are they useful guides to us in  
21 thinking about what's a reasonable amount?

22 You know, we adjust our updates based on what we

1 think a reasonable amount of profit is but we pick that  
2 number, frankly, out of the industry average or the air.  
3 And it might not be a bad idea to look back and say okay,  
4 these are administered prices. How much should we be  
5 setting aside for profit? What are the theories behind  
6 that, and then use it.

7 I wouldn't just use the hospice, though, as the  
8 industry to pick on. There's something clearly screwy going  
9 on in the hospice industry. And I tend to think that's  
10 because of the definition of the benefit, whether people are  
11 eligible just because they're going to die which means  
12 everybody is eligible. Or are they eligible because there's  
13 a clear benefit in substituting hospice for something more  
14 expensive?

15 And I think that's the part I think we need to  
16 focus in on is what is that definition? And how well  
17 thought-out is it? Is this a substitute benefit for more  
18 intensive care? Or is it a benefit for people who are going  
19 to die soon?

20 MR. HACKBARTH: In the way too many years now that  
21 I've been doing Medicare stuff, there have been many  
22 instances where people have talked about Bill's idea of

1 where you're imprecise in defining the product or being able  
2 to adjust for differences among patients, having a blended  
3 rate of some sort that is in part prospective and in part  
4 based on actual costs incurred.

5 I don't think that's anti-American. That's just,  
6 to me, a reasonable idea to consider. Now whether we want  
7 to do it in this particular instance or not, I don't know.  
8 I'm not that far.

9 But the fact is that there is imprecision in  
10 product definition and measurement in some of these cases.  
11 And so I'm open but not yet endorsing it until you come up  
12 with a better name.

13 MR. EBELER: Quickly, I started us down the blunt  
14 path, which is probably typical.

15 If you could flip to slide 12, I just want to  
16 piggyback on a conversation that Bob and Jim had. When you  
17 think about a short-term thing you do until we actually  
18 learn the content of what we're getting out of the hospice  
19 benefit, it's pretty easy to look at that chart and think  
20 about short-term arbitrary recalibrations of payment rates  
21 based on length of stay. It wouldn't be the most  
22 analytically sophisticated policy on earth, but I just want

1 to reinforce the comment you made, that there are things one  
2 can come up with here in the short-term.

3 I would be very hesitant to drop the cap until we  
4 know more about how that plays out because it strikes me  
5 that the cap is the only thing out there that we are certain  
6 of.

7 The other thing one can do, and Dave mentioned it,  
8 there's a whole lot of people coming in here. There's a  
9 whole lot of things coming in new that we are skeptical that  
10 it is the hospice benefit we think we want when we may need  
11 it -- which we all will, it's a benefit we all aspire to, I  
12 suppose.

13 You can also, for a year or two, simply limit  
14 market entry. There are any number of blunt tools that one  
15 can use until you have the data and content to better  
16 analyze this and come up with better policies.

17 It just seems to me there is a spectrum of things  
18 that we could consider in doing that. But again, I just  
19 think that chart really highlights the discussion Bob and  
20 Jim had about the potential for doing sort of quick and  
21 dirty things.

22 DR. STUART: I just want to make sure that we

1 understood what the profitability here is and what this  
2 margin really is reflective of. As I understood what Jim is  
3 saying is that the margin is calculated on an annual year  
4 before an adjustment for overpayment. Is that correct?

5 DR. MATHEWS: That's exactly what this chart  
6 shows.

7 DR. STUART: Okay. so what that means is that the  
8 25 and 30 percent margins that you're seeing in the top  
9 decile are before any overpayment is taken out. Now that's  
10 really critical because another thing that you told us is  
11 that length of stay is predictive of meeting the cap. And  
12 since meeting the cap is going to reduce, at some point,  
13 your profitability the question that arises for me -- and  
14 I'd like you go back to slide 10 on this.

15 So if you look at that next to bottom row, it  
16 sounds like, it looks like these homes that hit the cap are  
17 making out like bandits. It looks like they're really  
18 making out.

19 But my question is whether that's the current  
20 margin before overpayment? And whether it considers  
21 overpayment for previous years. It seems to me that we've  
22 got to put this on a dynamic frame and really understand



1 what the implications are of moving into the cap or moving  
2 length of stay, taking long length of stay patients -- which  
3 is profitably initially but increases the probability of a  
4 cap payment which is going to reduce profitability in the  
5 future. And it almost looks like we've got the potential  
6 for a real arbitrage here.

7           In other words, that a firm, either on its own or  
8 because it feels that it has to do this, it's looking at  
9 these overpayments. It's got these long lengths of stay.  
10 One way that it can meet the overpayment is to accept  
11 patients that have long lengths of stay. That gives them  
12 current revenues that could be used to repay -- I'm really  
13 worried about the dynamics on this thing.

14           DR. MILLER: We've talked about this. And we can  
15 tease some of this out. What do you do when you hit the  
16 cap? One thing is you keep going and you keep bringing in  
17 patients that generate revenue. There are different models.  
18 We've had some of this discussion. It gets pretty complex  
19 but we can try to tease some of these out.

20           That is, in a sense, one of the big questions with  
21 the cap is do you hit it and keep going? Or do you start  
22 changing your business model?

1 DR. STUART: Right. And it sounds to me like  
2 you've got two different kinds of firms here: one that  
3 really wants to be in it for the long term. And you can't  
4 keep going on a pyramid scheme like this forever. But there  
5 are others that may be -- and if they're independents I'd be  
6 really concerned about this -- it might be a short-term  
7 profitability game in which you could actually make out and  
8 then just quit the business.

9 DR. REISCHAUER: [off microphone] What do you do,  
10 declare bankruptcy?

11 DR. STUART: It depends on what happens over time  
12 to the profitability. It really does. You're increasing  
13 liabilities over time, depending upon the payback period for  
14 the overpayments. So there's a financial angle to this  
15 thing that is really separate, I think, from the quality of  
16 care and the service burden that's being provided that  
17 really needs to be investigated.

18 Because I think if somebody looks at this table  
19 without understanding that it doesn't include this increased  
20 liability of overpayments, you're going to get a very  
21 different impression. And so, unlike Bill, I'm looking at  
22 this and I'm trying to figure out what the after overpayment

1 margin is. I think you said, Jim, for some of these --  
2 maybe for all -- that the after payment margin was actually  
3 negative.

4 DR. MATHEWS: For the cap hospices reflected in  
5 this table here, the only number I can remember off the top  
6 of my head is the 2005 number. Their margin goes from the  
7 18.9 percent that we see here down to negative 2.9 percent.

8 But to put it in larger context, remember in 2005  
9 we're talking about total Medicare spending of \$8.1 or \$8.2  
10 billion and cap overpayments representing -- again according  
11 to this model -- about \$175 million. So for these cap  
12 hospices it is a big deal, especially given the range of  
13 variation that we see with respect to the dollar amount by  
14 which some hospices exceed the cap relative to others, and  
15 the variation in the percent of revenues attributable to cap  
16 overpayments relative to others.

17 Again, though some of them the overpayments  
18 represent 40 percent of their revenues. If they have to  
19 give those back, they are down the drain. Others, if they  
20 are exceeding the cap by 5 percent or 10 percent, maybe they  
21 can still make these kinds of adjustments we've been talking  
22 about and get back below the cap.

1           So again, a lot of variation here but most of the  
2 variation at the moment is within this group of cap  
3 hospices.

4           MR. HACKBARTH: We've just got a little less than  
5 10 minutes left and we've had an interesting economics  
6 seminar.

7           I have now four people who come from the clinician  
8 side of the world who have been waiting patiently to talk  
9 about this. So we need to move on.

10          MS. HANSEN: A bit more context for this.

11          First of all, the hospice benefit, as it was  
12 begun, is incredible. So from a standpoint of positive --  
13 from a standpoint of beneficiaries, which is the last  
14 comment, I think that there is great benefit, per se, for  
15 people in the benefit, and when you think about families and  
16 patients themselves valuing this.

17          My question is, and it's already built in but I  
18 just want to emphasize, having been on the long-term care  
19 side of things, that with the diagnoses of say dementia,  
20 Alzheimer's, and chronic ischemic heart disease or those  
21 conditions, that really starts feeling like a chronic care  
22 benefit as compared to a hospice benefit.

1           So when the program isn't so well defined it just  
2 allows that kind of organic growth of the program. So I  
3 wonder if it could be teased out? I know Arnie asked about  
4 whether there were any predictive components of it, and you  
5 mentioned the Alzheimer's disease. It could range  
6 tremendously. But there is, at some point, a profile where  
7 it moves into maybe what's called a palliative care period.

8           And I actually want to raise palliative care,  
9 because I noticed that hospice and palliative care somewhat  
10 are becoming synonymous as a frame. But hospice used to  
11 mean something specific. Palliative care means something  
12 also very different and could last a couple of years, in  
13 some cases. So the whole question of helping differentiate  
14 how the world moved between hospice to palliative care.

15           Some secondary impact on that, and that it what's  
16 interesting from a workforce standpoint, geriatric  
17 fellowships for physicians and some of the geriatric nursing  
18 advanced practice things have not drawn as well  
19 historically, and we all know that.

20           But what's quite interesting is there's been a hot  
21 demand for palliative residency specialization, as well as  
22 even nurses. So we've actually moved the workforce shift in

1 terms of the focus. I don't know what that means. But I  
2 just do know that it's interesting that the geriatrics  
3 classic all chronic disease comorbidity has now become far  
4 less popular than palliative care as a subspecialty.

5 So I just wondered if you would look into just the  
6 backdrop of that? Because that does have workforce  
7 implications.

8 Thank you.

9 DR. CROSSON: So I will speak in a clinical  
10 metaphor because it seems to me that when we're talking  
11 about the finances and talking about things like changing  
12 the margins and all that, we're really tinkering with a  
13 symptom as opposed to the underlying condition. And I think  
14 this is the point that Nancy was trying to make earlier.

15 Something has happened here which has morphed what  
16 was intended to be a clear benefit into something that's  
17 more like a long-term care benefit. And some institutions  
18 have been created to take advantage of that.

19 It's sort of like how did the hospice benefit end  
20 up getting applied to Alzheimer's disease? It doesn't seem  
21 like, to me, that's what it was intended for and I remember  
22 the beginning of this.

1           So while we may decide that there needs to be a  
2 short-term financial fix, it would seem to me some attention  
3 needs to be paid to understanding what the intended benefit  
4 was, what eligibility criteria are, whether that has to do  
5 with predictive modeling or simply something a little bit  
6 even clearer than that, which is simply limiting the  
7 diagnoses that are eligible for the hospice benefit, and  
8 then wrestling with the question as to whether there ought  
9 to be some other benefit created for whatever you want to  
10 call it, palliative care or long-term care, assuming that  
11 that would be affordable. I'm not sure it would be.

12           But don't we want to spend some time on that part  
13 of the issue, which is fundamental to creating this market  
14 opportunity that we don't like?

15           DR. CASTELLANOS: I'd like to make three points.  
16 One is I think the message that we've heard in the  
17 beginning, I want to make sure that everybody in the  
18 audience recognizes that this Commission is made up of a lot  
19 of different people from a lot of different backgrounds.  
20 But we all recognize the uniqueness of the hospice program  
21 and the benefit to the patient, the family, to the community  
22 and society. And it is really a hospice culture.

1           We're not throwing the baby out with the bath  
2 water. What we're trying to do is make the program more  
3 sustainable. But I think that message, it came across  
4 pretty heavy to me in the beginning and I know all the  
5 commissioners, I know how they feel, and they have a very  
6 uniqueness to the individual patient. That's important.

7           Two things that we talked about. One is most of  
8 the time in programs we look at the quality issues. I see  
9 very little -- and I don't see Arnie here either -- but we  
10 don't look at quality much in this program. There's been  
11 very little discussion on quality and how we measure it and  
12 patient and family satisfaction.

13           I know, Jim, you mentioned that you're going to  
14 provide some of that data next time. But in three periods  
15 we hit up to now we always look at quality. I don't see  
16 that we've done that very well.

17           Under the quality issues, Arnie asked to look at  
18 separated by length of stay and diagnoses. I would like to  
19 see if we could also separate it by nonprofit and profit.

20           And I know, Jim, you and have had a lot of  
21 different conversations on this. And one of the points I  
22 always looked at his I know patients change from one hospice



1 to another, and I'd like to know why they're changing. Is  
2 it because of the quality of care or what they get? Or is  
3 it change of location or what? I'm not sure if there's any  
4 data on that.

5 And the third question that you and I have talked  
6 about is in the data that you provided us in October and  
7 November one of the things he showed me is that increased  
8 physician costs -- and it was almost 20 percent a year or  
9 over 100 percent over a five-year period -- this excludes  
10 the medical director.

11 I'm wondering if we can drill down on those costs?  
12 Is it because of the palliative care that we're giving now,  
13 the chemotherapy or radiation therapy? Who is providing  
14 this care? Because I think that's separate. That's under  
15 Part B, which does impact on the Medicare spending.

16 DR. BORMAN: If I recall correctly, Jim, in one of  
17 your prior presentations you mentioned change in the benefit  
18 definition sometime within the last few years where it  
19 allowed people to requalify for additional days. If you  
20 could refresh us on that, or just me personally later, that  
21 would be fine. Because my recollection was that when I  
22 listened to you about that and saw this that the two do seem

1 to be married.

2           And in addition to the ability of companies to  
3 form up and whatever, it gets back to this benefit design  
4 that offered a potential entrepreneurial opportunity that  
5 may or may not have been too good. And so if you could  
6 refresh me on that, that would be great.

7           The second piece is just trying to look at this  
8 from a plain Jane general surgeon perspective, and somebody  
9 with a number of aging relatives and thinking about hospice  
10 and when I might need it. I know that Ron has said we think  
11 we have a shared idea of what hospice is. But if bet if we  
12 went around and talked to each other, we may actually have  
13 some differences in the concept.

14           And so I think that it would behoove us to make  
15 sure we're all on the same page, and that that would be that  
16 the object here in a very subjective way is probably death  
17 with dignity. That would be the simplest summary. That has  
18 lots of different things for every person as they face that.

19           And then there was this attempt at defining,  
20 within the last six months, and the economic correlate of  
21 that, I think, is that the expense to whomever, whether it's  
22 the individual, the person covering the bills, the insurance

1 company, the government, is very high in that final time.  
2 And so that one would think that we felt that a lot of that  
3 care was futile and that it generated a lot of expense and  
4 nobody was well served by it in the end.

5           So that it seems to me that if that is our shared  
6 notion of hospice, then what we see happening should, in  
7 fact, have a substantial measured difference in care costs  
8 in the last two to three months, I mean not just sort this  
9 month here that month there and whatever. That, to me, is  
10 on a very non-economist savvy viewpoints, if we would  
11 predict that the benefit of this is less futile care, less  
12 costs in those final few months of life, that ought to be a  
13 clear and consistent message that we get out of this  
14 information.

15           So that says either that the user population has  
16 changed, which I think we have found that because we have  
17 these people with primarily failing mental status pouring  
18 into the system. And that's only going to increase, one  
19 might think, with population trends.

20           There would be the question of are costs more  
21 because there's fewer people to meet the needs of these  
22 individuals? Are there fewer hospice trained staff? Are

1 there fewer facilities? Are there fewer pastors or  
2 whatever? The fact that it could grow so quickly suggests  
3 that there are indeed people willing to deliver this care.

4 And so I think the benefit definition, making sure  
5 that we're all clear on what we think is the priority need  
6 to meet for the beneficiary. And then saying okay, how can  
7 we craft something that does that? And what should be the  
8 outcome measure of that? I don't think this is it. And so  
9 I think we do need to be careful to be on a page about the  
10 benefit and that it really is in benefit design moreso than  
11 in trying to turn around and tinker with numbers that -- I  
12 had Jack's concern -- I'm glad he said it because it made me  
13 feel smarter, that somehow I'm not seeing where the  
14 subtraction for the overpayment part went.

15 MS. HANSEN: In the next report, related to your  
16 point there, Karen, the costs again, the updated costs for  
17 the last six months of life in general, just to have that as  
18 a backdrop piece.

19 Thank you.

20 MR. HACKBARTH: Okay. Thank you, Jim. Good job,  
21 much food for thought.

22 We will now have a brief public comment period

1 with the usual ground rules. Please identify yourself first  
2 and your organization. And since commissioners are headed  
3 to the airport, please keep your comments to no more than  
4 two minutes. And if the light comes on again, it means it's  
5 time to start.

6 MS. FRIED: I don't plan on talking that long.

7 My name is Leslie Fried. I'm here on behalf of  
8 the Alzheimer's Association. I direct the Medicare Advocacy  
9 Project.

10 And I was just a touch concerned with some of the  
11 comments regarding access to the hospice benefit for certain  
12 diagnoses, in particular Alzheimer's disease.

13 I just wanted to point out, and it may be in your  
14 report -- I don't know -- but Alzheimer's disease actually  
15 is the fifth leading cause of death by CDC reports for  
16 people 65 and older. So given that people do die of  
17 Alzheimer's disease, and that hospice is a benefit for  
18 people who are terminally ill and within the last six months  
19 of life, it's certainly an appropriate benefit for people  
20 with Alzheimer's disease. So I was just a little concerned.

21 I think doctors certainly have difficulty  
22 determining when are people within that six months. That's

1 why they are recertified every 90 days and then, after the  
2 second recertification, every 60 days. But I just want to  
3 clarify that Alzheimer's -- people die from Alzheimer's  
4 disease.

5 And that's just based on death certificate. Other  
6 people might have Alzheimer's disease but might have  
7 infections or pneumonia, et cetera.

8 So I just wanted to make that point. Thank you.

9 MR. SCHUMACHER: I'm Don Schumacher, President and  
10 CEO of the National Hospice and Palliative Care  
11 Organization. And before I did this job I ran a hospice  
12 program for 25 years in a couple of different parts of the  
13 United States.

14 I want to thank the Commission for hearing all of  
15 these issues, and specifically thank Jim Mathews for what I  
16 think is a very detailed and thorough examination of what we  
17 all recognize is a huge growth spurt in our industry and a  
18 growth spurt that is causing many of us some sleepless  
19 nights and quite a bit of worry, not just because of the  
20 growth that's taking place but of the concept that we've all  
21 been facing for some time that CMS and perhaps MedPAC and  
22 perhaps Congress would, in fact, use a blunt instrument

1 without looking at all of the detail that would go into the  
2 affect that that might have on a dying patient and family  
3 member anywhere in the United States.

4           There's a couple of pieces about this benefit  
5 which are unique. This is a risk benefit. When you are  
6 running a hospice program, you are encouraged, as a part of  
7 being a Medicare provider, to take of all beneficiaries  
8 regardless of their diagnosis, regardless of their length of  
9 time in the program, if they are, in fact, determined to be  
10 terminally ill as evidenced by two physicians' signatures.

11           Therefore it is not a surprise because dying, as  
12 you all know, is not an exact science, that there are some  
13 patients who are living in hospice programs longer than are  
14 other patients living in programs. And I find it rather  
15 troubling to think about the fact that if we have longer  
16 patients living in programs we have to find a way to  
17 disincent hospice programs to take care of them because it's  
18 costing the Medicare system more money.

19           I will say to you, and I know Jim mentioned this  
20 the last time -- the Duke study does show, the last study  
21 that has come out on cost savings, a cost estimate of \$2,300  
22 per patient, per beneficiary, at different points during the

1 disease trajectory. So I would hope that the Commission  
2 would look very thoroughly at the whole range of  
3 opportunities to cure this problem.

4 Do you know that if you're a hospice program in  
5 the United States right now you can get a license and not be  
6 surveyed for 11 years by Medicare? Do you think that that  
7 is an equitable way for you to receive a hospice license in  
8 the United States? Talk about wanting to change some  
9 things.

10 I have been to CMS multiple times asking them for  
11 more money for hospice surveys. When I was running a  
12 hospice program in Buffalo, New York I got a survey once  
13 every seven years. A lot of things can go wrong in your  
14 hospice program in a seven year period of time.

15 So if we're talking about blunt instruments, you  
16 might want to talk to CMS about ways that they can be more  
17 dutiful in supplying oversight of this benefit rather than  
18 beginning to take it out on the patients, their families and  
19 their providers that are trying to provide care.

20 The other part of this with CMS, I will tell you  
21 I'm very concerned is that this data collection tool that  
22 they've put out, we all support data collection. We don't



1 have enough of it. We need data collection. This is a  
2 faulty cockamamie data collection tool that is going to get  
3 them a whole bunch of garbage. We have been to them  
4 numerous times explaining why.

5           Just a small example of which is they are  
6 requiring us to have those medically necessary visits -- the  
7 nurse, the social worker, the home health aide, and the  
8 physician -- not only to keep track of in a routine home  
9 care setting, but in a general inpatient unit in a hospital.  
10 So we are now going to have to get from the hospital, as a  
11 part of the chart review, how many times a nurse went into a  
12 patient room and if the visit that was a visit, and if in  
13 fact it was medically necessary.

14           This is something that will not give them anywhere  
15 near the accurate data information they need to have. I  
16 have been and asked for a collaborative workgroup with  
17 Secretary Weems. We've asked for a collaborative workgroup  
18 with CMS so that we together could put a very thorough data  
19 collection tool. We're looking at trying to get some  
20 legislation put in so that every aspect of hospice care is  
21 tracked, that they can get the kind of information they need  
22 to make good decisions and give you the right information to

1 make your recommendations to Congress.

2 This data collection tool, I can assure you, will  
3 not do that. They're going to have a lot of garbage in and  
4 it's going to be garbage out, just like it was when they put  
5 together the first cost report for hospice several years  
6 ago.

7 This is a problem in our industry. We don't have  
8 the data. We need support to get that data. And we need  
9 more oversight coming out of the Federal government in order  
10 to ensure that what Medicare is paying for is being provided  
11 to every dying patient and their family.

12 So if we're talking about instruments, let's look  
13 at some velvet instruments that might have an opportunity  
14 not to punish everyone who is trying to provide services to  
15 dying patients but something that will give us a thoughtful  
16 instrument to give us the right outcome.

17 And if we're going to redefine the benefit -- and  
18 I do agree with Jim that it's time for us to take a serious  
19 look at it -- let's do it in such a way that everybody,  
20 especially the patients and their families in this country,  
21 benefit and are not punished in any way, shape or form.

22 Thank you.

1           MS. LUPU: I'm a little shorter than Don. Dale  
2 Lupu from the American Academy of Hospice and Palliative  
3 Medicine. We're the professional organization for hospice  
4 and palliative medicine physicians.

5           I wanted to respond to a couple of points. The  
6 first is that the Academy is very supportive of all the  
7 efforts MedPAC is doing and CMS is doing to look at and  
8 better define what kind of care is being delivered.

9           We agree with National Hospice and Palliative Care  
10 Organization that understanding the quality of services that  
11 is being delivered is equally important to understanding the  
12 payment. And we do need more information and we are aligned  
13 NHPCO and being very concerned that the instrument that CMS  
14 is going to be implementing is not going to give us the data  
15 that we need.

16           There was a question about the rapid rise in  
17 physician services under hospice that Medicare is paying  
18 for. The point that we'd like to emphasize is that there  
19 has been a significant change in the physician participation  
20 in hospice over the last few years, and that is what's being  
21 reflected in this data. A 500 percent rise is appropriate  
22 when the model that took place for about 20 years was a very

1 part-time medical director who spent several hours a week,  
2 maybe half a day, maybe a day a week primarily in the  
3 medical director administrative duties.

4           And now what has happened is as hospices have come  
5 to understand, and as there's become a workforce of  
6 physicians who do have these skills as their main  
7 professional area, hospices have begun to actually use  
8 physicians much more as clinician providers, working very  
9 closely with the attending physician but also delivering  
10 more care in the home, more visits, more actual clinical  
11 care being provided. And that's what you're seeing.

12           And so one has to look at that 500 percent rise  
13 but look and see have we reduced -- is that appropriate  
14 care? And we would say we believe when we look at it  
15 closely we'll see that that's been a major quality of care  
16 that's being provided.

17           And the third thing I just wanted to emphasize, I  
18 have forgotten who asked the question but there was some  
19 discussion around really what is the benefit? Is there a  
20 different benefit in the nursing home? What are we  
21 providing? Is this a long-term care benefit?

22           I would caution that from a clinical perspective,

1 although we have some data about populations, the difference  
2 in what the death rates are in populations from a clinical  
3 perspective, when one looks at an individual patient it is  
4 very, very hard to predict what is going to happen to that  
5 person.

6           And we need any blunt tools that we put in place  
7 from a policy perspective not to have incentives that push  
8 us back to where we were a couple of years ago where the  
9 hospices become so risk-averse or the physicians become so  
10 risk-adverse saying I can't predict so I'm going to only  
11 take the safest patients.

12           It is going to harm patients and families if we  
13 push them back into that under one week of care. That's not  
14 good. And so we need to be careful as we're trying to use  
15 these instruments to test them well. And we would really  
16 advocate for some demonstrations or some testing of policies  
17 before we experiment on the whole hospice population.

18           Thank you.

19           MR. HACKBARTH: Okay, we're adjourned. See you  
20 next month.

21           [Whereupon, at 11:16 a.m., the meeting was  
22 adjourned.]