

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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COMMISSIONERS PRESENT:

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

2 MR. HACKBARTH: Welcome to our first session in
3 this new cycle. Many, although not all, of the sessions
4 today are going to be oriented around -- at least initially
5 -- updates of what happened in the recent Medicare
6 legislation and its implications for MedPAC's agenda. Over
7 the next couple of days there are some exceptions to that,
8 an important one being tomorrow we will have an expert panel
9 with three guests on research on the use of imaging
10 services, a subject that we have touched on frequently in
11 the last couple of years.

12 So our first session today is on the initial draft
13 of our content character that goes at the beginning of the
14 March report each year. And Evan is going to lead that
15 presentation.

16 MR. CHRISTMAN: Good morning. As Glenn mentioned,
17 this presentation is going to review the broad economic and
18 financing challenges facing the Medicare program. The
19 purpose of this presentation is to frame the issues facing
20 the Medicare program and the challenges driving future
21 policy choices.

22 A key financing challenge is that growth in health

1 care costs for all players has exceeded growth in the gross
2 domestic product. You can see that on this table on the
3 second slide. In a recent analysis, CBO covered the growth
4 in health care spending per capita to the growth in GDP
5 adjusting for changes in demographics. The analysis found
6 that over a 30-year period health care spending has exceeded
7 per capita GDP growth by more than two points.

8 For these reasons, health care spending has grown
9 as a share of our nation's GDP and it is expected to
10 continue to do so. You can see that on the next graph. In
11 1980, health care costs were about 9 percent of GDP and they
12 rose to about 16 percent in 2005. And 2017 they are
13 expected to be over 19 percent of GDP. The upper three
14 areas are public spending such as Medicare and Medicaid and
15 other public spending. The gray bar is private sector
16 spending.

17 Public spending by Federal, state, and local
18 governments has risen to about half of all health care
19 spending and it is expected to grow faster than private
20 spending over the next nine years. About three-quarters of
21 the public spending is Medicare and Medicaid.

22 For Medicare I would note that these projections

1 assume the SGR mechanism requiring negative updates is not
2 overridden.

3 The rising share of public spending does not
4 suggest that it is less efficient in controlling costs and
5 other sectors. For Medicare the comparison is sensitive to
6 the periods compared. However, over longer periods of time
7 the rates of growth for Medicare and private health
8 insurance have been remarkably similar.

9 While the growth in health care as a share of GDP
10 may raise affordability concerns, from an allocation
11 perspective it is not clear that there is a correct level of
12 spending on health care. Some analysts have suggested that
13 a nation as prosperous as the U.S. should spend up to 30
14 percent of its income on health care. However others would
15 note that allowing spending to rise to this level could
16 require increases in borrowing or taxes that could reduce
17 the total economic output.

18 In addition, other skeptics might argue that much
19 of the growth is due to inefficiency in the delivery of care
20 and inappropriate incentives that raise volume. To the
21 extent that these factors account for growth, the increasing
22 share of GDP committed to health care may not reflect

1 society's preferences.

2 This graph highlights how Medicare's share of GDP
3 has changed. Again, I would note that these projections
4 assume the SGR remains as in current law with negative
5 updates.

6 In 1970, Medicare was three-fourths of 1 percent
7 of GDP and by 2005 it was 2,7 percent. In the long run the
8 Medicare Trustees assume that the rate by which Medicare
9 spending growth exceeds growth in GDP will gradually decline
10 and by the end of their 75-year projection period, Medicare
11 per capita growth will equal growth in GDP. However, even
12 with this assumption the share of the economy committed to
13 Medicare will grow. By 2040 its share will triple to 8
14 percent of GDP. I would also note that this graph shows the
15 long-run impact of Medicare Part D. In 2030 Part D
16 increases Medicare's share of GDP by about 20 percent.

17 This next slide reviews some of the major factors
18 driving growth. Most analysts believe that many of the same
19 factors drive growth for both Medicare and other sectors of
20 the health care system. This highlights some of the major
21 factors that researchers have identified. They are probably
22 familiar to you.

1 The first is technology. Most analysts believe
2 that 50 percent or more of the long-run increase in spending
3 is attributable to technology. New technologies and medical
4 technique can yield improvements in health but they can also
5 yield new costs and inefficiencies if they are targeted
6 inappropriately. As the Commission has noted, there is not
7 an adequate evidence base to allow providers and
8 beneficiaries to select treatments based on their
9 comparative clinical effectiveness.

10 Another factor is income. The nation's income has
11 been rising. Many analysts suggest that it is natural for
12 people to demand more health care as incomes improve, as the
13 marginal value of increased life span or function may be
14 worth more than other goods.

15 Insurance has provided beneficiaries with
16 financial protection from the costs of ill health but it has
17 also insulated beneficiaries from the full cost of care.
18 Consequently, some beneficiaries may consume more care and
19 some providers may deliver more care than they would have
20 otherwise. A special issue in Medicare is the availability
21 of supplemental insurance that covers the beneficiary cost
22 sharing for Part A and B. Estimates suggest that the

1 availability of this insurance may raise Medicare spending
2 by 10 percent or more.

3 Another factor is prices. Changes in prices are
4 particularly important in the U.S. system because so much of
5 our care is provided through the private sector. Prices
6 provide the incentive that can affect what services and
7 regions are served, what technologies are developed, and the
8 specialties physicians in training select. Every year as a
9 part of our Congressional mandate the Commission reviews the
10 reimbursement for Medicare providers to ensure that payment
11 levels are adequate to cover the costs of an efficient
12 provider and provide adequate access to care.

13 Changes in demographics and longevity also have
14 an impact on health care spending, particularly for
15 Medicare. With the retirement of the baby boom population,
16 the elderly are projected to grow as a share of the
17 population. In addition, life spans are expected to
18 continue to increase. These factors will cause Medicare
19 spending to grow and CBO has estimated that they will
20 account for approximately 30 percent of the growth in future
21 years.

22 Trends in disease morbidity also affect health

1 care spending. One analysis suggested that much of the
2 growth in per capita Medicare spending since 1987 has been
3 due to the increase in treatment for chronic conditions.
4 However, it is not clear how much of this increase is
5 attributable to an increase in the prevalence of these
6 diseases or an increase in the rates of the treatment for
7 these diseases.

8 Each of these six major individual factors is
9 important, but in practice we observe how they act together
10 in the delivery system. For example, the availability of
11 insurance can result in higher demand for services, which
12 could result in higher prices and encourage the use of more
13 advanced medical technology. These interactions, combined
14 with fee-for-service payment, reward providers for
15 delivering more services, not necessarily for delivering
16 more value.

17 This next slide looks at total health care
18 spending for the nation as compared to other industrialized
19 countries. As you can see, relative to those countries the
20 U.S. spends more per capita than any other country in the
21 world. This comparison shows exactly how much in 2006,
22 about \$6,700, significantly more than even the other higher

1 spending countries.

2 As you can see, the green bar on the left is the
3 United States and to the right are the next four highest
4 spending OECD countries, which are still significantly
5 positively lower than the U.S. The final bar on the right
6 is the average of all 30 OECD countries, about \$2,800, which
7 is less than half of what the United States spends.

8 In addition to international differences, there is
9 variation within the U.S. in how much care the average
10 Medicare fee-for-service beneficiary receives. This map
11 shows how spending varies among regions and the wide
12 variation in Medicare spending is further evidence of the
13 questionable efficiency of some of the program's current
14 spending. Studies of regional differences in Medicare
15 spending have found that areas with more spending do not
16 have improved patient health or satisfaction. And other
17 work suggests that the broader health care sector has
18 similar problems. Various studies that have examined the
19 efficiency of the entire U.S. health care system have
20 estimated that 25 percent or more of the care delivered
21 could be eliminated with no detrimental impact on health
22 outcomes.

1 In addition, the quality of care provided in the
2 U.S. has been found to be deficient. A study by the RAND
3 Corporation found that patients received only about half of
4 the care that would have been expected under evidence-based
5 guidelines. All of these findings indicate that the current
6 system is inefficient and often inefficacious and
7 opportunity exists to reduce expenditure growth and increase
8 the value of care provided.

9 To the extent that inefficiencies drive Medicare's
10 increased costs, they have important consequences for the
11 solvency of the program. The Hospital Insurance Trust Fund
12 is projected to be exhausted in 2019. At this point it will
13 have sufficient funds to pay only 80 percent of benefits
14 due. This gap between the fund's resources will gradually
15 widen and by 2050 the fund will have the resources to pay
16 only 40 percent of benefits due.

17 The financial burden of Part B and D will also
18 grow. The Supplementary Medical Insurance Trust Fund, which
19 funds these two benefits, is funded primarily through
20 premiums and a contribution from the general fund. The
21 general fund, which constitutes the majority of funding for
22 these benefits, equals about 12.5 percent of all corporate

1 and personal income taxes in 2008 and will grow
2 significantly in future years.

3 Medicare's darkening financial prognosis is
4 creating near-term challenges for both beneficiaries and
5 policymakers. Rising Medicare spending will impact
6 beneficiaries directly as an increase in premiums and cost
7 sharing. In 2008 Medicare cost sharing is expected to equal
8 about 26 percent of the average Social Security benefit and
9 by 2019 the burden is expected to rise to 30 percent of the
10 average Social Security benefit.

11 Finally, the 45 percent trigger was also tripped
12 again in 2008. This mechanism, created in the MMA, requires
13 the trustees to issue a warning if two consecutive trustees
14 reports find that general revenue will fund more than 45
15 percent of Medicare spending in the next seven years. Since
16 the trustees made a similar finding in 2007, the President
17 will be required to submit legislation next year to address
18 the warning. The trustees issued a similar warning last
19 year and consistent with the law the President submitted
20 legislation this year but the Congress opted to not act on
21 it.

22 In summary, Medicare and other health care sectors

1 face many of the same challenges that will become more
2 serious if action is not taken soon. All health care payers
3 will have to decide how much more of an increase in health
4 spending they are willing to allow, carefully considering
5 the trade-offs with other priorities and the well documented
6 deficiencies in efficiency and value of the current system.

7 Addressing growth for all sectors will be
8 challenging because there is no single cause and no single
9 solution. Multiple strategies that enlist the efforts of
10 many stakeholders are likely to be required.

11 In addition to pressure on financing, there will
12 be pressure to improve the efficiency and quality of care.
13 Addressing these issues will also require tackling the
14 challenges of a fragmented system.

15 The Commission has considered several ideas to
16 confront these challenges but more work remains. The system
17 we have today evolved over many years and addressing these
18 issues will take a sustained effort over time and hopefully
19 the Commission's work can serve as a starting point.
20 However, all of these data underscore the importance of
21 starting on reforms soon so future generations have the
22 tools they need.

1 I look forward to your discussion. Let me know if
2 you have any questions.

3 MR. HACKBARTH: Thank you, Evan. We will open it
4 up for discussion and, as we have discussed what I would
5 like to do is use the following ground rules. We will go
6 around once, give everybody an initial opportunity to
7 comment. I would urge you to make your comments brief.
8 When I say brief, I'm talking about no more than two
9 minutes. If you think 17 times two, that's 34 minutes.
10 We've consumed a big hunk of our discussion time. So please
11 no more than two minutes. And I will start gesticulating
12 and jumping up and down and looking unhappy if it goes on
13 much longer than that.

14 When you make that initial comment, if possible
15 what I'd like you to do is say I like the general direction
16 of this or I don't like the general direction of this and
17 here are two or three brief additional points. But we want
18 to be sure in that initial round to get your general sense
19 of direction if at all possible.

20 Then once we've finished the first round, what
21 Jack and I will be trying to do as it goes on is identify a
22 small number of topics that came up during the first round

1 for further discussion in a second round so we can really
2 hone in on a few things in that second round.

3 So that's the basic approach. And with that, let
4 me see a show of hands of who wants to go in that initial
5 round. We will just go down the row here. Karen, do you
6 want to lead off?

7 DR. BORMAN: Generally, I found this a very
8 helpful way to start thinking about it. Two questions or
9 comments. One is that I think one segment that we've left
10 out of this, as you say, are the other aspects of the fiscal
11 and economic challenges. I think it's understanding the
12 expectations of patients or society has health care
13 consumers. Because I think that is evolving and that is, in
14 part, triggering the demand. I think, for example, if you
15 knew how much of this was totally discretionary -- cosmetic
16 surgery for example and going forward, just to pick
17 something out of the air that is discretionary -- starts to
18 give you a hint as to what are the changes that are going on
19 in expectations. I think what you expect versus what the
20 government provides as a baseline may, in fact, be two
21 different things and we need to be sure not to ignore the
22 piece that the beneficiary/patient plays in this in terms of

1 expectation, in terms of adherence, and in terms of access -
2 - I think all of those things -- would be very important to
3 me to add to the conversation here.

4 My second thing would be in our discussion of
5 geographic variation, I would like to see us couple with
6 that that one of the challenges is to understand the reasons
7 for the variation. We tend to fall to some interpretations
8 that I'm not sure the data yet tell us. We can make some
9 things about correlations but not necessarily causality.
10 And I think one of our commitments here needs to be better
11 understanding the reasons for the variation.

12 DR. STUART: An observation and then a couple of
13 questions. The observation is that if we go back to slide
14 number two, the emphasis here is on per capita growth in
15 spending comparing Medicare, Medicaid, and other private
16 spending. When we move to slides three and four, it looks
17 like this is total program growth.

18 So my question is -- in this one in particular --
19 how much of that green bar is due to -- the growth in the
20 size of that green bar -- is due to demographic changes?
21 And how much is due to the per capita increase?

22 The reason I think that's important is that there

1 has been, in the public perception, the expectation is that
2 Medicare and Social Security are going to grow because of
3 the number of people that are coming onto the rolls. And so
4 I think it's really important in terms of trying to
5 understand this is how much of this is mutable and how much
6 isn't. Because clearly you're not going to have -- you
7 don't have control over the growth in terms of the number of
8 individuals who will be receiving these services. So it
9 would be useful to distinguish the source of the growth in
10 that third slide.

11 And the fourth slide, and this really is a
12 question, the next one. It looks as though the projections
13 have Part D as becoming a larger proportion of the total
14 spending, certainly relative to Part B. So if I look at
15 2010 Part D looks like a third or so of Part B. And when
16 you get up to 2080 there, it looks like it's a much larger
17 proportion. The growth in Part D has actually been
18 relatively modest compared to other aspects of the program,
19 at least since 2006. So I'm wondering, what's the basis for
20 that expectation, that Part D is going to grow?

21 MR. CHRISTMAN: I'm less familiar with Part D's
22 long-term piece so I'd have to think about it. But my

1 understanding was, at least for a period of time -- and this
2 may have changed -- that in the long run they expected those
3 to grow a little faster than B and A. But past a certain
4 point all of these go to the same growth rate.

5 DR. STUART: Well, I think that was true
6 initially, before the benefit was passed. So part of the
7 question, I guess, is where these numbers come from. This
8 is the 2008 Trustees' report. It struck me that the growth
9 in Part D actually had declined or the expectations of
10 growth had declined.

11 MR. CHRISTMAN: And I don't know that they have
12 rethought their long-term yet. We can look at that.

13 DR. CHERNEW: A few comments. The first one is I
14 like generally the chapter and where it's going. A few
15 specific comments. One is I think a stronger distinction
16 between the level of spending and the growth of spending
17 would be important. For example, the U.S. has higher
18 spending than other places, than other countries that
19 doesn't necessarily have more rapid growth. Areas on the
20 Dartmouth Atlas Chart that have high spending don't
21 necessarily have more rapid growth. Interventions that may
22 reduce the level of spending may not reduce the rate of

1 growth in spending. So I think a stronger conceptualization
2 of the distinction between the level and the growth of
3 spending would be useful.

4 My second comment is that I think more attention
5 to distributional issues matter, particularly with regards
6 to income and health status. Whatever we think is going to
7 be problematic with higher cost-sharing and premiums
8 relative to average Social Security benefits, if you look
9 for certain subsets of the population I think the problems
10 are even more challenging. And I think that that separation
11 within the system I think is an important thing to point
12 out.

13 The third comment is it would be interesting for
14 me to understand how much of the higher out-of-pocket burden
15 that you mentioned is due to greater use of care which
16 people could presumably deal with through substitution or
17 utilization patterns as opposed to through increases in
18 things like the deductible, the amount they're asked to pay
19 for use of a particular service.

20 And finally, at the end of the chapter there is a
21 section on different proposals. The whole chapter starts
22 about cost, then there's a bunch of proposals, then there's

1 a paragraph that says but of course these things might be
2 good but they really may not address cost, which is how the
3 whole thing was set up.

4 And I think thinking through in the chapter the
5 interventions related to cost versus the interventions
6 related to quality would help it hang better.

7 DR. CASTELLANOS: I like the direction we are
8 going. I think we all agree that the spiraling costs of the
9 Medicare system needs to have better control. We also need
10 to think about efficiency and we need to think about quality
11 delivered.

12 One of the points I would like to make is I'm not
13 sure what society's expectations are. Maybe they don't mind
14 spending more money if they can get it on a better delivery
15 system, more efficient with better quality. I think the 45
16 percent rule is arbitrary and I think linking everything to
17 GDP perhaps may be arbitrary.

18 When we look at responsibilities or how we're
19 going to look at it, I think we have to look at all the
20 providers plus the beneficiaries. Beneficiaries in our
21 society definitely have some responsibilities in controlling
22 the costs, not just to mention their lifestyle, the obesity

1 rate, smoking, et cetera.

2 DR. CROSSON: First, I'd like to compliment Evan
3 on the completeness of this analysis of the problem
4 statement. I think the bibliography itself is worth coming
5 to the meeting.

6 But I do have a problem I think beyond that in
7 terms of what we're trying to do with the chapter, and it's
8 similar to Mike's final comment. I'll use the medical
9 analogy, I did a biopsy of the chapter. And what I found
10 was the first 22 pages were the diagnosis and the last
11 three-and-a-half pages were the treatment. In fact, the
12 last three-and-a-half pages are sort of a categorical
13 listing of various approaches.

14 I would like to see one of two things: either we
15 simply make the chapter a thorough academic analysis of the
16 problem, or we -- and this would be my preference -- we have
17 a more balanced chapter which does some of both. By
18 shortening the diagnosis part, providing some general
19 context to what we think as a Commission the general
20 approaches to solving the problem ought to be, linking those
21 to some of the parts of the chapter that describe the
22 problem, and make this a piece which is a context for

1 Medicare policy in our mental construct.

2 In other words, this is not just an academic
3 statement of what the problem is. This is our view of what
4 the problem is, and at least some general thoughts about
5 directions to solving it. So that would be my thought.

6 DR. SCANLON: I am supportive of the general
7 direction and the content. What I would like to suggest is
8 that we beef up what we say about the issue of the
9 beneficiary and their out-of-pocket burdens because I think
10 the problem is current, not just sort of in the future.
11 It's current for the subset that end up with catastrophic
12 costs.

13 Considering Medicare from a big picture
14 perspective, I think we have to always remind ourselves this
15 is a program that doesn't provide catastrophic protection,
16 that you have unlimited Part B copay liability. Part A is
17 less of an issue but on the Part B side, particularly for
18 chemotherapies where those drugs are administered through
19 Part B, that this is an issue.

20 We've talked about this in other context before.
21 Here when we start to talk about Medicare supplemental
22 insurance it provides kind of a different direct link to the

1 issue. Why would someone want to have Medicare supplemental
2 insurance? It's because you'd want to buy catastrophic
3 protection. But the other reality is that the current
4 supplemental insurance may produce too much use because of
5 the first dollar coverage. And first dollar coverage is a
6 bad deal. To pay somebody 40 cents to write a check for \$1
7 for you is not a good purchase.

8 So the idea would be to try and talk about this --
9 when we're thinking about bigger reforms for Medicare in the
10 future, be thinking about it also from the beneficiary
11 perspective and catastrophic protection.

12 DR. KANE: I like the chapter and actually I've
13 used parts of it -- because some of it is from prior times
14 we've written it -- to help scare my students and other
15 people when they want to know what MedPAC is working on.

16 A couple of things that are at least of great
17 interest to me, I don't know if they are to anybody else.
18 But I think it's coming up more often now that what the
19 private sector does affects Medicare and vice versa, and
20 that we really need to, I think, delve a little more deeply
21 into how the two sectors can better collaborate.

22 That leads me to thinking it would be useful to go

1 back and do a literature review of what was good and what
2 didn't work about the old all-payer systems and get a better
3 sense of what that means and how we might -- that's the most
4 direct way of creating a collaboration with the private
5 sector. There's obviously less -- what's it called --
6 rigorous ways to do that, but that may also have value. So
7 I'd like to see us delve more deeply into how we can get the
8 private sector to be more on the same page on us more on the
9 same page with them, as well.

10 The other thought that came up as I read the paper
11 was at the very end, and also related to what I know about
12 the history of Medicare. In the very end there's a table on
13 page 40 about the tools that Medicare has and that the
14 private sector has and the differences between them. One of
15 the things that's on the Medicare side of the page says that
16 we are prohibited by Federal law from interfering in the
17 practice of medicine. I know that's been there since 1966.
18 But I'm very interested in knowing what does that mean? And
19 how does that play out as we evolve into episodes and pay
20 for performance and bundling A and B and medical homes? How
21 will that play out? Is that going to go away? Is that
22 going to come back and haunt us? And how should we be

1 addressing clarification of that provision in the law?

2 MR. BERTKO: Like everybody else, I am going to
3 echo that this is a good chapter. It's well written, and I
4 think in comparison with a lot of similar things, it's
5 thorough and it's readable.

6 My big suggestion would be in that introductory
7 chapter summary section, it would follow up on some of Jay's
8 comments here, that the last paragraph says here are some
9 solutions such as...

10 On slide five, for example, you did a great job in
11 the chapter taking apart those factors. But there could be
12 something that says technology, can use comparative
13 effectiveness. Insurance, like Bill was suggesting, can
14 make adjustments to Medigap. And having a list of those in
15 there, because I think there will be some readers that
16 really get stopped by the introduction. It's a good chapter
17 but there's a lot of meat to it.

18 MR. BUTLER: I think that we shouldn't
19 underestimate the importance of the chapter. As a new
20 commissioner, when I was preparing for this -- this is the
21 first chapter that I read some several months ago and I was
22 very impressed by it. So it is probably the first thing

1 that people read and we ought to take it seriously and I
2 know we do.

3 I also was impressed how well it was done then and
4 how well it's done now.

5 I did do though a comparison because I said I
6 think I read this before. I went back and it is basically,
7 an awful lot of it is a repeat of last year. So I tried to
8 say what is different? And I did note that the six areas or
9 so that we're focusing on in value -- where a value can be
10 added is new. Part of it is a question, is that our
11 declaration of the important areas that we're going to
12 suggest reform in ultimately?

13 If it is, and that's our working agenda, then I'd
14 like to know that. I think it's a good list, but I'd like
15 some clarification around that.

16 Now specifically with Mike's point, which was
17 exactly mine that I wanted to make is in the specific
18 recommendation. If you look at the charts -- and a lot of
19 times people don't read the words, they look at the charts.
20 Every single chart is growth trajectory. And there's
21 nothing on the current level of the distribution of current
22 resources.

1 So specifically a Dartmouth Atlas Chart or
2 specifically the charts that show that 25 percent of the
3 beneficiaries use 86 percent of the money, the variation
4 kinds of issues are at the heart of where dollars ultimately
5 can be saved I think could show up in a couple of charts
6 rather than just having the charts show the trajectory of
7 the spending.

8 MS. BEHROOZI: A lot of it sounded familiar even
9 though it's only been a couple of years I've been here
10 reading it again. I feel like maybe it's partly new, but I
11 feel like there's a little more of a sense of urgency in
12 painting the picture of the health care system in the United
13 States, in particular the Medicare program.

14 But I think to really complete the picture or to
15 enhance that picture, I would suggest a couple of additional
16 points that I think of as along the lines of myth busting,
17 to help get people ready for the fact that we need to make
18 major changes. And just a couple of ways in which I think
19 that the presentation can be beefed up a little.

20 On slide six and in the paper you talk about U.S.
21 spending compares to other OECD countries' spending and you
22 talk about regional variation within the United States not

1 being correlated to quality and the RAND study that says
2 people receive only about half of the appropriate
3 recommended care.

4 But I think it would be very stark to show where
5 the U.S. lines up in that -- I think it was a Commonwealth
6 Fund study -- of OECD countries in our quality scores
7 overall and on certain measures that kind of pop out at you.
8 I think that would be very dramatic to help people
9 understand this vaunted U.S. health care system that people
10 from all over the world come here for -- all of that, look
11 at how we compare to places that spend less. I think that
12 would be very stark.

13 I think another point that you make, it was
14 actually on page 18 of the paper, about how you say numerous
15 measures indicate that low income individuals and some
16 minority groups have greater difficulty in obtaining
17 appropriate care. Often people say, in response to looking
18 at costs in other countries, oh but care is rationed there.

19 Well, I would submit -- sorry, I'm talking like a
20 lawyer now here -- that we have rationing of care in this
21 country too, except it's done by income and socioeconomic
22 status. People forgo care because they cannot afford it.

1 That is becoming increasingly true, even for those who are
2 insured, whether private insurance in the under-65
3 marketplace or with Medicare as cost-sharing rises. And I
4 wonder if we can look at whether as Part B premiums rise
5 fewer people purchase it. I don't know, that's probably
6 easily obtainable.

7 But in general, the Part D information that we'll
8 will about later talks about how people, when they get to
9 the doughnut hole, the most common way of responding to that
10 is by not taking their medication. So that's rationing.

11 DR. DEAN: A couple of brief comments. First of
12 all, I would certainly echo what people said. I found the
13 chapter very useful and well written and helpful. And I
14 think it's a good introduction to the problems we face.
15 It's a little scary.

16 A couple of brief comments. First of all, in
17 response to Bruce's comment about Part D growing, there is a
18 projection that, in fact, pharmaceutical costs are going to
19 grow rapidly because of the introduction of a whole new
20 category of drugs, the biologics, that at least some people
21 project are going to be sort of an order of magnitude jump
22 in terms of cost. So I don't know whether that was factored

1 in here, but there is a belief that that's a whole new
2 approach to care that's going to be extremely expensive and
3 maybe that accounts for -- I don't know whether it was
4 factored in here or not. But it's certainly right that Part
5 D costs less than the initial projections but there are some
6 new things on the horizon that may change that. So I don't
7 know.

8 Secondly, the issue in these projections of
9 leaving out and just ignoring the whole SGR thing, I think
10 is a mistake. Because at some point that's going to have to
11 be dealt with as I understand it. I realize you have no
12 idea how that's going to be dealt with. But at least in
13 some sort of pretty bold faced footnote I would say it needs
14 to be mentioned that that's getting to be a big enough --
15 the fix of it is a big enough cost that it at least needs to
16 be noted. Now you can't put it on the graph probably but it
17 can't be ignored forever, I don't think. I don't know.
18 They've done a pretty good job so far.

19 And finally, to Mitra's comment, I would certainly
20 support that as well. The recent reports that the parameter
21 of mortality amenable to health care, the data showed that
22 we've actually gotten worse in the last three or four years.

1 And to put that ranking beside the spending rankings I think
2 would probably make the point even more boldly than it is
3 there now.

4 Thank you.

5 DR. MILSTEIN: I also am very supportive of the
6 general direction and think that the current chapter draft
7 is strong. My specific suggestions are that I do think we
8 could substantially increase the value of this chapter if,
9 for each of our prescriptions or treatment recommendations
10 at the end, we could give the readers at least a range of
11 notion as to what we think this might be worth if well
12 implemented.

13 We address this, for example, when the comparative
14 effectiveness people have come to talk with us periodically
15 and we've fleshed them out in our questions and said in the
16 best case scenario if tomorrow, whenever there were
17 treatment options of equal expected clinical outcome, we
18 always chose the less costly treatment, what would that be
19 worth on a total Medicare spend or total national spend
20 basis?

21 And I think that same information, even if it was
22 a rough estimate based on implementation in other countries

1 or by private sector payers, would be a very useful addition
2 to readers in terms of understanding what are these
3 different interventions worth on a static aesthetic basis,
4 on a one-time basis. That's comment one.

5 Suggestion two would be I think it would also be
6 nice for the readers if we could make the point that in
7 relation to at least some of the interventions on this list
8 that they can be conceptualized either as a one-time static
9 opportunity to reset the base lower or they could be
10 designed and implemented in a way that would create
11 favorable dynamic changes, that is continuous effort on the
12 part of the American delivery system to generate more health
13 with less spending. You can take almost any one of these
14 recommended interventions and help the reader understand how
15 they would have to be implemented if your goal was dynamic
16 impacts, that is continued impacts on rate of growth in
17 spending as opposed to a one-time lowering of the amount of
18 spending.

19 It doesn't apply to all of them, obviously. For
20 example quality standards for imaging, I think that
21 primarily as a static advantage, a one-time reset. But a
22 number of things, like how you design a pay-for-performance

1 program, could be implemented in a way that they would
2 generate perpetual improvements in performance, both cost
3 and quality.

4 DR. REISCHAUER: I support this chapter and I
5 think that over the years it's evolved to become a stronger
6 and stronger case. But I have the sense that we are
7 offering half a loaf, that what this chapter does is it says
8 long-term this program is unsustainable, puts heavy pressure
9 on the budget. Here are the reasons why health care costs
10 are going a whole lot. Here are the consequences of that.

11 But then it doesn't say what I would say next,
12 which is the rest of this report is going to be about unit
13 prices. And even if we moderate the growth of unit prices
14 in drastic ways that will irritate every provider in the
15 United States, that's not going to solve the problem here.
16 We have another bunch of sort of reforms that we advocate.
17 And while Arnie has a lot of ways of extending them and
18 implementing them, we haven't recommended those and most of
19 what we've recommended from a cost standpoint, in a sense,
20 is really rearranging the deck chairs on the Titanic.

21 We are all for pay for performance but it's budget
22 neutral. We are going to have a pilot project on medical

1 homes. I wouldn't put billions of dollars of savings on
2 that. Comparative effectiveness, I'm all for that but we
3 haven't drawn the next step which is you have to have the
4 guidelines, you have to use this in the payment system, et
5 cetera, et cetera, have reference pricing or something.

6 So Nancy can scare her students and Tom can be
7 scared in his office reading this, but the real message is
8 to scare people a lot more. And that is we're going to have
9 to consider some more fundamental changes if we really want
10 to address this. And they're going to have to affect not
11 just Medicare but Medicaid and the private sector, as well.

12 It needn't be more than a paragraph saying that,
13 but you're sort of left with the impression that we have
14 some reasonable ways of getting out of the unsustainability
15 here when, in fact, we really don't.

16 MR. HACKBARTH: We've got roughly 15 minutes here.
17 What I would like to propose is that we focus on three areas
18 which I hear in the comments.

19 One, several of you suggested ideas for
20 strengthening the discussion of the beneficiary connection
21 here. One take on that is the beneficiary's role in driving
22 the cost increase, namely their expectations for quality and

1 access, convenience, et cetera. The other side of it is
2 what are the implications of financial burden on
3 beneficiaries? And surely there are other takes as well,
4 but that would be one potential area for enhancement, the
5 beneficiary connection.

6 The second that people touched on in various ways
7 was related to the basic structure of the chapter. Jay
8 raised this initially by talking about how many pages are
9 devoted to the problem statement as opposed to the solution,
10 and several people followed in a similar vein, asking for
11 enhancement of the solution discussion. So that's one
12 potential path.

13 Another, and they're not necessarily mutually
14 exclusive, would be to use this as a document each year for
15 a statement of MedPAC's agenda, as Peter proposed.
16 Commissioners who have served on the Commission for a while
17 know that we're always looking for ways, in fact struggling
18 to find ways, to better tell our story so that -- we may
19 call these individual recommendations, but sometimes the
20 themes, the story, how they link together, is lost in the
21 detail of individual recommendations. We could use this
22 chapter to tell the story of the MedPAC agenda, where we've

1 been and where we see it going.

2 A third idea that came up here, Bob just touched
3 on, which is to be more pointed in our take on this context,
4 on all this data, on how bad the problem is. Bob's take is
5 the tools that we've got, even if you enact all of our
6 recommendations, the tools are pretty meager relative to the
7 scale of this problem. And we could use this chapter to
8 tell a story about the context that's much sharper.

9 In fact, in the extreme you could say we're going
10 to cut out a lot of these detailed data or put them
11 someplace else. And what we want to do is tell a story that
12 really heightens urgency. In this case, to lengthen the
13 detail almost has a dulling effect. I've seen all this
14 before. I know all of this, yada, yada, yada, it almost
15 causes the reader to turn it off as opposed to really
16 hitting him between the eyes. Maybe a short three or four
17 page statement that really was focused on the urgency of
18 this and made some sharp comments would draw more attention
19 to the problem than a 30-page chapter.

20 So there are some different ideas about how to
21 make this more pointed and effective.

22 Then the third theme that I heard in various

1 comments was the quality dimension and there's a lot of talk
2 about rapid growth in costs, a little allusion to quality
3 especially in the geographic variation. I think we say the
4 quality is not well correlated with costs. But that could
5 be made much more pointed using international comparisons,
6 as Mitra Tom suggested. Indeed, as Tom says, there are some
7 Commonwealth data that suggests that the U.S. is falling
8 further down the ranks in the international quality
9 comparisons, even while our costs soar. So we could enhance
10 the quality piece of this.

11 Now these are not mutually exclusive ideas by any
12 stretch. He could easily do the beneficiary strengthening
13 and the quality piece.

14 I think the one that is more fundamental, what are
15 we trying to do with this chapter, is how much time do we
16 want to spend talking about the statistics about the problem
17 versus what we want to do about it or statements that would
18 really create a more powerful sense of urgency. That
19 really, I think, could change fundamentally the character of
20 the chapter.

21 So with that prelude, let's do a second round of
22 comments.

1 DR. BORMAN: With regards to the beneficiary
2 theme, as we look at the piece of out-of-pocket and burden I
3 think it might be helpful to break that down into a couple
4 of groups because I think there are haves and have-nots in
5 this very clearly. I think we've tended to use the duals as
6 a measure of sort of the most vulnerable, the most have-
7 nots, and that's a group we can continue to look at.

8 I think we do have an evolving sort of higher end
9 group and as we think through this we're going to have to
10 look at structuring the benefit, whether you want to talk
11 about it in terms of tiered benefit or whatever you want to
12 call it. So we need to have an understanding of sort of the
13 size of maybe the high-end and low-end groups so we can
14 think going forward about matching the beneficiary to the
15 benefit, to the premium maybe a little bit better over time.

16 So as we look at the beneficiary analysis, it's
17 probably not in this chapter. I think as Glenn is saying,
18 there's a lot of merit to making this a conceptual or
19 philosophic chapter and let the details play out in other
20 chapters. My recollection is that we have that an ongoing
21 21st Century beneficiary project and maybe that's the place
22 to start moving some of this beneficiary discussion as a

1 chapter and as a focal point would help me, I think.

2 One comment about as we get into the international
3 variation in quality piece, perhaps we could find a few
4 things in which we do rather well. I think a wholly
5 negative picture kind of turns a lot of people off to start
6 with. And I think in all honesty there are some things we
7 do reasonably well. And so I would work to find a few
8 things.

9 And some of it is acute care things. Like we
10 probably do have very good care for appendicitis, for
11 example, some of those kinds of things. So let's find a few
12 positives here to balance. And maybe that helps us know why
13 are we doing well at this and things we're not doing well at
14 that we'd like to do well at? Is it because of the nature
15 of the care and the technology and some of those things? So
16 it may be informative to help that.

17 And then the other pieces, I would like to see us
18 highlight a little bit the high administrative cost because
19 that's something that certainly at an individual
20 practitioner office -- I've got a different form for every
21 policy almost, much less a given company, that I have to
22 deal with. And yet in the end, I think people on both sides

1 of the equation want to give and share the same information.
2 And why we can't get to that as a part of the benefit as
3 moving toward IT standardizing, we do have an opportunity I
4 think for recouping some of the administrative cost. And I
5 think this would be a hopeful place. Whether this is the
6 right chapter to highlight it or not, I think it does flow
7 from this comparison of costs.

8 DR. CHERNEW: As I said before, I think the oddity
9 in this chapter is the disconnect between the strong call to
10 focus on costs and the problems associated with costs in the
11 beginning and then the recommendations at the end where I
12 come down in the camp I think with Bob that we don't know a
13 lot about them being able to address the cost issue at all.
14 And so my view, for starters, is that the first two
15 paragraphs on page 26 have to be -- they're way too
16 optimistic for my taste.

17 And in that spirit, I would prefer a more focused
18 chapter, perhaps other chapters related to other issues, but
19 maybe a more focused chapter that maybe makes the cost issue
20 that people know well very clear.

21 And then instead of saying here's a solution in
22 some optimistic way, which is sort of the way that I read it

1 now, say there's a lot of things we can do. They can affect
2 quality, which is a wonderful thing. But they don't address
3 really much beyond a bump the way they're currently
4 implemented the problems we have just laid out. And I think
5 the chapter has to make very clear that doing all of these
6 things that we can all rally behind -- myself included --
7 are wonderful things but they don't solve the problem that
8 the original part of the chapter. And I think too often we
9 have the tendency to say costs are a big problem, here are
10 some good things, let's do them, without connecting those
11 things. And I think this chapter has to do that.

12 Now Arnie may be more optimistic in ways to make
13 these things control costs, and I wouldn't mind a conclusion
14 that says we have to take these basic tools and make them
15 control costs. But I think this chapter can't be the
16 chapter which says we have to find a better way to get to
17 improve quality. We can have another chapter about how we
18 need to improve quality. But if you start out with costs as
19 this crushing problem, I think the conclusion has to be a
20 call to how to deal with the cost problem better. Quality
21 obviously matters but it's a distraction, in my opinion.

22 MR. HACKBARTH: Let me raise a question for people

1 to react to it as we go around. There's something that
2 doesn't quite seem right to me about using the context the
3 chapter, as we've called it, as the place to describe
4 solutions. What we're supposed to do is develop
5 recommendations supported by analysis that we vote on. And
6 to use this as saying here are the answers seems to be a
7 shortcut to where we're supposed to be going. We're
8 supposed to develop recommendations on what the solutions
9 are, as opposed to lay them out in the first chapter of the
10 book.

11 Now of course, we've recommended certain things in
12 the past, so we've got a history that we can refer to. But
13 even if we're optimists, to say here are the solutions to
14 this grave problem just doesn't seem right in a context
15 chapter. So that's one thought.

16 And then a second that I'd ask people to react to
17 is maybe what we need is actually two distinct chapters.
18 Mark tells me that the context chapter has an audience, that
19 people use this material for various reasons, writing
20 speeches for their Senator or Congressman. There are people
21 who look for this every year, the updated information. And
22 so we want to continue to meet that demand.

1 But maybe what we need to do is separate out into
2 a shorter statement something about solutions or a statement
3 about the urgency of the problem, that the content would
4 vary each year. But it's a much more sort of pointed essay
5 view that is a little bit more hard hitting as a way to get
6 attention. So those are some thoughts that I would welcome
7 reactions to.

8 DR. CASTELLANOS: Just a couple of points,
9 specifically with the beneficiary. I would like to think
10 more of a cultural change where we can change the culture of
11 the beneficiaries or at least try to impact, that new and
12 better is not always the best way to do, shiny and bright.
13 Sometimes the old ways are just as good. We need to talk
14 about lifestyle changes. They have a responsibility and
15 they need to think about what society's expectations were,
16 and I think I mentioned it briefly.

17 Getting on Jay's point, I think we've made the
18 diagnosis. Now we need to think about treatments. We need
19 to get away from just again hammering the diagnosis but how
20 we can go ahead and treat the problems that we've diagnosed,
21 speaking as a physician.

22 We have to involve all the Medicare providers and

1 the beneficiaries, as I said. Being a physician, I'd like
2 to stress a little bit on the physician community. And we
3 talked briefly about this last year and we've talked again
4 this year. I think the fee-for-service provides perverse
5 incentives. And this is what's causing the behavior that we
6 see in the hospital community and what we see in the
7 physician community. And until we have some change in the
8 payment system, this is going to be a continued problem.

9 Now I understand that pay for performance,
10 accountable care organizations, and bundling has a
11 downstream effect but I think we need to get and hit the
12 problem within the physician community as far as a payment
13 system change.

14 MR. BERTKO: I'm going to support your last call,
15 Glenn, for something on urgency whether it's part of the
16 current context chapter or a new one. And in the line of
17 there is, in my mind, a clock ticking. In 2009 it will be
18 10 years. While the 45 percent trigger, I think, is a
19 useful warning, some people criticize it as being arbitrary,
20 which it is. But in 2019 there's not going to be anything
21 arbitrary. Part A will run out of money.

22 The second part of this urgency is that, I think

1 everybody around this table knows and others, that many of
2 these options for fixing the costs in Part A would be
3 multiple years to roll out, two, three, four years to get
4 through what CMS does to get there. We ought to bring that
5 to people's attention.

6 MR. BUTLER: Three comments. One was related to
7 what you said, which was where I was headed to. By
8 definition the title, context for Medicare policy, does
9 suggest it's a diagnosis chapter, it's not a solutions
10 chapter. And I think we ought to keep it that way and
11 handle the solutions elsewhere. So I'm reinforcing that.

12 Secondly, with respect to the charts that I was
13 recommending, I have a greater appreciation now that some
14 people just expect these annually and they want their charts
15 for this year. Having said that, my point was really
16 around, when I said I referenced Mike or Arnie saying
17 there's 10 percent right of the base that we ought to be
18 looking at as opposed to just the projected. If there was a
19 kind of two or three charts where we continue to track that
20 kind of base level spending that is an opportunity where
21 there's over utilization, I think that would be a helpful
22 part of the diagnosis.

1 The last comment, you made reference to me wanting
2 to maybe perhaps be the place where we display the MedPAC
3 agenda which some would think needs greater clarity. I
4 certainly would like to have it clear. But having said
5 that, maybe this isn't the place to put it exactly for the
6 reason that this is the diagnosis.

7 If we do put in it here, my point was I want to
8 know that that's what it is. It's not just that well, we
9 might do these things. Because it's not clear whether that
10 is the agenda or not.

11 So I probably would suggest that, given your
12 comments, that that gets lifted out of the chapter rather
13 than put in because it starts to dabble into the solution
14 side.

15 DR. DEAN: In terms of the comments about whether
16 we should include responses or solutions or however you
17 characterize it, it seems to me that there is a value in at
18 least laying out and trying to take these responses that are
19 listed pretty briefly at the end of the chapter and making
20 some sort of comment about what MedPAC believes are the
21 potential benefits of each of those responses so that some
22 priority as to which ones are likely to have the biggest

1 payoff and some comment in terms of -- maybe it follows on
2 what Peter just said -- what the priorities or the direction
3 of the Commission will be, not to get to specific solutions
4 but which of these is likely to be most useful in
5 responding.

6 I think part of the reason that we have failed to
7 make any progress in any sort of real reform -- and as an
8 aside, I'd certainly support everything that Ron said about
9 the perverse incentives that exist in the current payment
10 system -- but anyway, there is no single fix. And it's such
11 an intimidating problem, even for those of us that live with
12 it a lot, let alone the general public. If we're going to
13 make any progress, we need to make a point first of all that
14 there is no single one of these that's going to solve the
15 problem. But there probably are differences in terms of
16 which ones will have the biggest return. And I think it
17 would be useful to at least go out on a limb in a way. We
18 don't know but where do we think the payoff may lie?

19 DR. CHERNEW: Those solutions strike me as solving
20 a different problem and I think that's the problem in the
21 chapter, is how to get those solutions to solve this
22 problem.

1 DR. CROSSON: Just a similar comment. I said
2 initially that the strength of the chapter was the
3 completeness of the analysis of the problem. The weakness
4 was the little tail at the end which was just a listing of
5 solutions, as Mike said, out of context necessarily for
6 specific parts of the problem statement. But I also think
7 it kind of understates the work of the Commission, which is
8 a lot about recommendations about what Medicare policy
9 should be to solve the problems.

10 So I look at the same words, context for Medicare
11 policy, and I don't necessarily see just diagnosis. I see
12 diagnosis and our thoughts about relative treatments. And
13 it might be, as Bob said, that a lot of the stuff that we're
14 discussing and working on is very good but it isn't going to
15 solve the fundamental problem. We need to say that, as well
16 as suggest perhaps more radical ideas that we haven't worked
17 on yet.

18 It might be though, for the purposes of
19 continuity, that that would best be done by creating two
20 context chapters or two parts of a context chapter: one
21 which is more traditional which in fact ends at page 22 and
22 says the context for Medicare policy is something like the

1 issue of financial sustainability. And then a second
2 context for Medicare policy, the range of future solutions
3 or something like that. And make those distinct but
4 connected in terms of the way they're written and the way
5 the content flows.

6 MR. HACKBARTH: So the problem number one in
7 chapter two, so to speak, is where we've been, where we're
8 going, and some commentary on the strength of our toolkit,
9 whatever else we want to fit in that heading.

10 So let us work with a little bit of a
11 restructuring along those lines for next time.

12 Thank you, Evan. Good job on the first draft.

13 Our next session and the last before lunch is one
14 of our MIPPA updates, this one specifically on the
15 provisions on physician resource use measurement. Jennifer
16 is going to do that.

17 For the audience, we are scheduled to do this one
18 for 45 minutes and then have our public comment period. So
19 that would mean shortly after 12:30 we'd be at the public
20 comment period.

21 MS. PODULKA: Thanks. As Glenn mentioned earlier,
22 today you'll be hearing several presentations on the recent

1 Medicare Improvements for Patients and Providers Act of
2 2008, or MIPPA as we refer to think it. This is the first
3 one and one that I'm particularly excited to talk to you
4 about.

5 You may recall back in our March 2005 report to
6 the Congress we recommended that Medicare measure physician
7 resource use and give confidential feedback back to
8 physicians. I'm pleased to tell you that the recommendation
9 has been enacted by MIPPA which requires that the Secretary
10 of Health and Human Services establish a physician feedback
11 program using claims data to provide confidential feedback
12 reports to physicians measuring the resources used to
13 provide care to Medicare beneficiaries.

14 The program must begin by January 1, 2009, this
15 coming January, and the Secretary must conduct education and
16 outreach activities to prepare physicians. The Government
17 Accountability Office must evaluate the program by March
18 2011.

19 MIPPA grants the Secretary flexibility on several
20 characteristics of the physician feedback program. The
21 Secretary may choose to use other data in addition to
22 claims, provide feedback to physician groups in addition to

1 individual physicians, and include feedback on the quality
2 of care. The resources measured can be done so on a per
3 episode or a per capita basis or both and the Secretary may
4 choose to adjust data for beneficiaries' health status and
5 other characteristics.

6 Additionally, MIPPA grants the Secretary
7 flexibility to focus the physician feedback program on
8 several items. First, specialties that account for a
9 significant share of Medicare spending; physicians who treat
10 high-cost or high-volume conditions; physicians who use a
11 high amount of resources compared to other physicians;
12 physicians practicing in certain geographic areas; and
13 finally, physicians who treat a least a minimum number of
14 Medicare beneficiaries.

15 Even before MIPPA was enacted, CMS had already
16 begun work that they refer to as the Resource Use Report
17 pilot program which will comply with the law's physician
18 feedback requirement. Phase I of the RUR pilot will use two
19 commercially available episode grouper software packages,
20 Episode Treatment Groups or ETGs developed by Symmetry
21 Health Data Systems and Medical Episode Groups or MEGs by
22 Thomson Reuters, which was formerly Thomson MedStat.

1 Just a quick reminder here, episode groupers are
2 software packages that use clinical logic to assign all
3 types of health care claims to clinically distinct episodes
4 of care which are a series of clinically-related health care
5 services over a defined time period, such as all claims
6 related to a beneficiaries' diabetes over a year.

7 Then these episodes are attributed to physicians
8 based on patterns in the claims data. And then each
9 physician's pattern of resource use is compared to the
10 average resource use. Physician's patterns of resource use
11 are compared with the average resource use for similar
12 episodes by peers. The comparison can be made both in
13 aggregate by specific episodes or types of services.

14 For example, a physician might treat all diabetic
15 patients in a more resource intensive manner than their
16 peers or they might generally use more intensive imaging
17 services. Providing detailed information in addition to
18 aggregate measures makes physician feedback more actionable
19 by identifying differences in practice patterns that
20 influence overall results.

21 Continuing back on the slide there, both episode
22 groupers will be used to analyze Medicare claims, produce

1 alternative research use reports for several acute and
2 chronic conditions, provide confidential feedback to
3 selected physicians, and conduct one-on-one interviews with
4 a sample of these physicians who receive feedback. The
5 pilot will test several different characteristics of both
6 the measurement methodology and the feedback format.

7 Phase I of the pilot will focus on four acute
8 conditions and four chronic conditions, as indicated on the
9 screen, designed to capture a range of specialties and
10 conditions.

11 Phase I of the pilot will test several different
12 characteristics of the measurement methodology. I laid
13 these out in some detail in the paper so I'm not going to go
14 through anything but some examples here, however I'm happy
15 to discuss anything in more detail if you'd like on
16 question.

17 The pilot will test three risk adjustment
18 approaches to account for differences among patients. It
19 will test six approaches for attributing episodes to
20 physicians, including both attributing to a single physician
21 and attributing to multiple physicians, and it will test
22 several different benchmarking approaches.

1 First, it will explore multiple cut points for
2 defining both cost efficient and cost inefficient
3 physicians. For example, two standard deviations from the
4 mean, the top or bottom decile, and others.

5 It will also test multiple comparison groups used
6 to measure physicians' efficiency. Generally a physician's
7 resource use for a given episode must be compared with an
8 expected value, often determined by the average of
9 comparable physicians' resource use. Remember that in our
10 past analysis we compared physicians with other physicians
11 in the same market area and in the same specialty. The
12 pilot will test additional geographic areas and specialty
13 groupings.

14 The field test of the Resource Use Report to
15 gather physician input, CMS and its contractor for the
16 pilot, Mathematica Policy Research Inc., will distribute
17 RURs to a large sample of physicians in the same 12 sites
18 that are used for the community tracking survey, as
19 indicated here. CMS and Mathematica will conduct one-on-one
20 interviews with small samples of physicians who receive
21 feedback in three ways. Physicians will be asked their
22 opinions of the alternative RURs and the methodologies.

1 I'd like to note that a pretest of the one-on-one
2 interviews and feedback with physicians was conducted the
3 week of August 18th in the Baltimore-Washington area. The
4 RURs tested in this wave used per capita measures
5 exclusively. The next wave of RURs will be field-tested
6 later this month continuing through October and these will
7 include per episode measures. Eventually, RURs may include
8 both per episode and per capita measures.

9 CMS will revise the RURs based on the feedback
10 that they receive from physicians in the interviews and
11 based on the results of the phase I part of the pilot, CMS
12 may implement a Phase II, which could expand the evaluation
13 of physician feedback by including additional specialties,
14 conditions, geographic area, and feedback on quality
15 measures.

16 Before I move on to the next slide, I'd really
17 like to make the observation that CMS has been pursuing
18 these efforts for a few years now at least in part at the
19 urging of this Commission. The Agency is especially well-
20 positioned to execute this part of the MIPPA very nearly
21 immediately upon its passage. And speaking at least at the
22 staff level, the pilot encompasses a thoughtful and thorough

1 research design that could move Medicare in a direction that
2 we and the Congress have been pushing them for some time
3 now.

4 Moving along to our planned work, to gather both
5 your views and to complement CMS's feedback pilot we will
6 continue to explore best practices for building an
7 environment for effective physician resource use measurement
8 and feedback. We will do so by reviewing the literature and
9 conducting structured interviews with individuals and
10 organizations involved in these efforts. We will, of
11 course, present these findings and discuss potential
12 principles that should be adopted by any future Medicare
13 efforts at future meetings this year.

14 Our structured interviews will be augmented by
15 additional data analyses, by analyzing Medicare claims using
16 episode grouper software for four or five years now, 2001
17 through 2006. After we do so we will address the following
18 questions: first, do physicians' efficiency scores, which
19 are their measures of their resource utilization compared to
20 their peers, tend to remain stable over time? Second, what
21 effect do different attribution methods -- single, multiple
22 and others -- have on the types of physicians that are

1 assigned responsibility for episodes and what their
2 resulting efficiency scores are?

3 Also, we will explore the integration of quality
4 and resource use measures. In addition, as some of you have
5 suggested in the past, we will focus our analysis on the
6 most common expensive conditions or episodes to address the
7 following questions: are their episodes or conditions with
8 fewer physicians involved, both for attribution and for the
9 total care? And for conditions with multiple physicians
10 involved, what types of specialties are represented? Are
11 they duplicated throughout the episode? And finally, which
12 specialities tend to be attributed responsibility for
13 episodes?

14 Hopefully answers to these questions will give us
15 a more qualitative understanding of what happens in a
16 resource use measurement environment.

17 That concludes my presentation and I look forward
18 to especially your feedback on our work plan for the coming
19 year.

20 MR. HACKBARTH: Let me see hands of people want to
21 comment during our initial two-minute round. Karen, you've
22 got the lead.

1 DR. BORMAN: I share with you and the staff some
2 warm and fuzzies about moving in this direction because I do
3 think it can be a productive one, because I think it can
4 have intangible effect on the provider community that I
5 think may be very helpful and rewards professionalism, for
6 taking information about yourself, using it to modify your
7 practice and move forward. And so I think that's a good
8 thing.

9 In fact, there may be value in a subset of this in
10 exploring how to provide these data in a way that an
11 individual practitioner might be able to submit them almost
12 directly as part of maintenance of certification process,
13 which some if you are familiar with in terms of how to
14 maintain your specialty certification and is essentially a
15 universal requirement now going forward.

16 So to take this and give it a context that a
17 physician can use in another setting that is personal
18 improvement that impacts on their patients I think could be
19 a very good thing. So I'm supportive of this being a
20 significant work project for the staff.

21 Two specific things about the data. Number one,
22 again because we all have so many reservations about our

1 ability to identify good data, can we at least identify
2 outliers? I think that's very helpful. It's a place we can
3 rally around. It would be a very useful thing. I'd like to
4 continue to see that be part of the work.

5 DR. CROSSON: I also support the work. I think
6 that we've talked about it in the past and come to recognize
7 that at least some portion of variation in practice style is
8 simply due to lack of awareness from one physician or one
9 practice to the other of the fact that there is a difference
10 and providing physicians, albeit all of the difficulties in
11 the data and concerns that will be brought forward about the
12 data is not right, et cetera. The general experience has
13 been that for many physicians when presented with
14 information that suggests that that individual is an
15 outlier, it results in some thoughtfulness and change of
16 practice. It seems like if the cost of doing this is not
17 overwhelming, it's likely to yield some good results.

18 I had one specific question and that has to do
19 with whether it's possible in this analysis to take a look
20 at the practice setting also. That is, we are going to look
21 at specialties. Is it possible with the data available to
22 also look at the type of practice setting, group practice,

1 large, small, solo practice, single specialty group -- is
2 that attribution possible with the data that exists?

3 MS. PODULKA: That's actually a good point. For
4 our analysis, speaking for the MedPAC staff, not the CMS
5 pilot. But for our analysis, we can definitely try and
6 incorporate that. Like many things, it's going to be a
7 little fuzzy because we'll have to match on some other data
8 sets. But I think that's something that we can pursue.

9 MR. BERTKO: First of all, I'd like to recognize
10 CMS's efforts on this part. We sometimes don't give them
11 credit for really getting going and coming out of the gate
12 on this one. They've obviously been listening to at least
13 some of us saying this.

14 The second part is I'm really thrilled about the
15 emphasis on looking at the various benchmarking. MedPAC and
16 you guys on staff have done a lot of good work on
17 attribution rules and some of the other parts. But how do
18 you apply this and what are the appropriate benchmarks?
19 They have been thoughtful about what they're looking at and
20 I think maybe, Jennifer you guys and staff can maybe add to
21 that with them. I would encourage you to think along those
22 lines a little more.

1 DR. KANE: I am just going to do my broken record
2 part about is there going to be drug claims involved in
3 defining the costs? I know there isn't right away because
4 it's not going to be available. But I was wondering if
5 there was a possibility of even just focusing on congestive
6 heart failure and trying to make the effort to just get drug
7 claims linked to the congestive heart failure episodes as
8 soon as is possible. Only because some of these are much
9 more drug intensive types of episodes than perhaps hip
10 fracture, in terms of the proportion of resources and the
11 importance of how those resources are used for controlling
12 the episode.

13 So I just wonder if we couldn't selectively pick
14 one or two and see what happens when you bring it in when it
15 comes. I know we're going to come to that later. Because I
16 think it's going to be really hard to know what's going on
17 congestive heart failure, for instance, without drug claims.

18 DR. MARK MILLER: One thing is you have mentioned
19 this a couple of times...today. I didn't say that, just for
20 the record. That was Bob.

21 Actually, there are some good things to say here
22 and it's worth saying out loud. I think I said it to you

1 guys in the executive session. We kind of carried on for a
2 number of years about the need to get access to the data.
3 The most recent change in the law has opened that gate and
4 data has begun to move. In the last session tomorrow, the
5 second session tomorrow we discuss it more detail.

6 I want you to know, whether you say it or not, we
7 are aware of the need to do that. We will fold it in over
8 time but I also, as always, want to dampen expectations.
9 We've just gotten the data. The first year has probably got
10 some issues with it.

11 But yes, our long-term plan is to fold it into the
12 groupers. We can certainly do it on a selective basis and
13 look at condition specifics.

14 But the other thing I want to say is CMS has also
15 -- not only on this demo but on the delivery of the data --
16 stepped up to the plate. We got the request to them and
17 they delivered it and they worked very quickly to get it
18 done.

19 DR. DEAN: Just a real brief comment. First of
20 all, I think this is a really important thing and I think it
21 really needs to be pursued out although it's going to be
22 difficult.

1 One very specific question, does this method have
2 a way of attributing costs? When I see a patient who has
3 three or four diagnoses, one of which relates to say a
4 recent hospitalization -- the other three do not -- which is
5 the usual thing -- I rarely see, dealing mostly with older
6 patients and most of them have multiple conditions. And I
7 would probably deal with three or four diagnoses at a given
8 setting. It may be a trivial issue but I suspect there's no
9 way of doing that.

10 MS. PODULKA: Both software packages have numerous
11 settings where the user of the software package can make a
12 determination. They generally try and attribute, for
13 instance an E&M visit to a specific episode. You're
14 absolutely right. Frequently there's multiple conditions
15 being discussed in that E&M. That's definitely one of the
16 things that CMS, in a separate effort, is evaluating the
17 sort of clinical logic and how they operate with Medicare
18 data. There's always going to be a little fuzzy factor in
19 this but they're definitely aware of it and trying to work
20 on it.

21 MR. BUTLER: Building a little bit on Jay's
22 comment about practice setting, I think there are actually

1 three variables, not to further confuse your study because
2 you're looking for the impact of feedback. It is the are
3 you in an organized multispecialty group practice at one
4 end? But also are you accepting risk in the payment stream
5 is another very important variable. I'm not saying you can
6 do all of these but I would think these all have big
7 impacts. And do you have electronic health records?

8 Those three things at one extreme versus a solo
9 practitioner, family practice with manual charts and in a
10 fee-for-service environment are very different kinds of
11 settings and it would be interesting to see what impact
12 those have, in your spare time.

13 MS. PODULKA: Those are actually interesting and
14 I'm cringing. I'm not sure, I'll have to go back and think
15 about a dataset that could do that. Practice setting, I
16 know the data. This seems a little more trickier but almost
17 a more interesting breakout on the findings.

18 MR. EBELER: Thank you, Jennifer. This is really
19 interesting work. One question about whether we can relate
20 this to some of our other recommendations. We've talked
21 about medical homes. We've talked about hospital bundling
22 and have specific recommendations and we're exploring ACOs.

1 Can our work here link to and inform some of that policy
2 work? Because it strikes me that knowing something about
3 efficiency within what one would think of as a medical home
4 dealing with chronic conditions would really help us get
5 there. So it's really a linkage question, can we do some of
6 this work in ways that informs those policy streams, as
7 well?

8 MS. PODULKA: That's a really good question, not
9 one I've thought a lot about. Medical home might be
10 uniquely suited to an episode measurement approach because
11 one of our big issues in the Medicare arena is attributing
12 these episodes to physicians. But that's partially solved
13 by a medical home -- partially not entirely -- but the
14 physician is indicating a willingness to assume
15 responsibility for this patient's care.

16 So I could see fairly shortly down the road
17 integrating measurement with medical home, if that helps
18 answer your question.

19 DR. MARK MILLER: The other way that the -- and I
20 see the way I think you're pitching it -- is if we looked at
21 this could we use this to kind of shape policy directions we
22 are going? I would just remind all of you and anyone else,

1 the other way we've made the linkage is kind of the reverse
2 where when we've talked about this -- and some of this went
3 on in the SGR report -- of if you had these other
4 organizations, an ACO or a medical home, to be sure that
5 this information can be used and supplied to those
6 organizations so that they understand within those
7 structures what their practice of medicine is and how it
8 compares to other places.

9 So we've made the linkage kind of in the opposite
10 direction. But I see what you're saying and we can think
11 about it that way.

12 MR. GEORGE MILLER: Thank you, Mr. Chairman. I
13 think this is important work also and I'd like to link to
14 what both Jay and Peter said about the setting and the
15 source of the patients. And that is -- I don't know if it's
16 appropriate but I'll ask the question. Do you also look at
17 if that patient comes from the emergency room and if
18 hospitals are also paying a physician to be on call and what
19 impact that may have as you do feedback?

20 And also along the lines where a particular
21 physician may refer to a hospitalist or internist first and
22 then ask to be consulted, versus taking that patient in the

1 beginning, what impact that may have.

2 DR. CASTELLANOS: I think this is a good topic to
3 look at, variations in practice patterns. I'm a little
4 hesitant about some of the issues until we can look at the
5 details. Risk adjustment is going to be a significant
6 problem here. In urinary tract infections, some are life-
7 threatening and some are so called benign, unless you have
8 it.

9 The other concern is practice settings is really
10 important. If you're a urologist in the middle of South
11 Dakota, you don't have the resources available to you that
12 perhaps a urologist has at the Mayo Clinic or at one of the
13 cancer hospitals.

14 There's going to be a tremendous geographic
15 variation and I think this may be due to some of the
16 resources that are available. But I'm a little concerned.
17 We had a lesson with PQRI. That was set up real quick.
18 There was no lead time for CMS. And the data that's coming
19 out that, that should been out of that this summer has never
20 come out or it has come out incompletely.

21 I guess the question I have is what is MedPAC or
22 CMS going to do to allow the physician some feedback on the

1 data that is collected? And an issue is is there going to
2 be a time limit that you're allowed to look at the data and
3 comment on it in a timely fashion?

4 MS. PODULKA: The CMS pilot design includes
5 sending the Resource Use Reports to large samples of
6 physicians in the 12 communities used for the Community
7 Tracking Survey. I'm not sure exactly how much time but
8 they will give them time to review the report. And then
9 they're going to have, instead of focus groups with everyone
10 in the room at the same time, one-on-one interviews with
11 those physicians where they're going to ask physicians
12 questions about was this useful to you? Was it
13 understandable? Are there things you would change?

14 Presumably at that time, physicians could
15 certainly indicate this is too much information for me to
16 process in the little time you gave me. I need more
17 assistance, more time, more something.

18 There is a contractor evaluation of the overall
19 pilot which will go to the Agency. I can't promise when
20 that will be out. But as soon as it is we will share that
21 with the Commission and with the public.

22 MR. HACKBARTH: Jennifer, is public disclosure

1 part of the pilot?

2 MS. PODULKA: No. I do want to absolutely make
3 clear. This is all confidential feedback.

4 MR. HACKBARTH: This is one-to-one with the
5 physician at this point, Ron. It's confidential.

6 DR. REISCHAUER: Start with a question to John.
7 Haven't some large insurers done this?

8 MR. BERTKO: Yes, but not necessarily in this
9 thorough of detail.

10 DR. REISCHAUER: That's what I thought. What I
11 was wondering is whether there was going to be any effort on
12 CMS's part compare, contrast, piggyback on, offer similar
13 stuff for large insurers in some of these markets to use
14 themselves? Because you could get a much richer dataset if
15 one went that direction.

16 MR. BERTKO: I think there are at least four
17 companies, major ones, with big dominant groups of people,
18 members, that could contribute to that.

19 DR. CHERNEW: First, just to pick up on that
20 point, I think the motivation behind developing the groupers
21 that are used in this was other organizations that wanted to
22 do the activities so that they could then report back. I

1 think the other activities are actually stronger than this.

2 The comment that I wanted to make was that I think
3 as we think through this we have to distinguish between two
4 things. One of them is using this information as a study of
5 variation and efficiency, as a study of factors that relate
6 to higher income use, things that might cause variation one
7 way or another, and studying that. That is one activity but
8 I don't think it's the focus of what this is.

9 I think the focus of this is just to collect this
10 data, however flawed they may be, and give it back
11 confidentially to the physician and see if the mere
12 conveyance of that information changes behavior.

13 I hope two things then are true. The first is,
14 and it may be that you know the answer or you don't. I
15 think it's crucial that the evaluation have some relatively
16 strong study design so we can understand the impact of the
17 conveyance of information as opposed to getting conflated in
18 a range of things.

19 And I think it's important that the evaluation try
20 and understand, particularly if there's not much of an
21 effect, if there's not much of an effect because the
22 physicians fundamentally didn't believe the data, there were

1 all of these things they didn't believe about the data, or
2 because there was actually no teeth behind the giving of the
3 data. So if you sent me my teacher's scores but told me no
4 one else was going to say, that gives me a different
5 incentive to change my teaching scores than a number of
6 other systems.

7 And so I don't know how the evaluation is planned
8 or how the evaluation goes. But in terms of understanding
9 where to go from here, I think it's important that we make
10 it clear that they do that well.

11 DR. MARK MILLER: Jennifer, my understanding --
12 and you're a lot closer to this than I am. My understanding
13 is this isn't so much about will this information change
14 their behavior, at least at this stage of the demonstration.
15 It's more an exercise in how can we give you information in
16 a way that's understandable and actionable? It's trying to
17 figure out the physicians end of this transaction, I think.
18 Is that fair?

19 I'm not sure I've heard -- and again, I haven't
20 been as close as you are -- that there is an element to the
21 evaluation that says and did it change their behavior? But
22 I could be wrong.

1 MS. PODULKA: That's my understanding as well.
2 Bob, you mentioned this as well. Many of the other users of
3 this data have many, many more years of experience and they
4 are, in fact, using the results for very different purposes
5 than Medicare has at least thus far envisioned. They build
6 high-performance networks. They build two-tiered networks.
7 They have differential cost-sharing for their beneficiaries.
8 None of these types of more teeth type items are currently
9 considered for Medicare. They might be longer term.

10 So right now this is an instance where I think
11 Medicare sees that they need to crawl before they can walk
12 and then run.

13 This is somewhat unique, using Medicare claims
14 data to create feedback on Medicare care. And yes, it's
15 primarily designed to do a lot of sensitivity testing on the
16 different methodologies, the attribution like I mentioned,
17 and then the format of the report so that they can see, do
18 physicians get this and then say this isn't helpful to me?
19 Or there's things in here that are helpful, here's how to
20 improve it.

21 So you were right, it's largely about the feedback
22 on the report mechanism but also the content of that report

1 mechanism.

2 DR. MARK MILLER: I think the general thinking in
3 this Commission, when we started making these
4 recommendations a couple of years ago, was you've got to
5 sort through this and figure out whether these things even
6 work at all? We've been kind of grinding through that.
7 Then work at it from the physician's perspective, how does
8 the physician view this?

9 Then the next step is okay, first inform. And
10 then the question then becomes, again for this Commission,
11 should more teeth be added at that point? But I think my
12 comments are narrowly about the CMS demo. I think they're
13 just up to can we figure out how the physician is consuming
14 this information and how to make that work?

15 MR. HACKBARTH: We have just about 10 minutes
16 left.

17 What I heard in the first round is, not
18 surprisingly, there's general support for this direction.
19 It's not surprising inasmuch as we've made at least two
20 recommendations on this topic before. I would add my voice
21 to John and others who praise CMS's effort to get to this
22 point. It's no small task and lord knows they've had a lot

1 of other things on their plate. So I'm delighted that we
2 are as far along as we are right now.

3 The comments that I heard sort of fell into two
4 broad categories. One group reiterated concerns that we've
5 raised in the past. There are important issues to be
6 resolved using these tools around attribution and risk
7 adjustment and the like. We have, I think, consistently
8 reiterated those concerns and recognize the challenges
9 inherent, and I don't think we can say too often that these
10 are difficult things. Part of what we're trying to do is
11 figure out how well we can cope with these challenges.

12 The second set of comments were there were a
13 number of specific requests, can we look at this and the
14 effect of setting, for example, on behavior? We will do
15 what we can on that, what the data permit us to do. I would
16 add one item of my own to that list, and I've always
17 wondered how much the scores for an individual physician
18 vary if you first run the data or run the tools using
19 Medicare data and then run the data using a private
20 carrier's data for the same physician. It would obviously
21 be very reassuring if we got consistent results, even though
22 we're talking about different samples of the physician's

1 practice.

2 My fear has always been that you might get an A
3 from Medicare and a C from Humana, in part just because of
4 the differences in the population, small numbers, or
5 something.

6 So if there's some way that we could look at that,
7 maybe in conjunction with a private payer, run the data
8 using the same tools for the same doc and see what happens,
9 I'd be very interested in that result.

10 I saw at least one hand for a second comment,
11 Karen. Is there anybody else who has another comment before
12 we go to the public comment period?

13 DR. BORMAN: I just wanted to touch on something
14 that relates to the benchmarking comparison kind of
15 conversation. Recognizing the very informative first step
16 nature of the CMS project, and also we're trying to ask what
17 can you -- Commission staff -- invest time in that would be
18 helpful. One of the things that occurred to me is utilizing
19 datasets that are already available, not just the private
20 payers. The VA has an incredible dataset. The VA is
21 another part of our government, I think, and hopefully that
22 means that getting those data might not be quite the uphill

1 battle that are others, although I'm not so sure that's
2 true.

3 But at any rate, certainly some of these
4 conditions are regularly treated in the veteran population
5 and there might be just a way to give us that as sort of a
6 reality check, sniff test, something else. We recognize
7 that there are limitations to that population and the data
8 and whatever, but they do have a fairly transparent data
9 collection system. They do clearly have a fully electronic
10 medical record. They have made a huge effort to have
11 primary care networks.

12 I do think there are some features of the VA
13 system that make it worthwhile to know what would these look
14 like from the VA. It just seems to me those data might not
15 be too difficult to get as a comparison dataset.

16 MR. HACKBARTH: Thank you, Jennifer. Nice job.

17 We will now have a brief public comment period.

18 Okay, that's brief enough. We are just about on
19 time so we will reconvene at 1:30.

20 [Whereupon, at 12:29 p.m., the meeting was
21 recessed, to reconvene at 1:30 p.m. this same day.]

22

1 our recommendation, it does not call for a subsequent
2 evaluation of the SNPs.

3 Until MIPPA, SNPs could apply for approval from
4 CMS to enroll non-special needs individuals. We, the
5 Commission, recommended that this be limited. MIPPA says
6 that beginning in January 2010 all new enrollees must meet
7 the definition of special needs individuals.

8 Also, MIPPA adds two new requirements. SNPs must
9 have in place an evidence-based care model with appropriate
10 networks of providers and specialists, conduct an initial
11 assessment and annual reassessment of each enrollees
12 physical, psychosocial, and functional needs, and develop a
13 plan that identifies goals and objectives, including
14 measurable outcomes as well as specific services and
15 benefits to be provided, and finally uses a care management
16 team.

17 You may recall from last year's discussion that
18 special needs plans targeted population include
19 beneficiaries who are dually eligible for Medicare and
20 Medicaid, residing in an institution or in the community
21 with a nursing home certifiable designation, or who are
22 chronically ill or disabled. MIPPA makes requirement

1 changes to all three types of SNPs.

2 First, for dual SNPs, they must limit their cost-
3 sharing for dual and QMB enrollees to no more than they
4 would be charged under their Medicaid plan. Dual SNPs
5 cannot expand their service area unless they contract with a
6 state in that area. And dual SNPs must give potential
7 enrollees a written comparison of the Medicaid plan and
8 their plan's benefits.

9 For institutional SNPs, which can serve
10 beneficiaries in nursing homes and those in the community
11 who are determined to require a similar level of care, MIPPA
12 requires that that determination be made using a state-
13 approved assessment tool applied by someone other than a SNP
14 employee.

15 And then finally, for chronic condition SNPs,
16 which were designed for beneficiaries with severe and
17 disabling chronic conditions, these were not further defined
18 by CMS after the original law was passed so MIPPA adds the
19 following to their definition. These are those who have one
20 or more comorbid and medically complex chronic conditions
21 that are substantially disabling or life-threatening, have a
22 high risk of hospitalization or other significant adverse

1 health outcomes, and requires specialized delivery systems
2 across domains of care.

3 In addition, MIPPA calls for the Secretary to
4 convene a panel of clinical advisers to determine conditions
5 that should meet this definition and be appropriate for the
6 chronic condition SNP designation. They will be announcing
7 that next week, actually.

8 That concludes the update on SNPs.

9 DR. HARRISON: The Medicare Advantage payment
10 system has resulted in Medicare duplicate payments for
11 indirect medical education. The MA benchmarks, which are
12 used to help determine Medicare's payments to MA plans
13 include an allowance for IME spending for fee-for-service
14 Medicare. The Medicare program also makes IME payments
15 directly to teaching hospitals that treat Medicare Advantage
16 plan enrollees.

17 IME spending raised the benchmarks for 2008 by
18 about 2.5 percent. The Commission had recommended
19 eliminating the effect of IME payments on the benchmarks to
20 eliminate the double payments. MIPPA reduces the benchmarks
21 to eliminate the double payment. Beginning in 2010, each
22 county benchmark is reduced by 0.6 percent annually until

1 the total percentage reduction equals the percentage of
2 total fee-for-service spending in the county which is
3 attributable to IME payments to hospitals.

4 For example, if a county had 2 percent of its fee-
5 for-service expenditures attributable to IME then in the
6 first year the reduction in the benchmark would be 0.6
7 percent, then 1.2 percent in the second year, then 1.8
8 percent in the third, and then the full 2 percent
9 thereafter. Thus, the phase-out will be gradual, with some
10 counties having phaseout periods lasting a decade.

11 In the first year, however, the reduction will
12 approximate an across-the-board cut as 92 percent of MA
13 enrollees live in counties where the benchmark would be
14 reduced by the 0.6 percent.

15 MIPPA will require major changes for private fee-
16 for-service plans. Private fee-for-service plans differ
17 from coordinated care plans because they do not need to have
18 a provider network to pass CMS's network adequacy
19 requirements. Instead, if they offer to pay providers the
20 same rates as fee-for-service Medicare, they are considered
21 to meet the network adequacy requirements.

22 The Commission has been concerned that rapid

1 enrollment growth in private fee-for-service plans was a
2 manifestation that the benchmarks were high enough to allow
3 plans to thrive even though they had limited ability to
4 manage care or influence the quality of care.

5 Beginning in 2011, MIPPA requires that private
6 fee-for-service plans maintain a contracted network of
7 providers except in areas where there were fewer than two
8 networked plans offered the previous year.

9 Employer private fee-for-service plans are not
10 given the two plan exception. Employer private fee-for-
11 service plans will have to maintain networks throughout
12 their service areas. However, CMS policy changes will make
13 it easier for employers to offer networked plans across the
14 country, and I can give you more details on question.

15 Private fee-for-service plans will also have more
16 rigorous quality requirements beginning in 2010. The law
17 requires that private fee-for-service plans have quality
18 improvement programs, as has been required for HMOs and
19 PPOs. Also, the quality data reporting requirements for
20 regional PPOs and private fee-for-service plans will be
21 raised to the same level as those for local PPOs, though
22 still not as high as those for HMOs.

1 MIPPA contains a few other MA provisions. MIPPA
2 extends the cost reimbursed plans by one year, through 2009.
3 After 2009 they are prohibited in areas where there are two
4 or more organizations offering networked products that meet
5 certain enrollment levels.

6 MIPPA also eliminates \$1.8 billion, or all but \$1,
7 of funding for the regional PPO stabilization fund through
8 2014. The fund may be used at the discretion of the
9 Secretary to raise benchmarks for regional PPOs to attract
10 or stabilize regional PPO plan participation. The
11 Commission had recommended elimination of the fund because
12 it favored one plan type over others.

13 Finally, and of particular interest to us, the Act
14 assigns MedPAC two MA studies. The first is a report on
15 quality measures. The Commission has recommended that CMS
16 collect and calculate clinical measures from the plans and
17 from the fee-for-service program that would permit
18 comparison across MA plans and between the fee-for-service
19 program and MA plans. MIPPA requires a MedPAC study of
20 performance measures and patient experience measures that
21 can be used to make comparisons of the quality of care both
22 across MA plans and between MA and traditional fee-for-

1 service. The study should address technical issues, such as
2 data requirements and issues relating to the appropriate
3 quality benchmarks. The report is to be completed by March
4 2010 and is to include recommendations for legislative or
5 administrative changes, as appropriate.

6 We are also required to study and report on MA
7 payments. The study needs to include three sets of
8 analyses. The Commission is directed to study the
9 correlation between MA plan costs to deliver the Parts A and
10 B benefits, as reflected in plan bids, and county level per
11 capita spending under fee-for-service Medicare. The
12 provision also requires us to evaluate the accuracy and
13 completeness of CMS's measurement of county level spending
14 and, incorporating the findings from the first two tasks, we
15 are to examine alternate approaches to MA payment other than
16 the 100 percent of county level fee-for-service approach.

17 The report, along with any recommendations we deem
18 appropriate, is due March 2010.

19 Thank you. Jennifer, Carlos, and I are happy to
20 address any questions you have and look forward to your
21 discussion.

22 MR. HACKBARTH: Round one questions or comments?

1 DR. REISCHAUER: Just a technical question. When
2 you say that there has to be two or more networked plans,
3 what exactly is the definition of a plan? If I'm Aetna and
4 I offer a high and a low level plan, is that two plans or is
5 it one?

6 DR. HARRISON: There is some discussion about
7 that. The language was not as clear as it might have been.
8 We do know that CBO scored it as if it were two
9 organizations. So, for instance, Aetna would not be able to
10 offer just the two plans. It would have to be Aetna and
11 Humana or something like that.

12 MR. GEORGE MILLER: Another technical question.
13 On page eight of your report, the three main tasks: study
14 correlation between MA plan costs and county-wide level, are
15 you also going to examine the fact that taxpayers do
16 subsidize MA plans in itself? Will that be a part of the
17 evaluation?

18 DR. HARRISON: We would expect that we would be
19 looking at the different implicit subsidies or explicit
20 subsidies in the different counties.

21 MR. GEORGE MILLER: Thank you.

22 DR. CROSSON: I think the two tasks we've been

1 given have probably created the most exciting situation that
2 I've seen in a few years here, and I wonder how the staff
3 feels about that.

4 But clearly, the one that is fascinating to me is
5 the very last -- almost penultimate anyway -- bullet point
6 which is to examine alternate payment approaches and make
7 recommendations. Because that can mean -- that encompasses
8 a potentially very wide spectrum from simply making some
9 technical suggestions about how the existing county basis
10 process should be made more accurate, more fair or whatever
11 to fundamentally suggesting a redesign of the payment system
12 which, in fact, serves the purpose of remaking the Medicare
13 Advantage program because, depending on how the payment
14 system is constructed, you could imagine a smaller program,
15 a very much larger program, a program that for example is
16 set out now to achieve goals in a practical way that were
17 envisioned initially for the program or one that simply
18 continues some of the trends that have existed over the last
19 few years.

20 It would seem to me that -- one question is do we
21 have a sense of what the intent of Congress was with respect
22 to that spectrum?

1 And then secondly, I would hope that we would
2 spend some time in the next couple of months at the meetings
3 discussing what we think would be the mission of MedPAC with
4 respect to that. Because I can imagine again anything from
5 a relatively simple task to a relatively complex but
6 potentially very impactful one.

7 MR. HACKBARTH: Scott, do you want to answer about
8 Congressional intent? Or Mark, do you want to handle that?

9 DR. MARK MILLER: I'll take that. First of all, I
10 want to tell you how excited we are. I've been dying to say
11 that, ever since you...

12 [Laughter.]

13 DR. MARK MILLER: As any observer can see --
14 yourselves, the public, everybody -- we've had our
15 recommendations out there for a while. The Congress has
16 kind of stepped up to them in some draft legislation but
17 there hasn't been a lot of enthusiasm to embrace them in
18 their entirety. Some of the issue, and you've implicitly
19 referred to it George, as kind of the distributional
20 consequences of those decisions and how different equities
21 work across the country. And I think that their intent is,
22 in part, to say can you talk about options where underneath

1 whatever -- the aggregate spending, there are different ways
2 equities are kind of worked through.

3 Again, some of this can get to things like if you
4 had 100 percent of fee-for-service -- and let's just say for
5 a moment that's a governing principle, just for the moment,
6 although I think the Commission can decide to discuss that.
7 You could still arrive at that differently by having a
8 blend, for example, across the country.

9 And I think some of the Congressional intent was -
10 - I think they truly do want a broad discussion of options.
11 But I think part of what drove it is their own internal
12 arguments about the distributional equities of the program.

13 MR. HACKBARTH: We will come back to this some
14 more in round two, but for now let's get to round one.

15 DR. SCANLON: This probably adds to the
16 excitement. We've made some real improvements in terms of
17 risk adjustment, and we've also affected the selection
18 process by creating this lock-in for enrollment. But I
19 still have this question in my mind from some of the things
20 we've heard over the years here about the inflation creep in
21 terms of diagnoses that's not commensurate with reported
22 health status.

1 And so in thinking about going back to some of the
2 work that was done in the mid-90s about selection and how
3 well risk adjustment adjusts for patients' health status I
4 think might be a very good companion to looking at plan
5 costs and fee-for-service and then thinking about what would
6 you want to do in terms of a payment system. Because if you
7 understand the limitations of your risk adjustment, that may
8 influence what you want in terms of how you have the base
9 payments set.

10 DR. CHERNEW: I want to make two quick comments.
11 The first one is one of the things I would like us to think
12 about in some ways broadly is how the Medicare program can
13 become more clinically oriented in the way it thinks about
14 things. So instead of thinking about A, B, D, it might
15 think about heart disease or something like that. And so I
16 think one issue related to the SNPs which is important and
17 shouldn't be forgotten is it does at least give you a lens
18 to begin to think about patients around the clinical
19 connection as opposed to a type of service connection. I
20 think that's important. And as we do our work on SNPs, I
21 think that's an advantage of SNPs that transcends some of
22 the administrative issues of how they're paid and what

1 happens. Having them enables us, perhaps, to move the
2 system in a way that we may like.

3 The second comment I want to make relates to the
4 particular issue of the reports and the MA and fee-for-
5 service comparisons. And that is I think we need to be
6 cognizant as we go through that that these are not simply
7 two separate systems that operate independently, where you
8 compare the costs of them like two different factories that
9 are totally separate. The existence of one can influence
10 the other. There are spillovers between them.

11 So in thinking about the merits and the payment
12 and the whole series of things for the MA system, as you go
13 through that report, I think it's important to recognize
14 that the costs we might see in say a county that has a lot
15 of MA in the fee-for-service system may be affected by the
16 presence of the MA plans in that area. So that spillover,
17 that connection, shouldn't be missed in the report that we
18 do.

19 DR. STUART: I also have two brief comments but
20 first I want to second what Bill said about selection.
21 About a decade ago there were a number of studies that
22 looked at pre-selection Medicare claims for people that

1 ended up in HMOs and didn't. I agree that that study ought
2 to be done, particularly looking not just at those that end
3 up in MA plans or stay in fee-for-service but also the
4 characteristics of the MA plans that they go into. I think
5 that's going to help us learn a little bit more about these
6 private fee-for-service plans.

7 The second thing is a question. CMS recently
8 promulgated a rule that requires that every MA plan provide
9 event level data to all -- 100 percent event level data to
10 CMS that would be used for this purpose, to develop new risk
11 adjusters.

12 My question is will that data be available to you
13 for this study?

14 DR. HARRISON: I don't think so because I don't
15 think it would be collected until at least 2010.

16 DR. STUART: Because I think that's really an
17 important point because if you're looking at cost, you're
18 going to be comparing the cost reports presumably with fee-
19 for-service reimbursement, which are going to be obviously
20 an apples and oranges kind of issue. And so even if you
21 don't have those data available, I think it would be really
22 important to develop a research design that would use those

1 data when they become available.

2 MR. HACKBARTH: Just on this particular issue,
3 could you just elaborate a little bit more about the data
4 that you're referring to, Bruce? I think I understand but
5 it's a relatively recent development so it may be helpful.

6 DR. STUART: Mark might be in a better position to
7 do that than I. Mark?

8 DR. REISCHAUER: He might not.

9 DR. MARK MILLER: Again, let me say how excited I
10 am to be here.

11 [Laughter.]

12 DR. MARK MILLER: Here's what I know, Bruce. And
13 Scott, this is the stuff from the inpatient PPS rule, oddly
14 enough. Right?

15 MR. ZARABOZO: It is the collection of encounter
16 data from the health plans and our understanding is that CMS
17 is going to work with the health plans to determine exactly
18 what is to be submitted and how it is to be submitted. But
19 the requirement is essentially encounter level data for both
20 Medicare covered and non-Medicare covered services, is my
21 understanding of the requirement.

22 DR. MARK MILLER: At this point it's true that we

1 don't have a sense of what and when CMS is going to do. We
2 know from the rule that they have an intent to do it but we
3 haven't lifted from the Agency yet exactly what and how and
4 when they're going to proceed on this. And I think that is
5 some of the caution you're hearing about how quickly this
6 would be available.

7 DR. KANE: I've talked about this I think with
8 Mark and some of the staff before. I'm wondering if we
9 wouldn't also want to take a look at how the industry
10 behaves with this extra payment above costs, above the 100
11 percent of cost piece. Where is the excess going?

12 One assumption is that it's going to serve low-
13 income beneficiaries so they have access to benefits they
14 otherwise would not be able to afford. But another possible
15 place that the excess of payment above traditional cost is
16 that it goes into other forms of competitive behavior,
17 perhaps less need to raise premiums in the private sector or
18 particularly the large group or the small group.

19 It turns out that the reporting of that is not
20 great, so there may be a need to say we need to have better
21 reporting of this. States now require -- some states moreso
22 than others -- a lot more detailed reporting of the internal

1 cost -- almost like a Medicare cost report -- the internal
2 cost structures and lines of business reporting of these
3 plans.

4 We don't have that yet. But it seems to me that
5 if there's going to be a big argument over time about
6 whether the premium should be lowered to 100 percent of fee-
7 for-service from where they are now, what is the impact?
8 And if we don't have any idea where those excess monies have
9 been going, people can claim anything, that they're
10 supporting low-income people or whatever. But we don't have
11 any way to independently verify that. We can look at the
12 old orange blank NAIC forms. I know you've thought about
13 that.

14 But maybe we need to do something better than that
15 or ask for better data than that to be able to really
16 address where are these excess above 100 percent dollars
17 going? And that, I think, will help us with the next round
18 of discussions in Congress about whether the premiums should
19 be brought back down to fee-for-service other than just the
20 equity issue.

21 DR. MARK MILLER: Right. And just to make sure
22 everybody is in on the conversation, several months ago --

1 and I can't remember exactly what it was -- Nancy raised
2 this hypothesis with us that is there some behavior that
3 would be reflected on the private side in terms of premiums.
4 Carlos and Scott got some data and took a look at that. We
5 couldn't lift a real clear -- and we discussed it -- we
6 couldn't lift a real clear pattern off of it.

7 One thing for sure in responding to your comment
8 is we can certainly raise this as an issue and point to the
9 need for information to explore it. I would defer to you
10 guys if there is a different angle to go at that question.
11 I think we came up a little dry but I don't know if there
12 are other data sources that we can pursue.

13 When Mike said that spillover, spillover goes in a
14 lot of different directions. And I think the notion of what
15 the impacts are between MA, fee-for-service, the private
16 sector is something that we should make as part of these
17 reports.

18 DR. MILSTEIN: I share Jay's enthusiasm for these
19 mandated reports and wanted to especially emphasize two
20 points. One is the quality comparison. I think last spring
21 we surfaced a heretofore I think underappreciated fact,
22 which is a majority of these Medicare Advantage plans when

1 you look at health status of their populations they are
2 actually scoring worse than expected relative to baseline
3 two years earlier. That was something that was a very
4 important fact and we had no clear way of following up. I
5 think the mandated report on quality gives us a way of
6 beginning to drill deeper and understand that better.

7 And then the second comment, I guess is really an
8 elaboration on Nancy's point. Any shareholder of any
9 Medicare Advantage plan knows what their Medicare medical
10 loss ratio is, how much they're spending on medical care per
11 Medicare beneficiary on a risk adjusted basis. They know
12 it. It's not an area of ambiguity. Certainly there are
13 differences in how plans count medical loss ratio but I'd
14 say by and large in the majority it's a relatively
15 standardized approach. There may be a few plans like Kaiser
16 Permanente excepted.

17 And so I would hope if we are going to make well-
18 informed recommendations on report item three, examine
19 alternative payment approaches, that hard as it may be we
20 should do what we can to service information on what is the
21 Medicare medical loss ratio for Medicare Advantage plans?
22 What's the distribution of it? It gives us, among other

1 things, a sense of how much opportunity there might be for
2 efficiency gain.

3 MR. BUTLER: Just a logistical question. This
4 report is due in March of 2010. It's got some big questions
5 in here. There's obviously a lot of work between now and
6 then. Historically, or more specifically in this case, is
7 there interim reports or interim data that we look at as a
8 Commission that can help guide us? Or do we kind of freeze
9 in time until March 2010, and only kind of collectively look
10 at the report?

11 MR. HACKBARTH: Let me take a crack at that, Mark,
12 and then you can as well.

13 The normal process in doing a report like this is
14 that there will be frequent discussions. On one that has a
15 2010 report date, normally it would come back six or seven
16 times where you get interim reports, data analysis, further
17 opportunity to refine the questions, et cetera.

18 MR. BUTLER: Now I'm even getting excited. Okay.

19 [Laughter.]

20 MR. HACKBARTH: They don't just go off and bring a
21 semifinal draft. You see it build up from the ground over
22 time. Is it responsive to your question?

1 MR. BUTLER: That is. And then the second piece,
2 do we even taking advantage of that as we think about our
3 annual responsibilities here and take that data into
4 account?

5 MR. HACKBARTH: Sure.

6 MR. BUTLER: I would think so.

7 MR. HACKBARTH: Sure.

8 So another question I detected there was is there
9 any precedent for us issuing a series of reports here to
10 Congress? So as Jay pointed out at the beginning, you could
11 define this big or you could define it small. And so the
12 gist of the conversation I've heard to this point is bigger,
13 bigger, bigger. We're sort of adding new dimension.

14 On the other hand, there's been at least some
15 interest from the Hill in well, could you report earlier?
16 Conceivably, we could do both in the sense of having an
17 interim report on a narrower question and say future
18 installments are planned on X, Y, and Z and will be rolled
19 out over time.

20 I can't remember a case where we've ever used that
21 approach but I wouldn't necessarily rule it out. Is that
22 responsive?

1 Is there anything you wanted to add on that, Mark?

2 DR. MARK MILLER: You'll have multiple
3 opportunities. A common thing you'll see us as a result of
4 this conversation, we'll try and come back with a work plan.
5 For everybody, this is the way the Commission works. It
6 happens in public. We come through. We do the
7 presentation. People react. We take things in different
8 directions.

9 It is getting bigger as the comments go out. So
10 there's always a work management issue. We have to respond
11 to the mandate and we have always been on time and always
12 been responsive. So if it gets so big where we're going to
13 have to really decide what part of it is going to meet the
14 mandate.

15 And remember, just because this is a mandated
16 report, you can as a Commission choose to take up these
17 issues. This is a nice vehicle to start to build around
18 those. But we'll have to say stay focused on meeting the
19 mandate and the timing of that mandate and then other stuff
20 as you guys see fit.

21 MR. HACKBARTH: So to kick off the second round,
22 let me ask a question. My understanding of the

1 Congressional request and interest has been that at least
2 implicitly they want to hold open the possibility of further
3 MA savings, but they want some guidance on how that might be
4 accomplished while dealing with issues of geographic equity
5 that have troubled them. And so can we move towards 100
6 percent on an aggregate basis in another way other than
7 county level that might result in a better sense, from their
8 perspective, of geographic equity. That's sort of the
9 question that I hear them asking. Is that a fair summary,
10 Mark?

11 DR. MARK MILLER: Yes, I think that's a large part
12 of it. I suppose there's also just the question of whether
13 100 percent is the reference point.

14 MR. HACKBARTH: From our vantage point we said
15 that ought to be the goal over time. Congress hasn't ever
16 officially embraced that, but clearly with MIPPA they've
17 expressed an interest in trying to get some savings out of
18 the program. And what's held them back is the geographic
19 issue.

20 So in defining the scope of the project, Jay, the
21 first set of questions is different approaches for dealing
22 with the geographic issue. And then sort of a second wave

1 of issues came up around risk selection and related to that
2 how the industry uses excess dollars and the like. As you
3 know, you can imagine sort of a tiered response, picking up
4 with Peter's question, where we try to get an early response
5 on the geographic issue, although I'm aware of how
6 complicated even that can be, how many different
7 possibilities there are. But we could say we're going to
8 focus on that as installment one. If we could get it done
9 before March 2010, that would be great. But do so with an
10 eye towards also taking on some of these other issues in
11 successive volumes, if you will, of this report.

12 So let me just throw that out for discussion.

13 And Bob is first in the queue.

14 DR. REISCHAUER: Thank you, Mr. Chairman. I was
15 going to talk about Nancy's point which actually relates
16 also to Arnie's. You were sort of asking what happens to
17 the MA payments that are in excess of the plans' cost of
18 providing A and B benefits. The law says there are only
19 three permissible uses of it: extra benefits, rebates of
20 premiums, or give it back to CMS.

21 MR. BERTKO: Provider payments.

22 DR. REISCHAUER: Provider payments, yes.

1 And their data is all going to report that they do
2 those or they're in violation of the law. And their
3 Medicare medical loss ratios are all going to reflect those
4 same numbers.

5 So I'm just wondering whether the interest you
6 have in this topic is really better directed to the IG's
7 office rather than to the MedPAC staff. Because in finding
8 something like this, what we would be doing is finding that
9 they're breaking the fundamental law. And I think they're
10 probably better at hiding it than we are at finding it. I'm
11 sure there is some shifting of overhead costs and things
12 like that that go on in some induced inefficiencies in these
13 programs that use up some of these resources. But I'm not
14 sure that we should spend a lot of effort really in this
15 area.

16 And then there's sort of the second point which
17 you sounded like a member of Congress, I mean you had
18 sympathy for well, what if all of these extra benefits went
19 to the benefit of low income participants in these programs?
20 And what we have said historically on the Commission is why
21 should low income beneficiaries in MA plans get help that
22 those in fee-for-service don't get, if you want an equitable

1 system? Or maybe it should all be rechanneled into low
2 income subsidies for everybody.

3 DR. KANE: Can I respond?

4 For the first part, which is that they're supposed
5 to say X and so they're going to say X -- well, as someone
6 who looks at multiple data around -- what people tell
7 Medicare in their formal reporting isn't necessarily what
8 they tell shareholders or other parties. So sometimes it's
9 interesting to look at others sources of data beyond what
10 they're reporting to Medicare to see what you think might
11 also be going on. So I'm open here. I was hoping the NAICs
12 would be more useful and maybe they would be if we knew how
13 to ask more specifically and analyze in a different way.
14 I'm not sure. I think it's hard to do.

15 Maybe we should be looking at the shareholder
16 reports on EDGAR on the SEC's filings and seeing what they
17 say. In other words, looking at some of the traditional
18 ways these industries report about their own performance
19 might be a useful exercise. And I think that's the level I
20 was really at.

21 The second issue that we've already told Congress
22 what to do with low-income beneficiaries is fine, and I

1 agree with what we've told them. And I guess I'm just
2 trying to get back to well, is that even a true claim? And
3 so yes, I agree why should they be subsidized this way? But
4 I'm just wondering is it even a valid claim that that's
5 where all the excess is going, is taking care of low-income
6 beneficiaries?

7 DR. MARK MILLER: I just want to make one
8 clarification, and I'm sure you know this but just to make
9 sure that the rollout more broadly.

10 They're required by law to do certain things, as
11 you guys ticked off. But remember, each of those things are
12 fully loaded. I know you guys know. I just want to make
13 sure everybody knows. Administrative, overhead, and profit
14 margins go into providing each one of those benefits.

15 And I think that's some of what -- if I understood
16 what you were saying -- Arnie is talking about with the
17 medical loss ratio. And I know you know all of that. I
18 just want to make sure everybody does.

19 DR. SCANLON: I was motivated to look at this
20 whole issue of risk adjustment in part because I share Bob's
21 concerns about the other sources of data. So the idea of
22 having an estimate of what these individuals might have cost

1 in traditional Medicare is an indicator about value to me
2 because it's not dependent upon these data that by law have
3 to show certain things.

4 DR. MILSTEIN: My point is probably just as easily
5 handled off-line with Bob and Mark.

6 DR. CHERNEW: It actually turns out that we have a
7 proposal that I think is soon to be funded to look at this
8 issue by looking at how the plans behaved when payment rates
9 changed. I think the important thing is even if you knew in
10 some accounting sense where the money was going -- if you
11 could somehow say this is the part that was over 100, this
12 is how it's going -- that doesn't mean if you cut back
13 payments you would know how they would change in response.

14 So for the real point, which is what should you do
15 based on this, you don't know how they're going to respond.
16 And the essence of the work that we've proposed to do is to
17 look to see in the past as payment rates have changed over
18 time how plans have changed their behavior. And that you
19 can measure more easily, at least in some crude ways,
20 because you can see that the premiums were and you can see
21 what the benefits offered are.

22 So I think if you understand the plan response

1 that's a little different than trying to figure out whether
2 the money in some esoteric way is spent on the right thing
3 or the wrong thing. I think what we really care about more
4 is if we change payment one way or another what do the plans
5 do?

6 And it's hard to tell what that would be, even if
7 you could, in an accounting way, figure out what their
8 medical loss ratio was. Because if you paid them less, that
9 doesn't mean their medical loss ratio is going to change.
10 They could change care in a whole bunch of ways and keep the
11 same medical loss ratio.

12 DR. MARK MILLER: This conversation should go on.
13 To the extent that has been looked at -- and Carlos, I'm
14 thinking you're one of the people who have looked at this in
15 the past. I mean, one of the things we know is that the
16 extra benefits and the coverage of cost sharing gets scaled
17 back and plans drop out.

18 So I think in some ways empirically some of the
19 things -- depending on how the rates change -- is known.
20 And then the problem that you have is okay, is that okay?
21 Or how many plans do we want? How many extra benefits? I
22 think we kind of know, in some ways, what their immediate

1 reactions are.

2 DR. CHERNEW: I think that literature is kind of
3 sketchy but I agree there's some literature.

4 MR. HACKBARTH: I think this is an important point
5 in that it defines sort of the moorings of this work. What
6 are we trying to accomplish through this program? Are we
7 trying to maximize plan participation, additional benefits
8 for Medicare beneficiaries? That leads you to one sort of
9 policy.

10 Are we trying to, on the other hand, maybe a
11 different goal is to try to create incentives for the most
12 efficient plans, and that would lead you to a different
13 direction.

14 MedPAC is not neutral on this question. We have a
15 long-standing position that we think the private plans
16 should be welcome into Medicare. They should be used as a
17 way to import efficiency into the programs by engaging plans
18 that can do things that traditional Medicare finds it
19 difficult to do.

20 It should not be a vehicle for trying to provide
21 additional benefits to low income beneficiaries or anybody
22 else because there are more efficient lower cost ways that

1 that goal can be accomplished.

2 So rather than opening up all sorts of new issues
3 I'd say let's stick with our definition of what the program
4 goal ought to be and then answer the specific question are
5 there other ways that we might geographically adjust
6 payments other than 100 percent of the county level that
7 achieve the goal of rewarding efficiency, importing
8 efficiency into the program.

9 DR. CROSSON: I would add one other point there,
10 and that is that I thought and have thought for a long time
11 that one of the main goals was something called care
12 coordination. These plans are called coordinated care plans
13 for a purpose.

14 So it seems to me if we're going to think about
15 the relationship of the payment, our recommendations around
16 payment, to the fundamental idea underlying Medicare
17 Advantage we have think -- as was mentioned earlier -- about
18 some of the clinical aspects of what the purpose of these is
19 and what the relationship then is to how we recommend a
20 payment system.

21 DR. CHERNEW: I agree in general with the notion
22 of understanding what the purpose of the program is and I

1 accept the general MedPAC position. But I think the key
2 thing for the report, relative to the original point that
3 was raised is, if we were to make a payment recommendation,
4 whatever that is, the relevant piece of information at least
5 I would like to know is what the response would be for the
6 plans. So I'm less interested in rewarding efficiency or
7 not rewarding efficiency or doing any of these other things
8 which I think matter as much as, at least for starters,
9 understanding how plans would respond if we were to do
10 something.

11 So I would like to make the system more efficient,
12 higher quality, less money as opposed to have some other
13 goal. And to do that, regardless of what we think the goals
14 are, understanding how the plans will respond is the crucial
15 parameter. To see if it meets whatever goals there are, we
16 need to know what it's going to do to see if it meets those.

17 DR. DEAN: I had a question that relates to the
18 whole risk adjustment issue. As some of you know, there's a
19 special needs plan in South Dakota that was devoted to
20 cardiovascular disease that just announced that they're
21 closing down after about a year or a year-and-a-half of
22 operation. I talked to the medical director of that plan

1 and said what's the deal, what's the problem? His
2 explanation, and I'm sure it's not the only thing, but he
3 said that the subsidy that they get from CMS is a risk-
4 adjusted payment, I understand, based on their enrollment.

5 And he says that they were not able to get enough
6 information from the providers, from the physicians, in
7 terms of the information that came in on the claim forms
8 listed two or three diagnoses -- I'm wondering if this makes
9 sense -- where he says we know that many of those patients
10 have five or six diagnoses and would qualify for a much
11 richer subsidy but they simply weren't able to get the
12 information.

13 Like I said, I wonder, is that a legitimate
14 concern or is that something that's going to be a problem?

15 MS. PODULKA: We've heard the same concern from a
16 number of SNPs who have spoken with us over the past year
17 and a number of the organizations that represent them. It's
18 something that we're definitely tracking on. It's
19 definitely a concern. I'm not sure what the response is.

20 Basically it comes down to, if I understand it
21 correctly, the physicians who participate in the plan's
22 network aren't coding all of these diagnoses. But in part

1 that's the relationship between the plan and the physicians
2 and I'm not sure where we or Medicare fit into that.

3 DR. DEAN: He said that the requirement is only
4 that they are required to report up to three, or something
5 like that.

6 DR. HARRISON: I think what happened was let's say
7 you need to have congestive heart failure. Well, it turns
8 out that somebody would present themselves and say they have
9 congestive heart failure. But when they would look back in
10 the records to do the risk adjustment, they didn't have
11 congestive heart failure. And so sometimes there might be a
12 lag of a year and sometimes there might be codes that have
13 fallen off that it wasn't coded. And so I think that was
14 part of their problem.

15 Now of course, when you're comparing the fee-for-
16 service, this thing would go on the fee-for-service, too.
17 It just doesn't have the same payment implications.

18 MR. HACKBARTH: We are just about at the end of
19 our allotted time and I've got four people on my list: John,
20 Bob, Jack, and Karen. So if we could keep the comments
21 brief.

22 MR. BERTKO: Just quickly to address Mike, Nancy,

1 and maybe Bob on this. There was a natural experiment with
2 what happens when you compress rates from the BBA. So from
3 2000 to 2003 if you wanted to look back and see what
4 happens, you could. I don't think much knew is going to be
5 learned about it. So I would go back to the intent I think
6 that Scott described at the beginning for where we should
7 aim most of the work on the study.

8 DR. REISCHAUER: Two things. I was actually going
9 to talk about natural experiment, too. And it relates to
10 what Tom brought up when we're thinking about risk
11 adjustment and how good the existing system is relative to
12 maybe some others. There are plans that disappear from
13 counties and the folks in them go back into fee-for-service.
14 And developing a database which would be year one/year two
15 of these individuals and then seeing how from their year two
16 experience you would rate them versus how CMS did in year
17 one might be some kind of test.

18 The second point I was going to say is Glenn and I
19 at least won't be here for this -- free at last -- this
20 report. But having spent eight or nine years worrying about
21 this issue, and I know I disagree with Glenn on some of
22 this. But if we start out with a payment system that paid

1 no more than fee-for-service would in the nation as a whole
2 but we allowed geographic variation what would govern that
3 variation? I have argued in the past that Medicare has
4 monopsony power and its ability to dictate prices is not
5 shared by Medicare Advantage plans.

6 The question is could you create an index of
7 Medicare payments versus what market payments are in each
8 area, paid by larger insurers, and use that ratio to vary
9 the fee-for-service? I see Bill saying no, so Glenn, you
10 have one person on your side. Across the nation the
11 weighted average would come out to be fee-for-service but it
12 would reflect local market conditions.

13 This is sort of one of the arguments that
14 individuals representing rural districts would have, which
15 is there's only one hospital in the area and they can charge
16 these private plans whatever it wants.

17 So that's my contribution to the 2010 report.

18 MR. EBELER: I go back, in some ways, to Jay's
19 original comments, sort of reinforce that. I would
20 certainly support this idea of looking at this as a broad
21 project rather than a narrow how do we tweak it. It seems
22 to me it's a great opportunity. We have flagged a number of

1 underlying analytic questions or steps that need to build
2 into part of that.

3 The one we might want to think about linking is
4 the other study here which is the comparison of quality
5 within MA as well as quality outside of MA. Again, if you
6 really think broad scope and long-term here, and you
7 intersect our general principle about payment for quality,
8 you would want to at least think about those two studies at
9 the same time because they may feed your future payment
10 rates as you go forward.

11 DR. BORMAN: Listening to what Tom brought up and
12 some of the other discussion this leads me to comment that I
13 would share Bill's and other people's concerns about being
14 very careful about the risk adjustment, particularly for
15 entities that have robust IT capability in health care
16 reporting. The number of diagnoses is pretty easy to
17 manipulate and to increase very rapidly. And I would have
18 some significant concern on relying on those kinds of
19 things.

20 There's a great ability here to do a fair amount
21 of code creep. Just because if somebody has a problem-based
22 list, that list carries forward to every visit, every

1 treatment or whatever, whether or not that treatment or
2 visit anything to do with one or five of those things on
3 that list. And so I think we need to be very careful. I
4 would support being very careful about the risk adjustment.

5 MR. HACKBARTH: That will have to be it for today.
6 I think we have outlined a lot of potential directions,
7 important directions this might take. I would be happy to
8 see it get bigger rather than keep it small, especially
9 since I won't be here to have to do the work.

10 I think a question that we ought to come back to,
11 and I would ask Mark and the staff to think about, is
12 whether we might want to consider a phased strategy, an
13 earlier narrow response on the geographic question asked
14 with the subsequent installments plan on going into risk
15 adjustment and some other issues.

16 So that's a question to think about and the next
17 time we can take up this topic when we talk about the work
18 plan we can try to resolve that issue.

19 DR. REISCHAUER: Just a possibility, I was sort of
20 surprised when this report was due because it wouldn't
21 surprise me at all if the Congress got into this issue
22 before then. So I think we should be prepared to be asked

1 anyway for information on this or options on this before
2 then.

3 MR. HACKBARTH: And I think informally there have
4 already been some expressions of interest, could you get
5 this done sooner than the statutory due date. We need to
6 think a little bit about our plan on this one.

7 Thank you all, good job.

8 Next is the MIPPA update on ESRD.

9 MS. RAY: Good afternoon. MIPPA substantially
10 changes Medicare's payment system for outpatient dialysis
11 services. During this session, I'll summarize the changes
12 and answer any questions you might have.

13 Just a couple of sentences first, before I start
14 this slide, on Medicare's ESRD program. End-stage renal
15 disease is a disease-specific entitlement. Medicare
16 benefits are available to people with ESRD who are under age
17 65. Individuals who qualify for Medicare on the basis of
18 ESRD get all the same benefits as those who qualify on the
19 basis of age or disability. Most ESRD beneficiaries are on
20 dialysis.

21 Currently Medicare uses a two-part payment
22 structure to pay for dialysis services. Dialysis facilities

1 receive a prospective payment, called the composite rate,
2 for each dialysis treatment they furnish. In addition,
3 facilities receive separate payment for certain injectable
4 drugs, like epo, vitamin D, and iron. These drugs were not
5 available when the composite rate was first implemented in
6 1983. Spending and use of these drugs have increased
7 significantly during the past 20 years. In 2006 drug
8 payments accounted for about one-third of a facility's total
9 Medicare payments.

10 The Commission and others, including GAO, have
11 raised concerns about this two-part payment method.
12 Facilities have stronger incentives to control the cost of
13 services included in the payment bundle compared with
14 services that fall outside of it -- specifically injectable
15 drugs that are separately billable. Separately billable
16 drugs have historically been profitable for most facilities.

17 The Commission has a long-standing recommendation
18 for the Congress to broaden the payment bundle and include
19 commonly furnished services that Medicare currently
20 excludes. We recommended that when creating this expanded
21 payment bundle the Congress account for factors that affect
22 providers' costs, like patient case-mix. We also

1 recommended that the Congress implement pay-for-performance
2 for facilities and physicians who treat dialysis patients.
3 As you'll see, MIPPA is consistent with the Commission's
4 recommendations.

5 First, I'd like to mention two refinements that
6 MIPPA makes to the current payment method. It updates the
7 composite rate by 1 percent in 2009 and 1 percent in 2010.
8 The 2009 update is consistent with MedPAC's recommendation
9 in our March 2008 report.

10 Beginning in 2009, MIPPA mandates a site-neutral
11 composite rate. Hospital-based facilities were paid \$4 more
12 on average than freestanding facilities. MIPPA's change is
13 also consistent with the Commission's recommendation which
14 we made back in 2005.

15 MIPPA makes three changes to modernize the current
16 payment method. Consistent with the Commission's
17 recommendation, MIPPA broadens the prospective payment rate
18 by bundling the composite rate services with separately
19 billable services, including injectable drugs. The broader
20 payment bundle will start in 2011.

21 Second, MIPPA links payment to quality, and this
22 is also consistent with the Commission's recommendation.

1 P4P will begin in 2012.

2 Third, MIPPA creates a statutory annual update to
3 the prospective payment rate beginning in 2012. MIPPA
4 requires that the Secretary update the payment rate by the
5 ESRD market basket minus 1 percentage point. Under current
6 law, the Secretary does not have this mandate. Since the
7 implementation of the composite rate in 1983, the Congress
8 has changed the rate when it has decided that such a change
9 is needed to ensure the adequacy of Medicare's payment rate.
10 There have been gaps when the Congress did not update the
11 composite rate. Specifically, there was not an update
12 between 1996 to 1999, 2002 to 2004, and in 2008.

13 The broader payment bundle will include services
14 in the composite rate as of 2010, separately billable
15 injectable drugs and their oral equivalents, lab tests
16 furnished for the treatment of ESRD that are not in the
17 composite rate.

18 The Secretary also has the discretion to include
19 other services that are furnished to beneficiaries for the
20 treatment of ESRD. One candidate may be oral nutritional
21 supplements. Last year, the Commission discussed the
22 potential benefit of this service. Another possible

1 candidate the Secretary could consider are Part D drugs that
2 are used to treat ESRD-related comorbidities. Including
3 ESRD drugs paid for under Part D might help ensure that
4 beneficiaries receive appropriate care, it may improve
5 patients' compliance with their drug regimen, and it may
6 also ensure that providers do not substitute Part D drugs
7 for drugs covered under the broader dialysis bundle.

8 There will be a four-year phase-in of the broader
9 payment bundle beginning in 2011. Facilities have the
10 option to opt out of the phase-in and be paid completely in
11 full under the broader payment bundle beginning in 2011.

12 MIPPA sets the payment rate at 98 percent of the
13 estimated total payments if MIPPA had not implemented a
14 broader payment bundle.

15 Finally, the Secretary has the discretion in
16 setting the unit of payment. Currently, facilities receive
17 a payment for each treatment they furnish. Other options
18 include paying for dialysis on a weekly or monthly basis.

19 MIPPA includes several adjustments to the broader
20 payment rate. The first three you see here are mandatory
21 and the last three are discretionary. It requires that the
22 Secretary adjust for patient case-mix, which can include

1 comorbidities, patient weight, age, rate, ethnicity and
2 other appropriate factors. It also requires the Secretary
3 to adjust payments for high-cost patients and for low-volume
4 facilities that incur high costs.

5 The Secretary has the option to adjust for
6 geographic factors, for facilities that treat pediatric
7 patients, and for facilities located in rural areas. There
8 is a table in your briefing materials that compare
9 adjustments under the new broader bundle to the current
10 method and I'd be happy to answer any questions you might
11 have.

12 The pay for performance program will begin in
13 2012. You will see that much about the program is
14 consistent with the Commission's recommendation.

15 The Secretary must develop measures assessing each
16 facilities' anemia management and dialysis adequacy and, to
17 the extent possible, indicators of patient satisfaction,
18 iron management, bone mineral metabolism, and vascular
19 access. MIPPA requires that the Secretary develop a
20 performance standard that is based on levels of achievement
21 and improvement using the selected quality measures.

22 The law permits the Secretary to reduce the

1 bundled payment rate by a maximum of 2 percent for
2 facilities that do not achieve or make progress toward the
3 performance standard. Facilities achieving the lowest total
4 performance scores will receive the largest reduction in
5 pain. The individual and total performance scores will be
6 publicly available online and posted at each facility. And
7 the Secretary is also required to establish a process for
8 updating the measures over time.

9 Finally, I'd like to discuss with you two other
10 changes MIPPA makes related to kidney disease. First, the
11 law establishes a five-year pilot project in at least three
12 states to increase the awareness of chronic kidney disease.
13 This will begin in 2009.

14 The second change, beginning in 2010 the new law
15 covers up to six educational sessions for beneficiaries with
16 severe kidney disease but who are not yet on dialysis. This
17 is called Stage IV chronic kidney disease. The sessions
18 will instruct beneficiaries about managing their
19 comorbidities for the purpose of delaying the need for
20 dialysis, ways to prevent kidney related complications, the
21 different ESRD treatment options including in-center and
22 home dialysis and kidney transplantation, and the different

1 options available for vascular access.

2 That concludes my presentation and I would be
3 happy to answer your questions.

4 MR. HACKBARTH: Thank you, Nancy.

5 DR. CASTELLANOS: Nancy, it was a good report and
6 I'm glad to see we made a lot of progress. One of the
7 questions I had last year was where does the physician fit
8 into the bundle? And is his or her cost covered under the
9 facility fee?

10 Now in the real world what happens is that the
11 physician at the dialysis center is in charge of the
12 dialysis as it's occurring. And I think Karen, I don't mean
13 to put words, but I think your comment was when you were on
14 the CPT Editorial Committee you thought it was all bundled
15 and that was the intent. But we never really got a good
16 answer on that.

17 The real problem here is that these people are
18 sick, not just from dialysis problems but from other
19 comorbidities. It's very, very difficult for these patients
20 to come into the doctor's office is to be treated,
21 concomitantly for another non-dialysis related disease
22 process. And we were hoping that this would be allowed that

1 the doctor could see that patient at the time of dialysis,
2 not just for a dialysis-related problem but for his general
3 medical care. We were hoping we were going to get a
4 determination on that. Do you have any follow up on that?

5 MS. RAY: The physician gets paid based on the
6 Part B fee schedule, the physician managing the dialysis
7 patient gets a monthly capitated payment. And that payment,
8 like it's called, covers a month of care generally and it
9 covers the physician's outpatient care of the dialysis
10 patient. It is, in part, based on the number of times that
11 the physician -- often a nephrologist -- sees the patient,
12 whether it's once, twice, three times or four times a month.

13 I just want to be clear about this, Medicare pays
14 the physician directly. It does not go through a dialysis
15 facility. The facility is not paying the physician.
16 Medicare is paying the physician.

17 DR. CASTELLANOS: Let me just clarified this: he
18 gets paid just to manage the dialysis. How about for the
19 other non-dialysis disease processes?

20 MS. RAY: I can't speak for all nephrologists. I
21 think the extent to which a nephrologist cares for other
22 conditions, that's going to vary from physician to

1 physician. I would have to see in the literature if there
2 has been any survey work done on that. There's nothing that
3 I can recall that has been. I think that's going to vary
4 from physician to physician.

5 DR. CASTELLANOS: Thank you.

6 MR. EBELER: Thank you, Nancy. If you could just
7 elaborate on two aspects of the pay-for-performance system.
8 As I understand it, it's not a withhold. It's a reduction
9 of up to 2 percent if you don't hit the quality standards?
10 And the second is that the anchor for the quality measures
11 sound like a pretty low anchor. It's the lesser of where
12 you were on quality or what the national average is?

13 MS. RAY: The answer to your first question is
14 yes, that's how I interpret the law. And again, we will see
15 how -- CMS is going to have to presumably write a reg to
16 implement this and we will see how they implement it. But
17 yes, that is my interpretation.

18 Your second question is for the first year of the
19 program the law explicitly requires that the Secretary
20 implement P4P for dialysis adequacy and anemia. And yes,
21 you are correct, it's based on the performance, the lesser
22 of the facility's performance between 2007 and 2009 or the

1 national average, yes.

2 DR. MARK MILLER: Did you say that's just for the
3 first year? In subsequent years that standard changes?

4 MS. RAY: Yes.

5 DR. MARK MILLER: Because I hadn't caught that.

6 DR. BORMAN: Just two items. The first would be
7 in those educational sessions about Stage IV chronic kidney
8 disease. Was there any mention of -- specifically you
9 mentioned talking about access options and different types
10 of dialysis options if they came to that. I think one of
11 the pieces here -- and it has something of a quality piece
12 to it -- is are people being appropriately evaluated as
13 transplantation candidates at a suitably early point in the
14 course of their disease? Because certainly there are
15 patients who, rather than spending some prolonged time on
16 dialysis prior to receiving a transplant, would be better
17 served by moving fairly quickly to transplantation and
18 obviate a pretty big expense and also a period of time that
19 perhaps will increase their complications as a transplant
20 recipient. If you're sicker having sat on dialysis for a
21 while before you get your transplant the odds that you're
22 going to have complications go up.

1 So I think, in terms of making this the most part
2 proactive positive thing for patients that we can, that
3 there might be some value to thinking of this more broadly
4 in terms of all the options and thinking about
5 transplantation as an option.

6 And then my second comment would be trying to link
7 this to some other things that we're talking about. It
8 strikes me that some of these centers are another
9 opportunity for examining physician financial relationships.
10 We've sort of focused our ideas on ASCs, specialty
11 hospitals, and some of those kinds of things. I would just
12 suggest that a lot of these have been in place for a long
13 period of time. There's probably a fair amount of
14 information out there and we might want to broaden our
15 thinking on physician financial relationships to use this as
16 an example of a place that we could also do some
17 investigation.

18 DR. REISCHAUER: A clarification and then two
19 observations. The clarification is on page 10 of the
20 summary report you gave us it says payment for six sessions
21 will be paid for under a physician's fee schedule, however
22 only rural providers will be paid?

1 MS. RAY: Let me clarify that. What the law
2 specifically says is that physicians and certain
3 nonphysician practitioners are eligible and providers of
4 services located in rural areas. That's what the law says.

5 DR. REISCHAUER: What does it mean? I mean, is an
6 urban physician not a provider?

7 We'll move on to my second point.

8 DR. MARK MILLER: We talked about this. The
9 payments go only to the rural providers?

10 MS. RAY: I think the CMS lawyers are going to
11 have to look at this provision. The way it is written is
12 that it says that a qualified person is a physician or
13 certain nonphysician practitioners and provider of services
14 located in rural areas.

15 DR. MARK MILLER: Just to be direct, when we ran
16 across this, too, we had the same reaction. There may be
17 some lack of clarity about it, but first read was kind of
18 oh, this seems to go just one way. Is that fair?

19 MS. RAY: Yes.

20 DR. CROSSON: I may be wrong but what I just heard
21 was physicians and certain nonphysician providers and
22 providers in rural areas, meaning who don't meet the

1 criteria of the first set could still receive payment.

2 That's how I interpreted it.

3 DR. REISCHAUER: People who are illegally
4 providing medical services in rural areas are allowed to get
5 paid?

6 DR. CROSSON: There may be some sorts of
7 physicians --

8 DR. REISCHAUER: I just thought I had read it
9 wrong. I can live with the ambiguity.

10 DR. MARK MILLER: For the same reason that there's
11 \$1 dollar in the --

12 DR. REISCHAUER: I know why that's there.

13 I agree with whichever Commissioner said -- Jack -
14 - that the up to 2 percent reduction is too small an
15 incentive to expect much behavioral response for pay for
16 performance. And I think we should maybe say that at some
17 point.

18 The goal of the session was to see whether we have
19 any concerns about what's taken place. And the answer is I
20 do have concerns about all of these adjustments that the
21 Secretary will or can make. And it strikes me that some of
22 them are redundant and others might be dangerous. There is

1 a low volume which has to take place and it's a pretty big
2 incentive. It can't be less than 10 percent. I presume
3 what we're talking about is adjustment, it's always up in
4 this program. It's not an adjustment down.

5 And then there's a geographic adjustment which may
6 take place and a rural adjustment which may take place. I
7 guess I am concerned that we might have all three and they
8 might be stacked one on top of each other. And we might, in
9 the sense of having a low volume adjustment, be encouraging
10 inefficient sized operations.

11 I was wondering whether there was any discussion
12 at all of low volume, yes, but only if you're at least 50
13 miles from another one, as opposed to having a low volume
14 provider every other block in New York City, and whether we
15 should raise some of these concerns before the Secretary has
16 to sit down and really think through exactly what he or she
17 might end up doing.

18 MR. GEORGE MILLER: Along those lines that Bob
19 brought up, I was thinking of it in a different way but he
20 outlined it perfectly, at least for my question. That is as
21 we look at this do we have a way to determine if access is
22 particularly addressed if there are some variations or if

1 there's -- as the Secretary makes adjustments, how do we
2 impact access? Is there a way to measure that and make a
3 determination? If adverse is adversely affected, then what
4 happens at that point?

5 DR. MARK MILLER: Your point is to be sure that as
6 we go through the process of commenting on adjustments and
7 how they go forward with implementing the program, be sure
8 that part of our comments are driven by assuring access?

9 MR. GEORGE MILLER: Correct.

10 DR. MARK MILLER: Got it. No problem.

11 And actually, we pretty typically try and keep
12 quality, payment, access, and equity for the provider in
13 mind as a standard thing, but it's well worth repeating
14 here.

15 MR. HACKBARTH: Others?

16 So a number of issues and potential concerns have
17 been raised. What we would be doing is using the March
18 report chapter on the update as a vehicle for discussing
19 some of those issues?

20 DR. MARK MILLER: I think there's two things and I
21 was thinking about this as we were going along here, Nancy.
22 If there are issues that we want to raise in the March

1 report, and then obviously in the comment process when the
2 Secretary starts to say this is how I'm planning to proceed
3 on this, I'm going to do these adjustments. That's another
4 vehicle for us to go. Is that what you were thinking?

5 MS. RAY: Yes.

6 MR. HACKBARTH: Thank you, Nancy.

7 Next is the MIPPA provisions on DME.

8 MR. GLASS: Good afternoon. Today I will give you
9 and update on DME competitive bidding and the changes to
10 that program brought about by MIPPA. I will briefly walk
11 through how the competitive bidding program came about, how
12 the first round of competition which was briefly operational
13 in July of this year turned out, and how MIPPA delayed and
14 modified the program.

15 As a brief reminder, Medicare spending last year
16 on durable medical equipment, prosthetics, orthotics and
17 supplies -- which we will call DME - was \$8.6 billion.
18 There's several relevant characteristics of the industry.
19 First, it is a very unconsolidated industry. It has over
20 115,000 suppliers, over 90 percent of whom billed Medicare
21 for less than \$300,000.

22 Second, there have been some persistent reports

1 that the fee schedule prices are too high. For example, in
2 recent testimony the CMS Administrator pointed out that
3 Medicare prices are often several hundred percent higher
4 than Internet prices for the same items. Because many items
5 are commodities with little service element to them, this
6 could be evidence of inaccurate pricing.

7 A troubling characteristic is that in a recent
8 report the HHS OIG found an error rate of 29 percent in a
9 sample of claims. This translates to about \$2.7 billion of
10 improper payments. The errors in that report could range
11 from not having the right medical documentation all the way
12 to supplying equipment that no one ordered or wanted, in
13 other words, fraud.

14 Fraud has been a persistent problem for DME and
15 CMS has launched targeted actions in areas such as Miami and
16 Los Angeles which have a history of high incidence of fraud.

17 Against this background, competitive bidding for
18 DME has been proposed as a way to get more realistic pricing
19 and to eliminate marginal suppliers prone to fraud and
20 abuse.

21 The Balanced Budget Act of 1997 called for a
22 demonstration of competitive bidding for DME. The

1 demonstration took place in Polk County, Florida and San
2 Antonio, Texas from 1999 to 2002. Prices for the competed
3 items dropped by 17 to 22 percent with no significant
4 quality or access problems. In 2003, prior to the final
5 evaluation report, MedPAC recommended expansion of
6 competitive bidding for DME into the Medicare program, given
7 the results of final evaluation were favorable. As it
8 turned out, they were.

9 In the Medicare Modernization Act of 2003 or MMA,
10 the Congress required that Medicare phase-in competitive
11 bidding for DME as part of the program. Round one would
12 incorporate 10 metropolitan statistical areas and round two
13 an additional 70, with others to follow. It also gave the
14 Secretary the authority to change the fee schedule prices in
15 other areas in light of the prices coming out of the
16 competitive bidding. Round one started in July but was
17 stopped by MIPPA. Round two never got underway, although
18 the MSAs for it were chosen.

19 Looking at round one results: over 6,000 bids were
20 submitted in the 10 MSAs for the nine categories of DME that
21 were competed. Categories include, for example, hospital
22 beds and oxygen equipment.

1 About half the bids were disqualified for reasons
2 such as missing documentation or lack of accreditation. I
3 will get into that in more detail in a minute. The
4 remaining bids were analyzed and arrayed from lowest to
5 highest. The capacity of each bidder was noted and when
6 sufficient capacity plus a cushion was met, the median bid
7 of those winning bidders was made the price in the MSA.
8 Higher bidders were then excluded. As a result, not all
9 bidders were awarded contracts. 1,345 contracts were signed
10 with 325 different suppliers.

11 Suppliers without a contract were not eligible for
12 Medicare DME payments in the competitive bidding areas.
13 There was an exception for grandfathering. In oxygen, for
14 example, an incumbent supplier could choose continue to
15 provide oxygen for the people they had been doing it for but
16 they couldn't accept any new clients.

17 There was a single payment rate for each item in
18 an MSA and all winning bidders are paid that price. CMS
19 estimated that those payment rates resulted in 26 percent
20 savings compared to fee schedule prices. And the prices
21 were locked in for three years. Savings varied by category
22 and MSA. For example, prices for mail order diabetic

1 supplies dropped by an average of 43 percent. None of the
2 resulting prices were higher than the fee schedule. The
3 detailed results by MSA and category are in tables one and
4 two of your paper.

5 The contracts went into effect July 1st 2008 and
6 CMS sent out notices to beneficiaries and referral agents
7 such as physicians and discharge planners telling them which
8 suppliers were under contract.

9 The industry expressed great concern about the
10 competitive bidding program. It estimated that there were
11 4,500 suppliers in the 10 MSAs of which only 325 were
12 awarded contracts. The number of losers greatly outweighed
13 the number of winners and the industry contended the access
14 would suffer. Many suppliers simply didn't bid at all and
15 of those who bid, some were disqualified for lack of
16 financial documentation or failure to be accredited and some
17 submitted bids that were too high to win. It was expected
18 that there would be fewer suppliers at the end of the
19 process but the final number may have seemed a bit jarring.

20 The industry also contended that the lower prices
21 might lead to lower quality products being offered to
22 beneficiaries and that eventually even the winners would

1 suffer financially. There were also concerns about the
2 implementation of the program. There were reports of long
3 delays loading data into the automated system of data being
4 lost or garbled. Many bidders were disqualified for
5 financial stability because of missing documents or not
6 meeting standards, yet some bidders insist they had supplied
7 the documents and didn't know what the standards were.

8 There were also doubts raised about the
9 calculation of capacity, particularly for bidders with no
10 facilities in the area.

11 The final concern was winning bidders with no
12 current operations in an area or with no experience with a
13 particular category of items. For example, a winning oxygen
14 bidder who had not previously supplied oxygen.

15 There were other perspectives, however. CMS
16 estimated significant savings for the Medicare program and
17 therefore for beneficiaries who use DME. Those
18 beneficiaries have to pay a 20 percent coinsurance on DME
19 items.

20 CMS also stated there were more safeguards than
21 the current program has. Bidders had to be accredited,
22 although all suppliers will have to be accredited by the end

1 of September 2009. There would be monitoring of quality and
2 the financial stability rules would help weed out marginal
3 suppliers. Currently it is very easy to qualify to be a DME
4 supplier, as GAO recently demonstrated by setting up two
5 fictitious storefront operations. Taken together, those
6 safeguards and the bidding process itself would help reduce
7 the opportunity for fraud and abuse.

8 The winning bidders also had a perspective. They
9 had been able to successfully work through the process and
10 were willing to supply DME under terms of their contracts
11 for the specified prices for three years. They felt that
12 any problems could be rectified without delaying the
13 program.

14 In the middle of July the Congress passed MIPPA.
15 It terminated the contracts that had been awarded in round
16 one and had just taken effect at the beginning of the month.
17 It delayed the competitive bidding program as shown on the
18 slide. This is essentially an 18 or 24 month delay. But it
19 kept the same MSAs except for San Juan, which will no longer
20 be in the competitive bidding program. It also removed one
21 of the categories, negative pressure wound therapy items.

22 To cover the cost of delaying the program, the fee

1 schedule amounts for the competed items will be reduced by
2 9.5 percent in 2009 nationwide. The cut is less than the 26
3 percent savings began it is nationwide, not just in a
4 limited number of MSAs. Nevertheless, it is a significant
5 cut. In a hearing of the House Ways and Means Health
6 Subcommittee, when questioned as to whether the industry
7 would accept price cuts to get rid of competitive bidding,
8 the industry representative answered yes.

9 The legislation also has a number of other changes
10 to address concerns and to improve implementation, as shown
11 on the next slide.

12 The changes include OIG verification of pivotal
13 bid amounts and single payment amounts, timely feedback to
14 provide on missing financial documentation, and
15 accreditation of subcontractors and disclosures of plans to
16 use subcontractors. It also excludes certain complex power
17 wheelchairs group three or higher from competition and off-
18 the-shelf orthotics that a physician or hospital would
19 normally supply to patients as part of a professional
20 service.

21 One interesting change is requiring the Secretary
22 to use the regulatory rule and comment procedure to use

1 information from competitive bidding in setting the fee
2 schedule rates in other areas. Before the Secretary had
3 more latitude to do it as he saw fit. And it requires DME
4 suppliers to stock multiple types of diabetic test strips
5 and an OIG study to determine which ones. You have a more
6 complete list in the paper of other changes.

7 I would be happy to answer any questions that I
8 can and I look forward to hearing your views.

9 DR. SCANLON: I am not sure where to be on this
10 topic. In reading the chapter, it kind of reads like he
11 said/she said to a great extent. And so where one comes
12 down is uncertain.

13 At GAO I was there when we were pushing for this
14 idea because the problem of setting prices for DME over the
15 years has been incredibly difficult to resolve. There have
16 been other attempts to try and bring prices, Medicare
17 prices, in line with what you can get at the drugstore when
18 you walk in and pay cash. And yet we've never succeeded.

19 There is a huge issue here with respect to
20 implementation. And during the demonstration there was a
21 great effort devoted to the implementation and the oversight
22 of the implementation. And for CMS to pull that off on a

1 national scale or even on a 10 MSA scale is a whole another
2 question. So being reassured by a process of accreditation
3 is potentially risky because you can have an accreditation
4 standard but whether or not people adhere and continue to
5 adhere, that's another issue.

6 The other thing which I have a big concern about
7 which I don't believe it's been resolved is the whole
8 question which is that Medicare does not know what DME it
9 buys. You can tell me if this is wrong but products are put
10 -- similar products are lumped into a single code and
11 anything that qualifies under that code is paid the same.
12 We had an example where there was a 1,700 percent variation
13 in the retail prices of the items under a single code.
14 Medicare was paying right in the middle. So depending on
15 which item you supplied you either lost about 60 percent or
16 you made about 1,000 percent.

17 So it's this question of with that kind of a
18 situation and you competitively bid this, what do you expect
19 to get? I can cut the price 50 percent and still make 400
20 percent. Or is that going to be the kind of situation where
21 there's going to be continuing competition and we're going
22 to get prices down to the right level? Or were there really

1 legitimate quality differences among those items and we
2 really should be recognizing them?

3 Medicare needs to move to a better understanding
4 of what it's buying. And part of that is just to know what
5 it gets in terms of the products it purchases today. And it
6 doesn't, because everything has been lumped under these
7 single codes.

8 MS. BEHROOZI: Bob, you referred earlier to the
9 monopsony power of Medicare as a purchaser and I think it's
10 really a lock-in on DME, at least from the perspective of a
11 private payer.

12 When it comes to labs and when it comes to imaging
13 we have been able to be good purchasers and negotiate with
14 groups that provide those services and do considerably
15 better than the Medicare fee schedule. But when it comes to
16 DME, it's a lock. It's the Medicare fee schedule or
17 nothing.

18 I don't mean to be too provocative but it's right
19 here in the paper that the industry representatives said
20 that they'd be willing to come up with \$6 billion to get rid
21 of the bidding. So there's something that doesn't have
22 anything to do with appropriate pricing going on here and I

1 think that it's kind of right out on the face of it. It's a
2 real shame that the effort to introduce at least some of the
3 good parts of the market while protecting access and
4 predicting quality didn't go forward and the whole health
5 care system is suffering for it, all the payers and
6 certainly beneficiaries are suffering from it.

7 DR. KANE: I guess one comment I have is that a
8 political strategy of going from 4,500 suppliers to 325 is
9 guaranteed to be a failure. So I think maybe there are
10 other ways to do this. For instance, could you use bidding
11 to set the price rather than set the -- and I guess one
12 question is how much were higher volume expectations
13 bringing down those prices or not?

14 And then the next thought that came to mind in
15 that regard was where in the distribution chain are the
16 bidders coming from? Because you can have manufacturers,
17 wholesalers and retailers. I guess are there economies of
18 scale somewhere in that chain or not? And that's all
19 related to do we need to restrict it to 325 or just set a
20 price based on bidding, on competition, and leave it there
21 so you're not disappointing 4,200 angry suppliers.

22 The other question I have is what role -- this is

1 the kind of -- can you just go to drugstore.com and order
2 some of this? If so, there's a price right there. I don't
3 want to advertise any one retail drug store over another but
4 there are online prices. To what extent did they inform
5 this process? Or are we just out there once again kind of
6 hoping that these bidders will be real? To what extent are
7 these bids being checked up against what you can get on
8 drugstore.com?

9 MR. EBELER: A comment and a question. My comment
10 sort of builds on Mitra's and your explanation of sort of
11 the difference between the 26 percent and the 9.5 percent
12 was helpful in terms of technical budget neutrality. It
13 certainly suggests that there is several percentage points
14 of payment on the table that one could look at, recognizing
15 some of that may be volume. But there is still a pretty
16 wide gap there.

17 My question is could you say a little more about
18 what we know about the timing of the rollout of the updated
19 process? You've got a little bit in here, but do we know
20 anymore beyond this about when and how this is going to roll
21 out?

22 MR. GLASS: It says the competition has to occur

1 for round one in 2009. It doesn't say when the results of
2 that competition have to be put into the prices. In other
3 words, if you did it right away in 2009, could you put the
4 contracts in place by the end of 2009 possibly? Or the
5 beginning of 2010?

6 So the beginning of 2010 would be -- putting the
7 contracts in place by January 2010 would represent an 18
8 month delay. But if they can't do it that rapidly, then
9 maybe it could be up to two years. And CMS has not said
10 when they're going to start around 1.2, as they're calling
11 it.

12 DR. MARK MILLER: I guess since we're kind of
13 talking among ourselves up here, I wouldn't think that -- I
14 think CMS is leaning forward to get back on track. But I
15 don't think realistically they could have payments driven
16 off of bids faster than say 2010.

17 MR. GLASS: Everyone seems to be talking about 18
18 to 24 month delay or something like that.

19 DR. MARK MILLER: Glenn's off-line comment was
20 does the legislation require an 18-month delay?

21 MR. GLASS: It requires the competition occur for
22 round one in 2009. That's all it requires. It doesn't say

1 when --

2 DR. MARK MILLER: It doesn't say 18 months.

3 MR. GLASS: It doesn't say that.

4 DR. MARK MILLER: I'm sorry, I interrupted you.

5 MR. EBELER: That's okay.

6 DR. CHERNEW: I just wanted to respond to Nancy.

7 The thing about the bidding is you have to give people an
8 incentive to bid low. So it's hard to set up a bidding
9 system where you use the bidding to set prices if the people
10 who bid high don't in some way get penalized for bidding
11 high. So you need some bid design mechanism there. You
12 might not have to punish them completely but you need some
13 mechanism for giving people an incentive to bid low one way
14 or another.

15 The question I was going to ask before Nancy's
16 comment was it strikes me there's two somewhat separate
17 issues. One of them is it strikes me that people understood
18 that the payment schedule was too high or there was a
19 feeling that the payment schedule was too high. Competitive
20 bidding is but one way of dealing with that that has pros
21 and cons. It strikes me that the pro is over time if you
22 have that system it maintains its ability to work and maybe

1 it helps you fight fraud, although I can envision other ways
2 of dealing with fraud apart from if having -- if that was
3 your problem, you might find a different way of dealing with
4 it.

5 And of course the bidding process, as was pointed
6 out, has a number of problems in it in terms of potentially
7 the stability of the market and who's in and things like
8 this. And over time it might not always work as well as it
9 did initially. So I think it's worth some thought about how
10 to design either a better bidding system, if you think one
11 needs a better bidding system, or just a better way of
12 setting prices that may or may not rely on the bidding.

13 My inclination is part of that should involve the
14 consumer of these services to shop a little more than we
15 might enable them to shop in the 20 percent co-pay portion
16 might not give people enough incentive to make the decisions
17 on their own. But again, I haven't thought through how to
18 design that system yet.

19 DR. REISCHAUER: It has always troubled me that
20 Medicare bundles together sort of new procedures in
21 hospitals or DME into these categories and has one price. I
22 was wondering if we should enter that fray.

1 In the world of computerization having 5,000 items
2 is not difficult. When Giant buys soup from Campbell, it
3 doesn't pay one price for all soup. It pays Campbell
4 differently for onion soup versus mushroom soup. Why
5 Medicare can't enter that world, particularly in this area,
6 I just can't understand. Because it isn't like these
7 problems are often substitutable at all that are in the same
8 category. They're similar in some respects but a brace for
9 an arm or a brace for a leg, and you can't take one and put
10 it on the other.

11 DR. BORMAN: First, I would support Mitra's
12 comment that certainly, unless I'm missing something here,
13 there's something fairly bald-faced in this that deserves
14 address. And however we can get there is to the benefit of
15 presumably our customers and the beneficiaries.

16 One thing I would ask is particularly as I look at
17 a piece that was carved out of this, the negative wound
18 pressure treatment devices, there certainly is room in here
19 for comparative effectiveness to inform some of this
20 conversation. There are certainly seemingly many more
21 patients receiving that. Yet at least in my personal
22 experiences it seems like there's very few people with open

1 wounds anymore who aren't getting one of these devices. And
2 yet it appears that there were some wounds that healed
3 before the advent of these devices. So it's certainly does
4 raise some questions.

5 Another area that seems to me -- and Tom could
6 probably speak better to -- is that there seem to be an ex-
7 potential increasing number of people with diagnosed sleep
8 disorders and on various oxygen and CPAP therapies, and
9 things than seem to be warranted by guidelines and/or
10 efficacy.

11 So just trying to weave some of our themes
12 together, that if we need to re-examine this other than in a
13 pure competitive bidding way, that perhaps some of the
14 higher ticket items could be informed through the
15 comparative effectiveness discussion and sort of move it
16 away from the criticisms that were made in this particular
17 process.

18 MR. HACKBARTH: Based on the comments, it seems
19 like there are a number of different paths we might go down.
20 One, of course, is just be silent and not take this up, not
21 invest resources in it.

22 A second would be to reiterate our prior support

1 for the idea of competitive bidding, although I think that
2 since it's been several years since MedPAC has looked at
3 this I think that would entail our doing a pretty detailed
4 review of the process and potential issues and how the
5 process is run, and a fairly significant investment of time
6 and effort.

7 A third possibility is to say well, the notion of
8 competitive bidding is attractive for the reason that Mike
9 mentioned, because it creates an ongoing dynamic that will
10 tend to hold down payments over time. But there might be
11 other bidding models different than the one used here that
12 may be better, may provoke less political resistance,
13 whatever.

14 And then the fourth path is to say well, maybe
15 competitive that isn't the best approach at all. There are
16 other ways to get equal or at least comparable savings that
17 don't involve the process of competitive bidding.

18 I have heard some interest in each of those three
19 paths, not much in favor of silence. So let's do a quick
20 second round. Any reaction on which of these paths we ought
21 to be focusing our effort on? And please keep your comment
22 short because we are a little tight on time.

1 MR. GEORGE MILLER: Thank you, Mr. Chairman. I
2 would echo and support what Mitra said concerning the fact
3 that the industry spoke very loud and clear they would want
4 to do away with it. As a result I think we should speak
5 out, particularly if we're looking at the entire system of
6 saving dollars. I'm not sure of the methodology but
7 certainly we should speak very clearly that affording
8 working savings with some type of methodology for choosing
9 that is something this Commission should speak forcibly for.

10 DR. SCANLON: I think we should look at the issue
11 of competitive bidding and seeing how we could make it work.
12 And maybe an alternative model of competitive bidding is the
13 right approach. Maybe there is this sort of unidentified
14 other model out there besides competitive bidding.

15 In terms of both Mike and Nancy's comment about
16 the retail prices, there were efforts to collect retail
17 prices but the problem is that in a government program like
18 this the standard for when you can change the price was so
19 high that we never could get the retail prices to be used.
20 There was a process called inherent reasonableness. I think
21 over a period of I don't know how many years one price
22 managed to be changed out of all the items that were there.

1 So the issue is if there's another method besides
2 competitive bidding where the suppliers tell us something
3 that they're willing to accept, I don't know what it is.
4 But if it's out there that would be great, if it eliminated
5 some of the difficulties we're going to have with
6 competitive bidding. Because we're going to have
7 difficulties with competitive bidding. It's not going to be
8 a cakewalk.

9 I would echo Bob's comment. It would fulfill
10 GAO's wish. We were making this recommendation over and
11 over again, which is this is a world of computerization.
12 People are putting universal product codes on their products
13 already. And you're making them go and change those to HCPC
14 codes in order to get paid. The Defense Department even
15 uses the universal product code. So why can't CMS use it?

16 The response was always well, we'll have to set
17 prices for every universal product code. No, you don't.
18 You can start with the HCPC codes that you've got, have a
19 mapping from the universal product codes to HCPC codes. And
20 over time understand what you bought and refine your
21 definition of products.

22 It's not something that should be so difficult to

1 overcome. And it would help the providers, as well because
2 they're just needlessly having to create separate codes now.

3 DR. CROSSON: I guess to me the consideration in
4 terms of whether we spend time on this is whether we
5 actually have a customer for our work and whether CMS is, in
6 fact, looking for options or is set on this course, which is
7 to replicate the current idea and do it a couple of years
8 later and the like.

9 I was attracted by Mike's idea that there may be a
10 different way to do this. It seems like compared to some of
11 the things that we deal with the idea of setting a benchmark
12 price in this area at least intuitively shouldn't be that
13 hard, if you can look on the Internet and find out what it
14 costs. It's a lot easier to do than some of the other
15 benchmark pricing processes that we deal with. And then if
16 you could design sort of a benefit sharing relationship
17 between the beneficiary and Medicare in terms of the
18 beneficiary choosing the best value, you'd have a market-
19 based system that might make sense.

20 Now I listened to Bill and he was explaining that
21 that's not that easy. But to me if there is a customer for
22 this and if there are some concepts maybe in the first round

1 set of analysis and discussion that have some viability,
2 then I would be in favor of it. If in fact this course is
3 set, CMS pretty much wants to do what they want to do or
4 they feel that they've been directed to do something, then
5 it may not be the highest priority.

6 MR. HACKBARTH: The question of what CMS's intent
7 is, I think is complicated by the fact that there is an
8 election on the horizon. Clearly the idea of using
9 competition as a tool was a high priority for this
10 administration and for the Republicans when they controlled
11 the Congress. Whether it will continue to be a priority, I
12 don't know. Certainly the election could influence that.

13 To me what makes me want to take this on in some
14 fashion -- I don't know what the solution is -- is George's
15 point that when there is such a seemingly egregious problem
16 between what Medicare is paying and the generally
17 available prices to just turn and walk away from it is
18 troubling to me.

19 DR. CHERNEW: I was just going to respond to say
20 that in some sense this is a bit of a sentinel issue
21 independent of what we think is going to happen in DME per
22 se, because this reflects a whole series of aspects of

1 payment and payment system and the way the system works.

2 And so I think that we need to address this issue
3 not just in how we think DME should be paid, which is
4 important, but how we think the process can be used. If we
5 can't make competitive bidding or something like competitive
6 bidding work for DME, that carves out a whole set of other
7 approaches that just have to be off-limits where it's going
8 to be harder. And that might be the lesson learned.

9 So for that reason I think we need to take it on.
10 I do think it's actually worth some resources to understand
11 the aspects of the merits of the arguments pro or con and to
12 think about different ways of dealing with this. Certainly
13 one of the ways that historically people have tried to deal
14 with problems like this have been to contract out to other
15 organizations. So you, Medicare, aren't setting the price
16 for this particular product code but there's some other
17 organization that is supplying a broad set of things that
18 has an incentive that if they can get better prices from
19 suppliers. So you could think of other ways to spread the
20 risk or spread the cost of this high price, some of which
21 could be the beneficiary, some of which could be some other
22 organization. But someone should gather that rents from

1 being able to get a better price on this.

2 And we could think through that, and I think it's
3 worth it not because it's so important for DME but I think
4 it's worth it because I think the theme behind this
5 transcends just DME. And DME has some properties that might
6 make it -- this is going to come up for prescription drugs
7 too, I think.

8 DR. DEAN: Just a question. First of all, I
9 totally agree. My experience in listening to my patients is
10 there is huge abuse in this area and a lot of things get
11 supplied that never even get requested and so forth. So it
12 definitely needs to be addressed.

13 Are there protections in the current program or
14 the proposed approaches to make sure that we don't go
15 overboard in the other direction? For instance, there are
16 some of these services that are needed on a fairly urgent
17 basis, especially oxygen. And right now, even though I live
18 in a very isolated area, we have easy access to that.

19 I wonder, are there access provisions in the
20 proposed or existing --

21 MR. GLASS: In the demonstration they found that
22 access was not hurt at all or was not hurt significantly.

1 DR. DEAN: In the demonstration I don't think any
2 of those were carried out in any rural areas was it?

3 MR. GLASS: No, this is only in MSAs.

4 DR. DEAN: That's what I thought.

5 MR. GLASS: And CMS was proposing to monitor
6 access as time went on and bring in more people on contract
7 if, in fact, any access problems arose.

8 MR. HACKBARTH: Quick comment, Bruce?

9 DR. STUART: Very quick. Do we know how the VA
10 and DOD pay for DME?

11 MR. GLASS: We did look somewhat at how VA paid
12 for oxygen and I'm trying to remember the answer to that. I
13 can get back to you on it. I think it may have varied by
14 which VA district you were in.

15 DR. STUART: It just might provide some useful
16 context for this.

17 MR. HACKBARTH: So here's where I think we are.
18 George and Mike have laid out important reasons not just to
19 walk away from this. At the same time, I think we're very
20 much open as to what the best approach is to pursue. So I
21 think the task for you, Mark and David, is to help us
22 structure a discussion next time we take this up about what

1 path or paths we wish to explore further.

2 DR. MARK MILLER: I've been thinking about this as
3 it's been going along and we'll come back to you. I think
4 what I'll have is two plans, a kind of light resources/heavy
5 resources.

6 MR. HACKBARTH: Thank you, David.

7 Next up is public reporting of physician financial
8 relationships, a topic that we discussed in our last cycle
9 and there was quite a bit of interest expressed by
10 commissioners in the topic and potentially moving towards
11 recommendations on this issue.

12 So Ariel, when you're ready, you can go ahead.

13 MR. WINTER: Good afternoon. As Glenn said, I'll
14 be discussing public reporting of physicians' financial
15 relationships with drug and device manufacturers, hospitals,
16 and ASCs.

17 Before I start I want to first thank Hannah
18 Neprash and Jeff Stensland for their contributions to this
19 work.

20 We discussed this topic at our March and April
21 meetings, which led to a chapter in the June report. The
22 chapter expressed the Commission's interest in public

1 reporting system. And our goal for the March report is to
2 pick up where we left off and to move toward recommendations
3 on this issue.

4 For today's presentation, I will start with
5 physicians' financial relationships with drug and device
6 manufacturers. We will review key findings from the June
7 report and then outline a proposed framework for a public
8 reporting system and highlight some key questions.

9 I will also discuss options for public reporting
10 of physicians' financial relationships with hospitals and
11 ambulatory surgical centers. We expect today's session to
12 lead to draft recommendations, which we would present at a
13 future meeting.

14 I'm going to start by summarizing some key points
15 from the June report. Please bear with me if this seems
16 very familiar to you. The first point is that financial
17 relationships between physicians and drug and device
18 manufacturers are pervasive. Here are some examples on the
19 slide, which were also in the June report. A physician
20 survey found that most physicians have interactions with
21 drug manufacturers. According to a recent study, drug
22 companies spent \$7 billion on physician detailing, which

1 refers to visits from sales representatives to physicians,
2 and provided free samples worth \$18 billion in 2005.

3 The Association of American Medical Colleges has
4 observed that "medical schools...have become increasingly
5 dependent on industry support of their core education
6 missions." In addition, device companies have financial
7 ties to physicians related to product development,
8 education, training, and research.

9 Relationships between physicians and manufactures
10 have both benefits and risk. Physicians play an important
11 role in developing new drugs and devices by running clinical
12 trials and providing expert advice. In addition, marketing
13 efforts directed at physicians may lead to greater use of
14 beneficial treatments. But physician industry ties may also
15 undermine physicians' independence and objectivity.

16 According to studies in this area, industry
17 interactions are associated with more rapid prescribing of
18 newer, more expensive drugs and requests to add drugs to
19 hospital formularies. In addition, there's evidence that
20 clinical research funded by manufactures is not always
21 objective and publicly available.

22 The private sector and government have made

1 efforts in recent years to curb inappropriate relationships
2 between physicians and manufacturers. Industry and
3 physician groups have developed voluntary guidelines for
4 these relationships. For example, the PhRMA guidelines
5 limit gifts to physicians to those of an educational nature
6 that are worth less than \$100. The Office of Inspector
7 General has issued guidance to help manufacturers comply
8 with the anti-kickback law which prohibits companies from
9 making payments to induce or reward the referral of items
10 reimbursed by Federal health programs. But there's no
11 mechanism to measure and enforce compliance with these
12 guidelines.

13 There is also evidence that some inappropriate
14 practices may still occur. For example, a recent physician
15 survey found that some physicians were still receiving
16 tickets to cultural and sporting events from drug
17 manufacturers, which is a violation of industry and
18 physician guidelines. Several academic medical centers and
19 medical groups have adopted strict policies to limit
20 physician interactions with the industry. For example,
21 Stanford's Medical Center bans sales representatives from
22 patient care areas and no longer accepts industry funding

1 for specific CME programs.

2 Five states and the District of Columbia require
3 drug manufacturers to report payments they make to
4 physicians and other health care providers but only one of
5 these laws -- that of Massachusetts, which was just enacted
6 -- also covers device companies. Most of these laws have
7 significant weaknesses. The data collected are often
8 incomplete and not easily accessible. For example,
9 Minnesota is the only state to currently make public the
10 names of physicians who receive payments but this
11 information is not yet available in a searchable database.
12 In addition, payment categories are vaguely defined which
13 makes it difficult to analyze the data.

14 And option we discussed in the June report is to
15 have the Federal government collect national data on
16 physician industry relationships. Among the potential
17 benefits of public reporting are that it could discourage
18 inappropriate arrangements. The press and researchers could
19 use the data to shed light on physician industry
20 relationships and potential conflicts of interest. And
21 payers and plans could use the data to examine whether
22 physicians' practice patterns are influenced by their

1 relationships with the industry.

2 We also describe some concerns about a national
3 database on physician industry relationships. There would
4 be compliance costs for manufacturers. There would also be
5 administrative costs for the government to implement and
6 enforce the reporting law. Public reporting might
7 discourage beneficial arrangements between physicians and
8 industry. And public reporting would not eliminate
9 conflicts of interest. However, it would help identify the
10 prevalence of various arrangements and could lead to clearer
11 and stronger ethics policies.

12 In our June report, we indicated that we would
13 further explore key design questions for a public reporting
14 system. How comprehensive should the system be? What size
15 and types of relationships should be reported? And should a
16 Federal law preempt state laws? In the next several slides,
17 we propose a framework for a reporting system organized
18 around these three questions. I'm also going to touch on a
19 couple of other key design issues. At the end of the
20 presentation we will seek your input on the approach we have
21 laid out.

22 First, we'll explore how comprehensive the

1 reporting system should be. The first question is which
2 types of manufacturers should be included? In our
3 framework, we propose including manufactures of drugs,
4 devices, and supplies and companies of all sizes, large and
5 small, in order to achieve a level playing field.

6 The second question is whether payments to
7 recipients other than physicians should be included? In our
8 framework we propose including academic medical centers
9 because they receive significant financial support for
10 research and education from manufacturers. We also suggest
11 including continuing medical education organizations because
12 commercial support accounted for half of total CME revenue
13 in 2006, \$1.2 billion. We also propose including patient
14 advocacy groups and physician membership organizations
15 because they may receive grants from manufacturers for
16 research and education. For example, Eli Lilly has begun
17 public reporting its contributions to these groups on its
18 website.

19 One of the key questions is whether companies
20 should be allowed to withhold information that they deem to
21 be proprietary? There's a trade-off between allowing
22 manufacturers to protect sensitive information about product

1 development and the public's legitimate interest in learning
2 about the industry's financial relationships.

3 The Vermont disclosure law permits companies to
4 decimate information as "trade secrets" that is not publicly
5 disclosed but this policy resulted in 72 percent of payments
6 being withheld from disclosure in 2006 and 2007. One option
7 for navigating this issue is to allow companies to delay
8 reporting of payments to physicians that are related to the
9 development of new products such as consulting agreements
10 and the funding of clinical trials.

11 This delay could be tied to a point at which the
12 development effort becomes publicly known. Clinical trials
13 of drugs and devices become public when manufacturers
14 register them on a website maintained by NIH. Under a law
15 passed in 2007, companies are required to register phase II
16 and phase III trials.

17 For other payments related to new product
18 development such as consulting agreements, reporting could
19 be linked to FDA approval of the product. Because the
20 product may be under development for several years, you may
21 want to consider setting a time limit such as two years,
22 after which payments would have to be reported regardless of

1 FDA approval. In other words, reporting could be delayed
2 until the earlier of FDA approval or a set number of years.

3 The next set of questions relate to the size and
4 types of payment that should be reported. State laws have
5 different thresholds for payments that must be reported to
6 the state, ranging from \$25 to \$100. We propose that the
7 lower end of this range be the threshold for reporting under
8 a Federal system two reasons: first, this would enable
9 collection of data on smaller gifts and meals. Second, two
10 of the three states with higher thresholds, thresholds
11 higher than \$25, also have a ban on some types of payments
12 which we're not proposing for a Federal law.

13 In addition, we would need to decide which types
14 of payments or transfers of value should be reported. Our
15 proposed framework includes a comprehensive list of payments
16 and relationships, ranging from relatively common to less
17 frequent interactions. They are listed on the slide here.
18 Many of these categories are included in at least some
19 existing state laws.

20 An important question here is whether companies
21 should have to report free samples provided to physicians.
22 On the one hand, this would increase compliance costs for

1 manufacturers. On the other hand, reporting of samples
2 would provide a more complete picture of industry
3 relationships with physicians. According to a survey
4 conducted in 2003 and 2004, 78 percent of physicians
5 received free drug samples in the last year. As we
6 mentioned earlier, drug companies provided free samples
7 worth \$18 billion in 2005.

8 The third important design question is whether a
9 Federal law should preempt state laws. The argument in
10 favor of preemption is that it would reduce compliance costs
11 for manufacturers because they would only have to comply by
12 with one uniform Federal law rather than multiple state
13 laws. In addition, a single source of information should
14 reduce confusion among users.

15 An argument against preemption is based on respect
16 for state autonomy and the potential for the Federal
17 government to learn from state laws. A potential compromise
18 would be to allow states to collect information that is not
19 collected under a Federal law. In other words, a Federal
20 law would a minimum floor. For example, if the Federal
21 excluded reporting of free samples, state laws could require
22 such reporting. But if states passed their own laws under

1 partial preemption, companies would have to comply with
2 multiple requirements, thereby increasing their compliance
3 costs.

4 Another significant design question is how to make
5 the data easily accessible to the public. This is a
6 relevant question given the difficulties of accessing data
7 collected under state laws. First, it would be important to
8 create an online database that is easy to search and
9 download. Second, the payment category should be clearly
10 defined and standardized so that information is consistently
11 reported. And third, the database should allow users to
12 search for payments by type, amount, physician, and
13 manufacturer.

14 Finally, we consider some implementation issues.
15 First, which agency should administer a reporting system?
16 The Congress could choose to delegate responsibility to the
17 Secretary and allow him or her to choose an agency.
18 Possibilities include the FDA, because it regulates drugs
19 and devices, or CMS because it pays for a significant number
20 of these products. Both agencies, however, have severe
21 funding and staffing constraints. A third option could be
22 OIG because it has responsibility for investigating

1 financial relationships that may violate the anti-kickback
2 statute.

3 Second, the administrative costs of implementing a
4 reporting system are unclear. According to Minnesota, the
5 cost of collecting the information from the industry and
6 posting it on a website is minimal. But Minnesota's program
7 does not yet have a searchable electronic database, which
8 might increase the costs.

9 Further, we lack data on costs incurred by states
10 to monitor and enforce compliance with the system. We may
11 want to consider asking Congress to provide sufficient
12 resources to the Secretary to administer a reporting law.

13 Now we'll turn our attention to reporting of
14 physicians' relationships with hospitals and ASCs. The
15 number of physician-owned specialty hospitals more than
16 tripled from 2000 to 2008, from 46 to roughly 175. There
17 were also an unknown number of general hospitals with some
18 physician ownership. The number of Medicare certified ASCs,
19 most of which have at least some physician ownership, grew
20 by over 60 percent from 2000 to 2007, to almost 5,000
21 facilities. There has also been an increase in joint
22 venture facilities owned by physicians and hospitals such as

1 imaging centers and cardiac catheterization labs.

2 The Commission has previously express concern that
3 some of these types of relationships may be designed to
4 increase volume of services without improving quality and
5 coordination of care. Evidence from the studies of
6 physician-owned hospitals suggest that physician ownership
7 can affect the volume of services in a market.

8 Currently, it is difficult for payers and
9 researchers to obtain information about these financial
10 relationships. We said in the June report that collecting
11 this information and making it available to the public would
12 help payers and researchers examine how these financial ties
13 might influence patient referrals, quality of care, and the
14 cost of care.

15 Here we summarize the current rules on hospital
16 disclosure of financial relationships with physicians.
17 First, hospitals enrolling in Medicare must report
18 individuals -- including physicians -- who own 5 percent or
19 more of the hospital but these data are not publicly
20 available.

21 CMS also requires hospitals to inform Medicare
22 patients if they are physician owned but this information is

1 not provided to CMS or other payers or researchers.

2 Finally, CMS will be collecting detailed data on
3 financial relationships from a sample of up to 500 hospitals
4 in a survey called the Disclosure of Financial Relationships
5 Report. Hospitals will be required to report information on
6 physician ownership and other financial relationships,
7 including the value of compensation arrangements.

8 Here we describe two options for CMS to collect
9 data on physician/hospital relationships and to make it
10 public available. Option one is to require all hospitals to
11 provide information on all physician owners to CMS, which
12 would post this information on a public website. Because
13 CMS already collects data on individuals who own 5 percent
14 or more of the hospital, the additional reporting burden for
15 this option should be minimal.

16 Option two, which is more extensive, is to create
17 a public database of information on other financial
18 relationships between physicians and hospitals such as
19 leases and joint ventures. Because of the need to balance
20 transparency with limiting the administrative burden on
21 hospitals, you would probably want to select only certain
22 arrangements for reporting. Before deciding which

1 relationships to include, it may be prudent to wait for a
2 review of the information that CMS will collect through the
3 DFRR, which may shed light on the prevalence of various
4 arrangements.

5 Here we describe the current rules on ASC
6 disclosure of physician ownership. Just like hospitals,
7 ASCs enrolling in Medicare must report individuals who own 5
8 percent or more of the ASC but these data are not publicly
9 available. CMS has proposed requiring all ASCs to disclose
10 physician ownership to Medicare patients but this
11 information would not be provided to CMS. And finally,
12 physician-owned ASCs that comply with an anti-kickback safe
13 harbor must disclose their ownership to patients but not to
14 CMS.

15 An option here would be to require that all ASCs
16 report all physician owners to CMS, which would post this
17 information on its website. Because CMS already collects
18 data on physicians and other individuals who own 5 percent
19 or more of an ASC, the additional reporting burden should be
20 minimal.

21 So to conclude, we are seeking your guidance to
22 help shape draft recommendations based on today's

1 presentation. Specifically, the proposed framework for
2 public reporting of physician relationships with drug and
3 device manufacturers and options for public reporting of
4 physician relationships with hospitals and ASCs.

5 I'd be happy to answer any questions you might
6 have about the presentation.

7 MR. HACKBARTH: Thank you. Let's just go down the
8 row here.

9 DR. CHERNEW: I just have a quick clarification
10 question about the 5 percent ownership in hospitals or ASCs.
11 It was written as if an individual owns 5 percent. But I
12 could envision certain types of administrative entities that
13 could mask -- I don't own it. I own some part of some other
14 practice or something, and that other practice entity owns
15 some portion of it.

16 So I could see a scenario where you could get
17 around those types of issues, and where actually you might
18 feel like you had a strong financial incentive to do
19 something but it didn't show up in entity and sort of
20 complicated other arrangements that could get around those
21 types of rules.

22 I was wondering if that came up and if you have

1 any thoughts on that issue?

2 MR. WINTER: That is a good point. I believe the
3 enrollment form requests just the names of individuals. It
4 might also request entities that own 5 percent or more, but
5 I'd have to check that. It does require reporting of
6 information about partners and things like that, so that
7 might come. I will take another look at the form and see
8 what it says but you do raise a good point about the broader
9 issue, if you just require reporting of individual
10 physicians will you then be missing out on other financial
11 interests.

12 DR. CHERNEW: So I guess if there were 21
13 physicians that owned something evenly, if every single
14 physician would own less than 5 percent, but it could still
15 be very significant portion of that physician's -- because
16 the thing would just be bigger.

17 MR. WINTER: Right now that would not show up.
18 That would not be reported to CMS.

19 DR. CASTELLANOS: First of all, I think it's a
20 good presentation and I think it's very apt to be -- we need
21 to talk about this now.

22 I'm fully in favor of public disclosure. I think

1 we have two issues here. One is the relationship and one is
2 financial interest. I think as far as the relationships, as
3 far as that goes, we just need to be very consistent. We
4 need a level playing field and we need to be comprehensive.
5 I would hope that by -- what I'm saying by consistent is a
6 lot of the medical specialty societies -- and I know the AMA
7 has already gone on record on some of their recommendations.
8 I would hope that when we make some recommendations that
9 we're all together in the same field, at least on some of
10 the issues or the small issues.

11 As far as financial interests, I'm for total
12 transparency. I don't think it can work any other way.
13 Both with the ASC, both at the specialty hospitals, joint
14 ventures, employment contracts and the independent
15 diagnostic treatment centers. I think we need full
16 disclosure and transparency. It's not going to work any
17 other way.

18 DR. CROSSON: I think I agree with Ron on that and
19 I continue support this set of initiatives. There's a lot
20 of things in here. I can't comment on all of the questions.
21 I would comment on a couple. I do like the approach to
22 dealing with the issue of the proprietary information

1 loophole. I think that's very well thought out and I would
2 support that. It would seem to work very well.

3 One area I think that's the most complicated for
4 me is the samples area. As we've dealt with various issues
5 impacting drug costs and the practice of medicine that has
6 been the most difficult one. The use of samples clearly has
7 the intention and the effect of increasing the use of newer
8 higher cost agents rather than older equally effective
9 agents.

10 On the other hand, it's also helpful financially
11 to beneficiaries and to non-Medicare patients. And in some
12 certain cases it's helpful to certain physicians in the
13 practice of medicine. For example, when we began looking at
14 this issue some years ago we had a lot of complaints from
15 our dermatologists who use tiny little tubes. And there are
16 so many variations in the response of individuals to various
17 dermatologic agents that it's easier, and in fact cost
18 effective, to test little tiny amounts of multiple agents
19 until you find out which one works. And the sampling
20 process is one way of doing that.

21 Now eventually, we decided to dispense with that
22 and actually, in our own organization, manufacture tiny

1 little tubes of stuff but I can't recommend that to
2 everybody.

3 Having said all that, I would to come down I think
4 again on the side of disclosure. One of the issues is the
5 question of how much of a cost burden this would cause.
6 When I asked folks in California, they well, none at all
7 because California already requires the reporting of this
8 information by -- I hope this is correct -- by the
9 pharmaceutical companies with respect to the provision of
10 samples. So one thing might be to find out if it's
11 possible, whether that's accurate. I think it is. And in
12 how many states that actually already is the case. So much
13 additional burden would this be on the pharmaceutical
14 companies?

15 In the end, probably the value of doing this would
16 be longer term and that would be to help understand what the
17 impact of the provision of samples is on Medicare costs and
18 also increasingly now, with the doughnut hole, on the out-
19 of-pocket costs to beneficiaries. We might learn something
20 from this.

21 MR. WINTER: If I could just answer the question
22 about which states require reporting of samples, of the five

1 states plus D.C., all of them except Massachusetts, I
2 believe, specifically exclude samples from public reporting.
3 Massachusetts' law, which was just enacted, is quite broad.
4 There are no explicit exclusions. It says any fee,
5 payments, or economic benefit provided to a physician must
6 be reported. That remains to be seen how that's interpreted
7 when the law is implemented, whether that is understood to
8 include samples or not. So information on samples is not
9 currently being reported by any state.

10 And our information is that California does not
11 have a reporting law. I will double check on that but what
12 we found is that they do require manufacturers to set I
13 think a limit on aggregate payments to physicians in a
14 single year. I'm looking at Hannah for confirmation and
15 she's nodding her head, which is good.

16 DR. CROSSON: I'm sorry then, perhaps I was
17 misinformed.

18 MR. WINTER: We will double check. That was just
19 our understanding.

20 MR. GEORGE MILLER: Thank you, Mr. Chairman. I
21 also want to echo that I think this is a very good report
22 and I fully appreciate all of the work that went into the

1 report. I would just like to echo what was said earlier
2 about the financial interest statement in this report. I
3 think it's very important that we are totally and completely
4 transparent, and that goes across the board in every area
5 with full disclosure.

6 I also want to talk a little bit about the notion
7 of a level playing field because, especially on the
8 specialty hospital side, at least from what I read and what
9 I know personally and anecdotally that the reason specialty
10 hospitals come in existence particularly is because they
11 deal with certain DRGs that pay better. You rarely see a
12 group of physicians or others get together and start
13 emergency rooms, as an example, to meet a need. It is very,
14 very specific.

15 So I think full disclosure in some regards. I'm
16 not sure if this goes far enough, but certainly full
17 disclosure. And I would even suggest we make a
18 recommendation that is any financial interest, not 5 percent
19 but any financial interest.

20 Many of the ASCs and the surgical specialty
21 hospitals have non-compete clauses in their agreements which
22 means that they don't want someone to go out and then build

1 another facility close by and move that business. That's
2 why they have non-compete. So again I'm very supportive of
3 this report.

4 DR. MARK MILLER: Let me say something really
5 quickly, since this has come up twice on the 5 percent. The
6 5 percent -- and Ariel, just make sure I'm right here --
7 anybody with 5 percent ownership, and I think it's
8 predominantly individual, but 5 percent ownership in either
9 hospital or ASC has to report that to CMS now. That
10 information is not public.

11 Our point is as long as you're in there getting 5
12 percent, why don't you get any ownership -- and Mike has
13 made a good point about individual versus others -- and make
14 it public. So we're asking you to think about going below
15 the 5 percent, not accepting it. And you're agreeing.

16 DR. SCANLON: I'd echo the support for this very
17 strongly. I think we need incredible transparency here
18 although I'm about now, in some ways, to contradict that by
19 saying I worry a little bit about having a threshold that is
20 too low and that we get too much information and the
21 important information is lost. \$25, I can't even fill my
22 Prius anymore for \$25.

1 So I would be interested in a threshold that is
2 something of a cumulative payment for a period of time, a
3 quarter or a year, and something more like \$100. Because I
4 don't want to have a ton of \$25 payments and not see what
5 the important ones are in that.

6 The second point is a question more, and that is
7 sort of the issue of the ability of the Federal government
8 to preempt state law in this area. We do have that thing
9 called the Constitution, which leaves certain powers within
10 the province of the states. And so the question is in this
11 area would the Federal government actually be in a position
12 to do that? Or would it have to be done with the carrot and
13 stick approach which we use a lot, which is to say if you
14 don't do it we're going to do X or Y? Or if you do do it,
15 we will do X or Y.

16 We have ERISA, seems to be a clear preemption, but
17 the circumstances of that may not apply in this case. So
18 there's a question of we shouldn't go forward unless we know
19 we have a reasonable legal basis for it.

20 DR. KANE: I'm a little concerned about the
21 complexity of what's going to become the reporting
22 requirement. I'm very supportive of the general idea and I

1 think the devil will be in the details. I'm just thinking
2 about when you start looking down into who owns what, the
3 whole opportunity to create shell organizations -- there's
4 just going to be an enormous -- for those who really want to
5 be deceptive -- and we've seen that happen before -- it's
6 going to be really hard to figure who really owns that
7 hospital if they have six different shell organizations
8 which represent 100 different people.

9 So one of the things that came to mind is what
10 kind of audit capability are we going to recommend here?
11 Because if someone is honest, that we'll be fine. But the
12 people who you most want to catch, like the guy at
13 Harvard/Mass General, the psychotropic king for children, he
14 just didn't tell the truth to Harvard or to Mass General.

15 And so I think you will get a lot of honest people
16 out here and then the ones that you really want to catch,
17 I'm not sure how you will catch them unless you come up with
18 a way to audit that. And that really adds just an enormous
19 amount of cost. So we need to think about either the audit
20 capability or an enormous penalty if you do get caught not
21 complying. And I think we need to talk about that somewhere
22 and how we would deal with it.

1 The other piece is, being someone who deals with
2 CME a lot in my own school, we are required at this point to
3 disclose -- to get CME credits, you've got to disclose where
4 you were born and who your mother is practically. So in
5 fact, the CME organizations are trying to do disclosure, and
6 that's actually part of being accredited to be CME.

7 I'm just thinking now our CME organization gets
8 put in a public dataset for receiving money from Pfizer, who
9 hands out money pretty regularly for public health issues.

10 Is the point there that you want Pfizer to stop
11 supporting the public health CME? Or that you want people
12 to -- I guess I'm saying where are you going with that? I
13 guess we need to think more about what the goal is. I'm
14 happy to dump Pfizer but then I don't know what that means
15 financially or programmatically.

16 So if the goal is to ensure that physicians aren't
17 being unduly influenced, knowing what goes to CME isn't
18 going to do it for you I don't think. And some of these
19 intermediate organizations, because you can't link it down
20 to a physician and say that physician is changing their
21 behavior because Pfizer supports the School of Public
22 Health. It's just a harder linkage to make because there's

1 an intermediary organization there.

2 So if you really want to just say where are the
3 financials where the physicians are being financially
4 influenced, then I wouldn't broaden the reporting
5 requirements to every intermediate organization that gets
6 the money because you can't link it back down to the
7 individual doctor very easily. So I'm just thinking of the
8 complexity of this and how to maybe look for this to
9 possibly simplify it for that value added that you might get
10 out of it.

11 And it always does have to be offset by what
12 you're going to discourage because I can tell you already
13 that if people are worried about what it looks like to have
14 Pfizer giving my school money and it's going to be public,
15 they would probably say forget it, we don't want to do that.
16 And there are some potential downsides to that.

17 I don't know, I think we need to disclosure but we
18 need to think very carefully what's the goal and how do we
19 narrow the weapon to hit the target rather than everybody
20 who's ever received any money from a pharmaceutical company.

21 And then think about how do we audit that or
22 penalize that the noncompliant or you'll get garbage

1 in/garbage out and you won't catch the people that you
2 really want to.

3 MR. WINTER: Glenn, can I just give one point of
4 information in response to Nancy's comments about the CME
5 disclosure?

6 I mentioned Eli Lilly is putting on its website
7 payments or grants to physician organizations, patient
8 advocacy organizations. It also includes medical education
9 grants under the context of CME. And 12 additional device
10 and drug manufacturers said in a letter to Senator Grassley
11 that they intended to do a similar type of disclosure on
12 their own websites. So it wouldn't be one central database
13 but on their own websites disclosing medical education
14 grants.

15 DR. KANE: That's okay. I'm just saying if we
16 said that this should be a Federal law that you do that,
17 you're sort of implying that there is something bad going on
18 there. And I guess there's a difference between that and
19 Eli Lilly voluntarily doing that.

20 And I will say I know our organization is starting
21 to sort of shy away from wanting to take anything. And is
22 that what you want? We need to think about what we're

1 encouraging, as opposed to what we want to hit right on the
2 nail head.

3 MR. BUTLER: I wasn't here when we did the report
4 last year but I sense a lot of energy around this topic for
5 sure, not just because it's important but I sense a
6 legislative schedule, too, that if we're going to weigh in
7 we probably would want to weigh in sooner rather than later
8 on this one, from everything I understand.

9 The first comment, I'll try to stick with our
10 ground rules. You've asked us so many questions to comment
11 on so I'll try not to do it all.

12 Conflict of interest sometimes can be viewed two
13 ways. One is there are a lot of good things that are going
14 on, as Nancy said. But they ought to be disclosed. In
15 fact, they're excellent things but they need to be disclosed
16 so everybody's aware of them. The first is having conflict
17 of interest in disclosures because you really don't think
18 it's a good idea and you're trying to get rid of it or
19 discourage it. And so I think we ought to think about some
20 of these things in that light as we begin to categorize.

21 Even when you talk about the thresholds, \$25, are
22 we trying to just mask or get around a decision around say

1 drug samples or something like that rather than just coming
2 out and saying is that a good idea or not? We ought to
3 declare on some of the categories perhaps more directly
4 rather than trying to finesse it through a dollar threshold.

5 Frankly, if you had it at zero, you might even
6 relieve administrative burdens and do away with it
7 altogether if that's what you want to do. So that's just a
8 general comment.

9 We've got two different categories here, one is
10 the drug and device relationships with physicians and then
11 the second is the hospital/physician relationships. They're
12 really quite different. They have some themes to them that
13 are the same, though.

14 I would be definitely in favor of the Federal
15 versus the state to the extent that you can do it. I would
16 be in favor of going beyond individual physicians to
17 physician organizations and academic medical centers. I
18 guess I would caution a little bit on the reporting side,
19 being at an academic medical center. Sometimes what a
20 device company may categorize in their books as a certain
21 item could be categorized as something quite different in
22 our book. So how do define those things is not -- what one

1 person calls a research grant somebody else may call
2 something else. So there are some definitional things to
3 work through that I think are important if it's going to be
4 publicly disclosed.

5 On the hospital side, too, I think that we need to
6 be broader than just the option one, which is -- you posed
7 two options. We need to be broader. It does give me a bit
8 of a headache to think about reporting everything under the
9 sun. Administratively that would be difficult and probably
10 inappropriate. I don't know that you need to know the rent
11 that physicians pay in physician office buildings. That's
12 subject to other fair market test as it is now, so you don't
13 have to disclose those things as I wouldn't think.
14 Nevertheless, it ought to be broader than is proposed under
15 option one.

16 Here I think there's a principle that's important
17 though, and that is I think it should be used more for the
18 screenings of the patterns of behavior in order that we can
19 develop better policies as opposed to a database that can go
20 after specific compliance issues where I gotcha on this
21 particular physician or something. So I think it's more of
22 a filter or a screening to determine where we ought to

1 direct our attention versus the database where we're going
2 to find the bad actors. I think that should be done in a
3 different way.

4 MS. BEHROOZI: To quote Mark, "I'm really
5 excited." The ball is really rolling here.

6 MR. EBELER: You said that too enthusiastically.

7 MS. BEHROOZI: I'm sorry, I tried.

8 I think you're right that time is of the essence
9 because so much is happening around this now. Because the
10 more evidence that comes out -- no, the more data that comes
11 out, rather, the more you can link it to evidence of -- not
12 in all cases by any means. But in cases where it ought not
13 to happen that there is improper influence of prescribing
14 patterns or treatment patterns or whatever.

15 Existing, as I do, in an environment where we are
16 required to pretty much report everything, we just are used
17 to it. You just report everything. You take that side of
18 your general ledger or whatever, all the payments out, and
19 you report them everywhere you're supposed to report them
20 and let other people do with them what they may. And
21 unfortunately, given some people's feelings about the labor
22 movement, they don't do very nice things with it but we've

1 been living with that for a long time. And it has created
2 some good things for the labor movement.

3 So whether it's something that might be
4 characterized frankly by the industry -- I'm sorry, I'm
5 violating the rule and responding. So there's so many
6 points.

7 Just in terms of broad reporting, there may be
8 cases in which the industry or the recipients would say this
9 is a good thing. We appreciate that Pfizer is supporting
10 the School of Public Health. Pfizer wants to advertise that
11 it's supporting the School of Public Health. But it's done
12 in a very random individual sort of spun way rather than all
13 of it being accessible in one place, not only reported by
14 publicly accessible. And I think it's a very important part
15 of all of the recommendations, that all of the information
16 be publicly accessible and in an easy format. It's not that
17 hard to do anymore on the Internet. Definitely, in terms of
18 the trade secrets exemption that can swallow the rule, that
19 clearly seems the wrong way to go.

20 In terms of clinical trials -- I don't know, this
21 might be a dumb suggestion -- not only in terms of timing
22 but is it worth it to just report the fact that a company is

1 paying somebody to do a clinical trial without identifying
2 the substance of the trial, at least up to that point where
3 the substance of it needs to be reported elsewhere. Because
4 then that gives other people an incentive to say hey, hasn't
5 two past? Or shouldn't it be in phase II by now, to seek
6 the underlying information about it.

7 On the question, though, of samples. Having said
8 kind of the same things I've been saying before, supporting
9 the broadest kind of disclosure, in terms of the value of
10 the information for drug companies to report every sample
11 they give to every individual doc, if we're concerned about
12 the influence on prescribing patterns, it's a different kind
13 of influence than giving somebody, for example, baseball
14 tickets or paying them a third as much again as their salary
15 to make them feel good about a particular drug company or
16 look at that drug company through a certain lens.

17 Jay, I think you said it that patients also like
18 the idea of free samples. If you list all the docs getting
19 free samples from certain drug companies, that might drive
20 business their way because want to go there to get those
21 free samples.

22 It's not quite -- it seems to me, in the same

1 nature as the other kinds of influence. And I wonder what
2 information would be of the most value. Maybe reporting
3 that geographically or something like that. It's almost
4 more like direct to consumer advertising where maybe a
5 market is influenced. Although if people have looked at it
6 and found that it's useful to report it on a physician level
7 basis I'm certainly not against it. But I just wonder if
8 it's worth thinking about whether it's different.

9 DR. REISCHAUER: I think this work is moving
10 forward very well and I agree with lots of the comments, as
11 will be obvious. I'm for broad inclusiveness in this, in
12 general. I wonder if we need something about journals,
13 newsletters, et cetera, that food group.

14 I'm not that much in favor of letting them
15 withhold information that's deemed by them to be
16 proprietary. That strikes me as a loophole which you could
17 drive an aircraft carrier through. And better to be
18 nonspecific about what the purpose of the grant was then to
19 not disclose it for a few years. So I would come out there.

20 I'm with Bill on the threshold. I would be for an
21 annual amount and it would be fairly high, \$100, \$200 even.
22 And I would make sure it was indexed because these things

1 have a way of getting to be totally irrelevant after a few
2 years.

3 But I think we demean lots of professions to think
4 that they're going to be influenced by a hamburger and a
5 free pen.

6 I wasn't clear, are we making the receiver and the
7 giver both provide the information?

8 MR. WINTER: Just the provider, just the
9 manufacturer in the case of the drug and device
10 manufacturers.

11 DR. REISCHAUER: With respect to the free samples,
12 the world is changing now and more people are under
13 formularies. And the importance of this -- and there's more
14 of the PDP calling back and saying I'd like to substitute
15 this for that. And so I think some of the concern about
16 this, which I think was serious and very legitimate a decade
17 ago, is less serious now. And we should weigh that because
18 there are advantages, as others pointed out, to not having
19 to report the free samples.

20 With respect to preempting state law, Bill I think
21 is right. But I also wouldn't worry tremendously about this
22 because my guess is the states will get out of this business

1 if there is an adequate Federal law and there will be a lot
2 of pressure from provider groups and from giver groups to
3 say look, the Federal law is enough. So I wouldn't waste a
4 lot of time worrying about which way we came out on that
5 one.

6 DR. MILSTEIN: I also agree with this being a
7 useful area of policy development and there have already
8 been a number of comments on what are some of the key
9 planning variables that you want to take into account. I
10 agree with most of the comments. A couple of others that I
11 would like to throw into the mix, not because I know in
12 advance that they are feasible but just because I think it
13 would be valuable to have staff look into the feasibility of
14 it and give us some feedback, would be opportunities to
15 increase the specificity of what's disclosed.

16 What I refer to as -- for some of these categories
17 it might be more informative not only to disclose that
18 certain financial interests are at stake, but that relative
19 to peers in the same community there's disproportionate use
20 of a facility in which one has a financial interest. I
21 think that might be a little bit more specific to what it is
22 that we are trying to capture and induce provider reflection

1 on.

2 And then the second variable that I think would be
3 -- at least I would value some staff feedback on feasibility
4 -- is the variable of salience of what is disclosed to
5 beneficiaries for whom these services are being ordered.
6 For example, I think if I were a Medicare beneficiary about
7 to have a nonemergency hip replacement I would like to know
8 without having to go to the Internet if I was not Internet
9 savvy as to whether or not the proposed artificial joint
10 that was being prescribed for me was one in which the
11 surgeon had a financial beneficial interest in. So that
12 would be another dimension in terms of recommendation. If
13 you could explore the feasibility of it I think I would at
14 least find it very valuable.

15 DR. BORMAN: This is really nice work and I think
16 it really has crystallized the questions. I may wander down
17 a slightly different path than many of your all's
18 commentaries I think, however. First, let me say on a
19 personal basis, I think total transparency, complete
20 disclosure, how can we be against that? I think maybe we
21 need to look at this -- and Nancy brought up a little bit,
22 what's our goal and where are we trying to get to?

1 Frankly, I think the biggest thing that can come
2 out of this is affecting people at the margin. There's
3 three groups of folks here. There's people who aren't
4 creating issues in the way that they do this. Whatever
5 conflicts or potential conflicts they have, they're managing
6 them appropriately. And that's the kind of professionalism
7 that we hope would be 100 percent and that we're all
8 saddened to say may not be 100 percent.

9 For that group of people, we want to make this not
10 difficult to them. We don't want to make life harder for
11 them. And I think that's really important here because we
12 can get wrapped around the axle on a lot of details here. I
13 think we want to keep in mind that there's a large volume of
14 people here that are behaving appropriately and the first
15 thing we want to do is do no harm.

16 There's a group of people who are doing very bad
17 things. Hopefully, a very small group, but a group of folks
18 who are doing very bad things. They are very creative
19 people. The six shell corporations, I'm not sure I could
20 have articulated but they're very bad people. And I'm not
21 sure that we can come up with a sequence of recommendations
22 or things that clearly will capture all those people. We

1 may need to expose them to the light of day best that we can
2 and then figure out what to do about them.

3 Then there's people in the margin that maybe are
4 skating on some thin ice, that maybe are doing some things
5 that maybe they haven't totally thought through and that
6 when forced to or when somebody reports here's this
7 relationship, the sum total of that will cause them to stop
8 back. Just the sheer publicity that has surrounded this in
9 both professional and lay press may, in fact, be modifying
10 some behavior. And that's probably where this process can
11 have some impact.

12 But I would worry very much about our ability to
13 hurt the great majority of people and companies and things
14 that are doing good. The suggestion or the example that
15 Nancy offered about CME sponsorship. I personally encounter
16 in a number of organizations in which I'm involved the
17 increasing difficulty of getting support for good reasons.
18 The bureaucracy to get through at a given company to get
19 \$1,000 to support residents getting a text, a trip to a
20 simulation center, or whatever, has become quite incredible.
21 And to some degree we are penalizing -- we are hurting some
22 things that maybe we'd like to support.

1 So I would just ask that let's try and make this
2 not too complicated and at least foster the ability of the
3 good to continue.

4 DR. DEAN: I think Karen probably characterized it
5 extremely well. Obviously, I totally support the direction
6 or the activity. But I think your characterization of it is
7 important. And we want not to lose sight of why are we
8 concerned about this in the first place, and that there is
9 some bad behavior out there. But hopefully it's limited to
10 a relatively small proportion of the profession and we need
11 to get to that rather than making it difficult for
12 everybody.

13 With that in mind, I think that argues for raising
14 the amount or the value of the relationship that we're going
15 to try and look at. So I agree with Bill and whoever else
16 has said it, that the \$25 level I think is way low.

17 Secondly, the samples issue is a complicated one
18 but my inclination would be not to include samples at this
19 time for a whole lot of different reasons, even though there
20 are lots of concerns about that. But for the most part,
21 physicians don't benefit from the availability of samples.
22 In fact, it may complicate our lives for some of us. So I

1 would tend to leave that out.

2 But it's a concern. There's a very interesting
3 article I've got in front of me that just came out in the
4 Annals of Internal Medicine that demonstrates the extent to
5 which some of these companies will go. This is an article
6 about how one manufacturer set up, ran, and completed a full
7 clinical trial of a new drug that was timed to be released -
8 - the clinical trial was designed to be released at the same
9 time the drug was released. And instead of involving just a
10 few researchers that would have been far and away the most
11 efficient and effective way to run the trial, they involved
12 several hundred community physicians and labeled them as
13 investigators. The whole purpose of the thing was to
14 introduce them to this new drug. The purpose was totally
15 withheld from the participants all the way around and only
16 came out in a subsequent lawsuit.

17 And even to go farther, the physician that ended
18 up as the lead author of the paper that appeared in the
19 Annals of Internal Medicine -- which is a highly respected
20 journal -- did not even participate in the trial and didn't
21 know anything about it until after it had been completed.
22 The company had written the paper and he was asked if he

1 would like to have his name put on it, which he did -- which
2 I think is highly questionable.

3 In any case, it's incredible how far these efforts
4 and how extensive some of these efforts of promotion are.
5 So anyway, whatever that's worth.

6 MR. EBELER: Ariel, in the paper you mentioned
7 some research that looks at the impact of some of these
8 relationships. And I think Karen has raised a good point.
9 There is different relationships here. You don't want to
10 affect the vast majority of folks who are doing the well-
11 intended thing.

12 But my understanding of the research over time is
13 that the relationships that do occur, the provision of
14 samples and everything else, does trigger at the margin
15 changes in behavior. Different prescribing practices, lower
16 use of generics and things like that.

17 MR. WINTER: Right, that's an accurate summary of
18 the research. These were studies that were been done in
19 1980s and 1990s so there's not been a lot of stuff done
20 since then. But there's a pretty comprehensive literature
21 review published in 2000 which found that interactions with
22 the industries associated with more rapid prescribing of

1 newer drugs, less prescribing of generics, and those sorts
2 of things.

3 MR. EBELER: There's no implication of that of
4 sort of a bad actor. It's just over the course of time
5 people change -- at the margin change their behavior.

6 MR. WINTER: [Nodding affirmatively].

7 MR. HACKBARTH: Let me make a few quick comments
8 on the discussion to this point. Almost all commissioners
9 have spoken and clearly there is enthusiasm for taking up
10 this issue.

11 There are so many questions here that were laid
12 out in the presentation. We sort of jumped around, as Peter
13 pointed out. Different people have taken up different
14 questions. So it's a little bit difficult to make too much
15 of that piece of it. I do hear a theme, at least among some
16 commissioners -- and I share this so I'm highlighting it --
17 about carefully weighing the risks and benefits of this. I,
18 too, think transparency is a good thing. But even good
19 things can have unintended consequences. And so I think as
20 we go through the individual issues and subsequent
21 conversations, we do need to take due care that we structure
22 things so that we try to minimize, at least, unintended

1 consequences.

2 I expect the next step here is to sort of
3 systematically march through the issues that you laid out in
4 your overview presentation and we'll do that at the next
5 meeting. I'm not prepared, at least, to try to summarize
6 where we are on any of those at this point in time.

7 I have for people who wanted to make a second
8 comment and then we will be out of time. And I'd ask those
9 four to please keep it brief because we're already about
10 five minutes over. I have Mike, Jay, Ron and Mitra.

11 DR. CHERNEW: I would just encourage some thought
12 to thinking about which activities should be disclosed by
13 whom. So in some cases, like ownership of a hospital or
14 something like that, it strikes me that that should be
15 disclosed by the physician. And the threshold should be --
16 maybe it's just the warm glow of us filling out these
17 sheets. It should be a threshold based on is it significant
18 in terms of your income, not significant in terms of the
19 percent ownership of some facility that you have.

20 Whereas other things, the trial story, for
21 example. That strikes me that you could have never expected
22 the individual physicians to deal with. They didn't know

1 one way or another. So that has to fall in a different
2 organization.

3 So I just think there needs to be some nuances to
4 the different activities that are going on and what
5 organization or individual needs to disclose them and what
6 makes sense to them.

7 DR. CROSSON: Just to return for a brief moment to
8 the sampling question, because I reflected, Ariel, after
9 your comment about what, in fact, I had heard. And I
10 believe I misspoke when I said I thought that California
11 required reporting. I think what I was actually told was
12 that the pharmaceutical companies were required to account
13 for the provision of drugs, including samples, when they
14 were provided to physicians.

15 So it might be -- in assessing the impact it might
16 be useful if you can to check on that also, whether that is
17 either an internal issue for the companies or, in some
18 cases, a state requirement, accounting and not reporting.
19 Because obviously if the accounting is going on then the
20 reporting becomes much simpler.

21 DR. CASTELLANOS: Again, when it comes to time
22 limits I don't think we can drill down on anything

1 significant. I think we'll all have the opportunities later
2 on to drill down.

3 Just three things, and really what Tom and Karen
4 has said, you don't want to throw the baby out with the
5 bathwater. And Karen's point about doing no harm is really
6 important.

7 The only other question, and maybe it's throwing
8 something into the mix that we don't want to do, but last
9 year when we discussed this we talked about direct to
10 consumer advertising. I noticed there was an absence of
11 this. Is this something we don't want to deal with with
12 this topic? I know we dealt with it last year with this
13 topic.

14 DR. MARK MILLER: There was no intent to leave it
15 out. We are trying to structure kind of a transparency
16 policy here on the physician ownership and then the drugs
17 and devices. And we just hadn't kind of got our arms around
18 -- you know, this is kind of a divide it into. So we
19 haven't said that DTC is off the table. But we felt like we
20 could kind of head towards recommendations on disclosure
21 policies here in sort of a coherent way and DTC is coming up
22 later.

1 MS. BEHROOZI: I guess it's in response to a
2 number of people who have talked about not throwing the baby
3 out with the bath water or doing harm. It's not all about
4 gotcha. It's not all about pointing out the bad people
5 doing the bad things or even some people in the middle who
6 might not realize they're doing bad things. One of the
7 purposes -- I was actually trying to find it in the slides -
8 - is just for researchers to examine the impact of payments.
9 Maybe it's something that explains a lot of this geographic
10 variation that we're looking at and leads MedPAC or any
11 other agency to come up with policy recommendations that
12 aren't about saying these physicians are doing bad things or
13 these medical schools or whatever are doing bad things.

14 But there's restrictions on advertising for
15 whatever, alcohol and things like that, for those reasons.
16 Maybe there are other policy things that we would do in
17 connection with influence that we see through these patterns
18 of payments.

19 I think that selectivity in deciding what needs to
20 be reported, the more selectivity not only makes it more
21 burdensome and confusing and eludable, but also enhances the
22 notion that these are the bad things. These are the shady

1 things. And the more you make it across the board, the less
2 it is about targeting anyone as a bad actor and makes it
3 easier to comply with.

4 MR. HACKBARTH: All right, thank you. We look
5 forward to more on this.

6 Our last session for today, or at least before the
7 public comment period, is on beneficiary-centered
8 assignment. This is under the Part D low-income subsidy.
9 We have a guest, a familiar guest. Welcome, Jack.

10 DR. SOKOLOVSKY: Before I introduce somebody who
11 needs no introduction, let me just set the context for this
12 work. As I'm sure most of you know, when the Medicare drug
13 benefit was implemented in 2006 Medicaid beneficiaries who
14 were dually eligible for Medicaid and Medicare switched
15 getting their drug benefits from Medicaid to Medicare. And
16 those beneficiaries who did not choose a plan of their own
17 were randomly assigned to plans that met a low income
18 threshold in each region.

19 In subsequent years, many beneficiaries have been
20 reassigned to plans when the plans that they were already
21 in, when the premiums in that plan no longer fell at or
22 below that regional threshold.

1 In earlier years, and I believe it was Nancy who
2 first started this line of research, she suggested that
3 maybe randomly assigning people on the basis of their
4 premium was perhaps not the best way to go for the
5 beneficiary and also for the government. And so in our
6 first attempt at looking at this, we looked at the
7 feasibility of assigning beneficiaries to plans that best
8 covered the drugs that they were already taking so that
9 although they would be reassigned, the disruption would be
10 less. And we also looked to see whether, in fact, it made
11 any difference.

12 We found that it was feasible, that some states
13 were doing it. And we also found that on a drug by drug
14 basis there was a considerable range of costs for particular
15 drugs. And so many of you said well, but these
16 beneficiaries don't take one drug. What happens when you
17 look at the whole regimen of drugs that they're taking?
18 Does this disparity continue? Or is it kind of washed out,
19 one drug is cheaper in one plan but another drug is cheaper
20 in another plan?

21 So our team of researchers from Georgetown
22 University and NORC at the University of Chicago have looked

1 at this issue and Jack is going to present the results here.

2 DR. HOADLEY: Thank you, Joan. I'm glad to be
3 back here again to talk about this issue.

4 Joan has mentioned the basic situation that this
5 is in, which is what I've got on the first slide here. I
6 just really will make two points on this. One is that in
7 the very first year of the benefit there were certain
8 reasons why CMS particularly was interested in doing random
9 assignment. They wanted to avoid steering beneficiaries
10 into any particular plan. And they also thought that random
11 assignment would have some value in stabilizing the market
12 because all of the qualifying plans would be guaranteed a
13 certain share of beneficiaries in that first year.

14 The other point I want to make is that it sort of
15 feels like if you don't know all of the specifics about how
16 this goes on, why is this an issue on an ongoing basis?
17 There are not that many new beneficiaries in any given year.
18 But as John mentioned, as plans come and go from meeting the
19 threshold for qualifying for the assignment of low-income
20 beneficiaries and beneficiaries not having to pay a premium,
21 there can be quite a few beneficiaries who need to go into a
22 new plan in order to maintain that status. In fact, 2

1 million, roughly, had to be reassigned for 2008. So this
2 does become an ongoing issue and there are new rules going
3 into effect for next year that further change how this is
4 done.

5 As Joan mentioned, our previous report did look at
6 this, was a limited look looking at one drug at a time. In
7 the process of that, we defined this concept of beneficiary-
8 centered assignment as any kind of method of trying to
9 assign beneficiaries to a plan that provides, in some sense,
10 a good match with the current drugs they use. I will talk
11 about a couple of specific ways of implementing that in a
12 minute.

13 Our previous study did show that it appeared that
14 you could design a system of beneficiary assignment to
15 reduce the out-of-pocket costs that beneficiaries pay,
16 potentially to reduce the need they have to use drugs or for
17 their current drugs anyway to be off formulary or to have
18 utilization management requirements. We thought possibly
19 you could design beneficiary-centered assignment to at least
20 avoid adding Federal program cost if not potentially to
21 save.

22 So as Joan said, we wanted to go forward and try

1 and talk about this in a broader way instead of looking at
2 one drug at a time, to really look at what a real person
3 would look like. So our key questions were do the results
4 change when considering larger portfolios of drugs? Do the
5 results change when considering all of the costs, premiums,
6 deductibles, and copays? Previously we just looked at the
7 co-pays for particular drugs. What benefit of beneficiary
8 assignment might work best when you take into account both
9 beneficiary and government costs? How do the costs for both
10 the beneficiary and the government compare to what we're
11 doing now under random assignment?

12 And finally, what would happen if you allowed
13 beneficiaries to be assigned to enhanced plans? I will talk
14 more about that near the end, but basically the kinds of
15 plans that have some benefits beyond the basic benefit.

16 I won't say much here about the methodology. I
17 can respond to questions on it. But basically we looked at
18 five regions. We're looking at 2008 plan structures and
19 specific cost of those plans in 2008. We created 10 sample
20 beneficiaries using 2004 MCBS data. Our idea was we wanted
21 some people with some complexity. So in the end we wanted
22 people who qualified for the low-income subsidy and we ended

1 up with all 10 of our sample folks using at least four
2 drugs. So it's important to emphasize they're not
3 representative because obviously there are a lot of
4 beneficiaries who don't use that many drugs. But the whole
5 point was to show what happens when you have more
6 complicated patients.

7 The first answer really is that yes, plan
8 assignment does matter. If you look here at our 10
9 beneficiaries and you look at Jason down on the bottom, for
10 him it doesn't matter that much. His out-of-pocket costs
11 are only \$3 different whether he's in any of the 12 plans in
12 the New York region. The government's costs are
13 equivalently not very different. There's \$130 or so
14 difference.

15 But for most of the other beneficiaries the
16 differences are more extreme. The two I've highlighted in
17 red -- although it looks orange up there -- show you really
18 the most extreme variation. So for Betty, her costs can
19 vary from just under \$200 to over \$3,000 out of pocket cost
20 depending on which plan she's assigned to. And again
21 assuming she continues to use her current drugs.

22 Ellen, similarly even worse, \$160 to over \$6,000

1 in costs. You can look at the government side of this, you
2 see similar contrast for what the government is picking up,
3 depending on the cost.

4 What drives these differences? The major factor
5 is what drugs are off formulary for a particular plan. So
6 as soon as the drug goes off formulary -- again for the
7 moment assuming the person continues to take that drug --
8 they then are responsible for the entire cost of paying for
9 that drug. The government does not pick up the cost of an
10 off-formulary drug. So basically the government does better
11 when there are more drugs off formulary for a particular
12 plan assignment and the beneficiary does worse.

13 What can the beneficiary do? Of course, there are
14 options. They can substitute a different drug with the help
15 with their physician. In many cases that may totally
16 appropriate. In some cases, that may not be clinically
17 appropriate.

18 They can request an exception. That's not always
19 an easy step. We've heard in focus groups that it doesn't
20 happen very often and neither physicians nor beneficiaries
21 tend to like to do that.

22 They can pay the full cost out of pocket with no

1 government subsidy if they can afford to do so.

2 They can simply skip taking the drug with whatever
3 consequences. For some drugs that may be minor. For some
4 it may be serious.

5 Or they can take advantage of their options that
6 other beneficiaries don't have of switching plans, even in
7 the middle of the year.

8 I would also note that plan premiums really
9 weren't what's driving the difference. It really is the
10 cost of the drugs and the off-formulary drugs. Premiums are
11 a small factor but not a very significant one.

12 So our goal in looking at some different ways to
13 implement beneficiary assignment is to see if we can reduce
14 the beneficiaries' cost, as well as the hassle that they
15 face if they have current drugs that are not on formulary
16 and they need to either consider switches or exceptions
17 while trying to keep the government's costs as low as
18 possible. So we devised three rules by which we can to
19 beneficiary assignment.

20 The first one is the simplest, find the plan that
21 has the lowest cost for the beneficiary under the LIS rule.
22 That's basically what the beneficiary would be doing if they

1 used the plan finder and picked a plan using the plan
2 finder.

3 But as you will see, there are some reasons why
4 these may not turn out to be the best ways to do it. So we
5 tried a couple of alternatives. Rule two simply tries to
6 minimize the number of drugs that are off formulary since
7 that is the biggest driving factor in figuring out where
8 plans become more expensive.

9 Rule three then is trying to minimize the total
10 cost paid by the beneficiary or paid on behalf of the
11 beneficiary, regardless of whether it's a beneficiary cost
12 or a cost that the government is picking up for it. This is
13 really like the plan that the beneficiary, if they weren't
14 subsidized, would be picking using the plan fighter. We
15 thought maybe that was the cheapest overall and perhaps that
16 would be the best balance of minimizing costs for
17 beneficiary and for government.

18 So what happens? Here we picked one of our
19 beneficiaries, and this is Ellen who -- as you remember from
20 the other graph -- was one of the more expensive ones. She
21 uses a lot of different drugs. I think she uses about eight
22 or nine drugs total. You can see that like the first

1 example, her costs can vary quite a bit from a little over
2 \$1,000 to over \$6,000 across these nine plans.

3 We sort of used the median total beneficiary cost
4 as our way of replicating a random selection. So randomly
5 she gets put in plan G. But that means her costs were
6 \$3,000, the government's costs were \$3,500. And you can see
7 there that there are some potentially better choices for
8 both her and the government, thought of together.

9 But as you also see there, it's kind of hard to
10 figure out if you just looked at this and said what's the
11 best balance to put her in, it's not obvious.

12 You will see here that under the three different
13 rules we get three different assignments for Ellen. Rule
14 one, which puts her in plan D, puts her in the plan that has
15 her very lowest costs but you could increase her costs just
16 a little bit under rule three by about \$60 and lower the
17 government's costs by about, \$6. Is that a trade-off we
18 would be willing to take as a policy option? Under rule
19 two, which has the fewest drugs off formulary in this case,
20 it doesn't seem to do very well because it adds \$1,100 to
21 her costs while essentially not changing the government
22 costs.

1 Of course, this is one person's example and
2 everyone looks different. But you can see from this the
3 complexity of trying to balance off different aspects of
4 government and beneficiary costs.

5 So here we take our 10 beneficiaries in our five
6 regions and simply average across them. Again, I want to
7 emphasize this is not intended to be representative or what
8 this would look like in the scoring, because if you were
9 scoring this you would have to look at the real distribution
10 of beneficiaries and lots of other things like that.

11 But what this does illustrate at least is the
12 potential for how you can improve things. So on the left
13 hand is the random assignment -- again we used a proxy of
14 median spending. In this case, because we wanted to
15 actually put somebody in a real plan rather than use some
16 kind of calculation here. But all of the rules, one, two
17 and three, did better for the beneficiary than the random
18 assignment by quite a bit. It was almost \$700 cost for the
19 beneficiary in the random assignment on average across our
20 10 beneficiaries in five regions. But between \$200 under
21 rules one and two and then as much as \$400 under rule three.

22 So the beneficiary does better with each of these

1 rules but does the best, by definition, under the plan that
2 minimizes beneficiary cost. Rule two tends to add about \$41
3 on average for the beneficiary in order to obtain \$150
4 savings for the government. Is it a good trade off to make?
5 Are we willing to add a bit of extra cost to the beneficiary
6 to make the government's costs come down? That's a policy
7 option.

8 Rule three does bring the government's cost down
9 further but starts to put the beneficiary's increased costs
10 up to the point that it's going to be a little bit more
11 noticeable. It goes up almost \$200 from rule one. So in my
12 mind, at least, that's a harder option to take but again
13 it's another potential trade-off.

14 So what happens if you were to allow this
15 additional option of enhanced plans? Again, remember that
16 an enhanced plan is one that starts from the basic benefit
17 and adds something to it, whether it's gap coverage, what
18 it's taking away the deductible, whether it's lowering the
19 copays but something that adds some value. And so any
20 beneficiary who is making the choice for themselves without
21 being a subsidized beneficiary may pick an enhanced plan
22 because for their particular situation the extra premium is

1 worth it to acquire the extra value.

2 So we wanted to see if that could be true. And we
3 restricted this because again part of the whole system of
4 low-income benchmarks is to give plans some incentive to
5 keep their premiums low. So we said we're only going to
6 pick enhanced plans that have their premium for the basic
7 portion of their benefit below the benchmark. But we would
8 allow the government to buy the enhanced plan, paying the
9 extra premium, if it turned out that that created some
10 savings for both the beneficiary and the government.

11 On this averaging across again our 10
12 beneficiaries in five regions, it seems to do that. So
13 under rule one, if you add in the enhanced plans, you get
14 about a \$50 or \$60 savings for the beneficiary and a bit of
15 savings -- about \$30 or \$40 just for the government. But
16 both entities create some savings.

17 Under rule two it's similar, about \$30 savings for
18 the beneficiary and a little over \$100 savings on average
19 for the government. Again, this would have to be tested
20 with a wider range and a real scoring but it does suggest at
21 least the possibility that allowing the government to buy
22 into some of the enhanced plans, getting that extra enhanced

1 value that those plans come with could end up saving both
2 the beneficiary and the government some money.

3 So concluding this, we do see that beneficiaries
4 seem to gain access to some or all of their currently used
5 drugs with less hassle and lower cost using beneficiary
6 assignment as opposed to what they're getting through random
7 assignment where they've got the possibility of ending up in
8 a plan that's good for them but they have the possibility of
9 ending up in a plan that's really very much a poor risk for
10 them. The government might experience at most a small cost
11 increase compared to random assignment. Again, that needs
12 to be further tested in a full scoring sense.

13 We also took note, in comparing the regions,
14 although I didn't present this detail, that in the regions
15 with fewer qualifying plans you often had a bigger swing.
16 And so there was the potential for even more value there.
17 And as benchmarks and potentially a shrinking of the market,
18 this could be a more common situation. So at least the data
19 suggest that despite possibly a little bit of extra
20 government cost beneficiaries assignment could become a
21 rational approach to improve access and reduce cost and that
22 uncertainty for low-income beneficiaries.

1 And then what we'd need to know from here to
2 further understand this, there are certain things we can't
3 get by just doing these kind of simulations off of sample
4 beneficiaries. And eventually, as drug claims really are
5 available to folks, and possibly with some other data, we
6 would like to be able to answer questions such as what do
7 beneficiaries really do when they hit an off-formulary drug?
8 Do they, in fact, switch to a different drug? Do they
9 request exceptions? Do they pay out of pocket? Are any
10 low-income folks really paying those extra costs out of
11 pocket? We certainly think some non-low-income people do
12 with people with limited resources may not. Do they stop
13 taking the drug? There's certainly some reason to suspect
14 that that may be happening. And how often do they, in fact,
15 switch plans? Are they already assigning themselves to a
16 more suitable plan on their own without the help of an
17 assignment program?

18 With that, I'll take any questions.

19 DR. STUART: I have a question and an observation
20 and a comment. Let me start with the observation first.
21 This market in which plans are competing with each other
22 based upon what they can offer to beneficiaries is driven,

1 in large part, by the assumption of formulary compliance.
2 And by that I mean if the plan is going to get the best
3 price from the drug company for having their particular
4 product on the formulary, they are only going to be able to
5 do that if they can, in some way, enforce utilization of
6 that drug.

7 Now enforce is not a legal term here, it's an
8 economic term. So I think you want to think about how the
9 market works when you think about the implications for the
10 research that you're involved in here.

11 Now the second thing, and this is an observation
12 as well, it seems clear for this population that switching
13 to a covered drug, if they stay in that particular plan, is
14 more than likely to be the action that's taken here,
15 particularly when you're dealing with the numbers of the
16 magnitude that you're looking at here. People who are on
17 LIS are not going to be paying \$6,000, so they really are
18 forced to switch and to stay on the formulary drug, as long
19 as they are the ones that have to pay it, which is my third
20 point.

21 And I don't know how this works. I know that Medicaid
22 and State Pharmacy Assistance Programs under certain

1 circumstances can cover drugs that are not covered under the
2 Part D plans, and I'm not sure how this actually works in
3 practice now. But to the extent that a low income
4 beneficiary who was Medicaid eligible lived in a state that
5 would provide some kind of wraparound coverage then it might
6 be Medicaid or the state assistance program that actually is
7 the one that was bearing the economic burden if the
8 individual doesn't switch to a covered product.

9 DR. HOADLEY: My understanding is in the case of
10 Medicaid few states are picking up off-formulary drugs as
11 part of their Medicaid. They may be picking up some of the
12 excluded drugs, the benzodiazepine barbiturates, that Part D
13 simply doesn't cover at all although they will start in a
14 few years.

15 The State Pharmacy Assistance Programs, however,
16 in some cases -- and of course, they only exist in a subset
17 of states -- some of them would be helping to pick up off-
18 formulary drugs. So certainly that's an additional
19 complexity that's going on in those kinds of things.

20 I think your general point about where the
21 incentives are when they're off-formulary it seems like
22 you're probably right, and most people are getting

1 themselves switched or doing without. Embedded within this
2 is also some cost differences having to do with high-tier
3 and low-tier drugs where the low-income person gets no
4 financial difference. They're paying the same, for any
5 branded drug, paying the same copay and the government is
6 picking up the difference. So that's a part of it, although
7 it's the off-formulary drugs that our data suggest is really
8 what's driving these kinds of larger differences.

9 DR. CHERNEW: That was really fascinating and an
10 area close to my heart. I had a few loose questions that
11 may end up being research things.

12 The first one is I have mixed feelings about this
13 based on whether I think the formulary restrictions are good
14 or bad. I spend a lot of time awake at night worrying that
15 the person is not going to take the medication and won't
16 switch and it will be a medication that's really important.
17 And I really would like it to be the case that if there was
18 a medication that was really inefficient, that you could get
19 the person to switch to the much more efficient medication
20 and it's very hard to tell which is true.

21 So understanding something about the clinical
22 nuance of what types of drugs these are and what the likely

1 outcomes would be is fundamental to understanding whether
2 this is good or bad because I wouldn't want to get into a
3 situation where we were assigning people to drugs that
4 allowed them to continue inefficient and perhaps harmful
5 drug consuming behaviors. But I also wouldn't want to
6 assign them to a plan which because of its structure
7 discouraged them from taking clinically appropriate
8 potentially life-saving medications. And those two things
9 both might be going on here and that matters a lot.

10 The second point I want to make relates to this
11 enhanced plan thing. When the beneficiary and the
12 government benefits I think what has to happen there loosely
13 is the plan pays more. And so I think that's sort of
14 inducing some sort of adverse selection. So I can't imagine
15 that if you had that deliberative assignment of people that
16 were taking drugs that the plan was covering well and you
17 put them into certain plans that that wouldn't induce a
18 change in what the plans did. And so I think this is in the
19 spirit of what Bruce said, but I don't think you can take
20 sort of the plan response.

21 Some of the this I think takes what the plan did
22 is set and then says that conditional on what the plan did

1 how do we put people around? But I think if you started
2 moving people around with different conditions
3 systematically based on where the drugs were, you would see
4 the plans themselves changing their premium or their
5 coverage or something. And I think that would matter.

6 All of that said, I do think that as you go
7 forward some deliberative thought as to how one might do
8 this would likely get us a better outcome than random
9 assignment but it's not completely clear to me yet how.

10 DR. HOADLEY: Two quick comments on that. One on
11 the second point, yes, it definitely does create a kind of
12 adverse selection. But of course, the plan finder for
13 everybody who is picking plans is fundamentally doing that.
14 And we've seen that with the very rapid rise and fall of the
15 enhanced plans that provided full gap coverage. It was
16 selected into them exactly the people that needed them and
17 they were more expensive and plans stopped doing that.

18 On the first question, we've tried to think about
19 could you go in and make adjustments to the assignment based
20 on more substitutable drugs, trying to optimize. But the
21 idea that you could do this in some kind of systematic way
22 for beneficiaries in an open season kind of framework is

1 kind of mind-boggling, that you could somehow put in
2 clinical factors.

3 But we did see certainly, and there's examples in
4 the full report, underneath some of the cases where you see
5 okay, in one case it's a PPI and most clinicians would agree
6 that substituting amongst different PPIs is quite readily
7 doable. In other cases, the drugs in question were drugs
8 where it wasn't so clear that a substitution could easily be
9 done. So you can certainly see the instances of those kinds
10 of cases. But sort of figuring out on a policy basis what
11 to do with that, that's the hard part.

12 DR. REISCHAUER: All economists think alike.
13 Bruce made one of the points and Mike made the other. I'll
14 just put a footnote on his second point, which is what's
15 best for the beneficiary is worse for the plan. And if
16 plans set their premiums based on a certain amount of
17 irrational behavior that everybody isn't using plan finder,
18 what you might get is a situation where Jack assigns
19 everybody to the best plan for the beneficiary, the plan
20 then loses money in that year, has to jack up its premiums
21 the next year, which puts it above the benchmark, which
22 means you then have a whole bunch of people you have to

1 assign in the following year. So you're sort of maximizing
2 turmoil while minimizing yearly costs for the beneficiary.

3 DR. HOADLEY: I think that could very well turn
4 out to be a scenario.

5 MR. HACKBARTH: I think the other implication of
6 this is GAO only needs to appoint one economist to the
7 Commission.

8 [Laughter.]

9 MR. BUTLER: We're going to talk about the Part D
10 work plan tomorrow, so I'll try to limit it to this
11 discussion. But of all of the things we've talked about
12 today, I think the number and mix of drugs an elderly takes
13 has as much to do with the costs of health care ultimately
14 as almost anything that is occurring, both positively and
15 negatively.

16 And so when I look at this and I look at the
17 impact of that drug costs, per se, to the individual or to
18 the government it is a very interesting exercise. But the
19 compliance to the appropriate mix and range of drugs, if
20 taken or not taken, I bet you the cost or cost savings
21 associated with that probably would trump these numbers
22 wildly, is my guess. I'm not an economist.

1 So my point would be your question is related to
2 the compliance and what happens in the behavior of the
3 beneficiaries in their use of the drugs is probably the more
4 important research question then simply are we going to get
5 them into the cheapest best options in the short run.

6 DR. MILSTEIN: This is very useful, but whenever I
7 see an analysis in which the economic unit is anything less
8 than total cost of care, I'm concerned. And so I wondered,
9 are there any state Medicaid programs that in their
10 supplement to Medicare capture the Medicare claims
11 experience in enough detail such that it would be possible
12 to assess the impact of these patients who were
13 involuntarily switched on a broader range of outcome
14 variables than drug spending? For example, total cost of
15 care to both Medicare and the Medicaid program, and some
16 clinical parameters we might reasonably be concerned about
17 such as higher rates of ER use or hospital admission
18 associated with patients who were involuntarily reassigned.

19 I think it's extremely useful but not that easy to
20 interpret in terms of policy recommendations.

21 DR. HOADLEY: I think that's an excellent point.
22 And it's probably not so much as states might have the

1 data, because the states are really only facing the marginal
2 cost of the other services is really fundamentally a
3 Medicare question. And the opportunity once we see merged
4 Part D claims with Parts A and B claims will be to be able
5 to look at there adverse consequences? Are there new
6 hospitalizations? Are there reduced costs because of --

7 DR. MILSTEIN: I'm sorry, but do we really have to
8 wait? For example, if there's even one or two state
9 Medicaid plans that do capture reasonable Medicare claims
10 detail in their wraparound of Medicare, could we not mine
11 that database for starters? And I know that for example I
12 was a junior collaborator on some research in South Carolina
13 Medicaid. I can't answer whether or not drug coverage was
14 captured, but we got quite good detail on what Medicare
15 covered as a primary for dual eligibles from the Medicaid
16 data system in South Carolina.

17 DR. HOADLEY: The problem continues to be that
18 even the state can't look at what the drug use on the Part D
19 side is until these claims work their way out. So they're
20 not able to see what drugs people are taking right now under
21 Part D.

22 DR. MILSTEIN: But when they wrap around a Part D

1 plan --

2 DR. HOADLEY: Most states aren't doing a
3 wraparound for Part D. Even those that are, some of the
4 SPAPs, the State Pharmacy Assistance Programs, may be able
5 to see some of that for a subset of patients and that may be
6 one possibility, yes.

7 DR. CHERNEW: Arnie, I'm sorry to interrupt but
8 we're actually working with a long-term care pharmacy to do
9 this for -- some subsidy patients are in nursing homes. And
10 for the ones in nursing homes you can get the drug part from
11 the long-term care pharmacy. And then you can get the
12 utilization data separately. You don't get all of the other
13 data that's not coming from the long-term care pharmacy but
14 you can understand the answers to the health outcomes and
15 the hospitalization type things if you imputed a price. And
16 so we're dealing with the randomization in that project.

17 DR. CASTELLANOS: I'd love to give a real world
18 experience on what happens and I think Tom, you may want to
19 do it and Karen, you may want to ask that.

20 Do they request exceptions? Yes, the patient does
21 and the physician does. I look at this as an unfunded
22 mandate because I'm obligated morally to try to help the

1 patient. I can't tell you how much work that is for the
2 physician office and for myself and how many times I call 1-
3 800-busy and never be able to speak to somebody.

4 But it's a hassle, as Jack said. And it would be
5 nice if we could somehow smooth that exception process.

6 Quite honestly, if they're astute and healthy and
7 intelligent they look to switch plans. Most of the time
8 they do. But if they live in Southwest Florida where I live
9 they don't have that ability. They don't have family,
10 support. They have very few people to go to. So what do
11 they do? They stop taking the drug. It's not fair but
12 that's what happens. This is my real-world experience.

13 MR. HACKBARTH: Any other initial comments?

14 So what I've heard is sort of a series of
15 questions. At first glance this seems to make eminent good
16 sense. But then there's sort of what are the second order
17 effects? How is beneficiary behavior affected? How us
18 ultimately the total cost of care affected? How is plan
19 behavior affected? And all of those seem like reasonable
20 questions that you'd want to address before you start down
21 this path.

22 Any reactions to that, Jack? And how many of

1 these questions can we tackle short-term as opposed to long-
2 term?

3 DR. HOADLEY: I think that's the challenge, is
4 trying to sort through. I think some of the simple things
5 that we ought to be able to get a handle on, the claims
6 data, should start to become available within a couple of
7 months. Some simple questions are how many of these low-
8 income beneficiaries are, in fact, changing away from the
9 randomly assigned plan each year? Is it 1 percent? Is it
10 20 percent? We actually don't know that. Some of the real
11 basic bits of information, if it is more like 20 percent
12 then maybe the ones who are the worst mismatches are getting
13 that corrected. If it's a much smaller number, maybe that's
14 not happening.

15 Now that by itself won't tell us are the right
16 people switching, what are the kinds of circumstances. But
17 there are definitely some good questions to ask. My
18 personal view would be try to begin to move toward some of
19 this and you can further fine-tune through some of the
20 implications over time. Maybe in some cases what we can't
21 kind of look at here is if people are in a plan year one,
22 year two, they've reached a certain equilibrium with that

1 plan. They've gotten themselves switched over eventually to
2 the right drugs maybe for that plan's formulary -- this goes
3 to what Bruce and Michael were talking about and Bob.
4 They've made some adjustments, the economics has played out.
5 It may have taken a while to get there. Eventually they got
6 with their doctor to get either the exception or make a
7 switch.

8 And then, of course, that plan suddenly becomes
9 ineligible. Are there ways potentially to let the person
10 stay in that plan even though that plan is no longer
11 benchmarked? That raises some other questions. I think
12 there are some different kind of things you can think about.
13 But we are asking people potentially to really -- they've
14 made the moves, they've gotten adjusted to one plan. And
15 all of a sudden because of the way the rules work, they're
16 going to be switched and they've got to, at the very least,
17 go through all of that disruption.

18 DR. STUART: I'll keep this short. This study is
19 based on the presumption that the formulary is a given and
20 the people are kind of moving around, and how you can move
21 them around so that they fit their formulary right.

22 The other way that you might look at it is to say

1 is the formulary right? Current CMS policy is that there is
2 a safe harbor if the CMS rules regarding the formulary
3 development are followed.

4 Now that's also something that I think we should
5 take a look at, and maybe we can talk about that tomorrow,
6 because there really are two parts of this. First of all,
7 there really is a clinical issue associated with whether
8 drug A or Drug B should be on that formulary, depending upon
9 whether certain individuals would respond better to one or
10 respond better to the other. If there's good clinical
11 evidence that that's true, then maybe the current policy of
12 allowing the plan to make a decision to have just one of
13 those on the formulary is bad public policy.

14 The second way that one can get around this is
15 through this exceptions procedure. The way it is now my
16 understanding is that the plans have quite a bit of
17 flexibility in terms of how they handle this. There are
18 clearly some CMS rules in terms of they do it but it's
19 pretty easy to make it hard to get an exception. So that
20 would be the other way around, is instead of trying to
21 switch the beneficiary from one plan to another is to just
22 make that exceptions procedure work better if, in fact, the

1 switch shouldn't be made.

2 DR. CHERNEW: I was just going to give a number.
3 There is -- I think it's a Health Affairs study by someone
4 named Newman in 2007 that suggested that 11 percent of non-
5 institutionalized dual eligibles switched in 2006 to give --
6 so roughly 10 percent of the people. And the
7 institutionalized people have further protections because if
8 their drugs are off-formulary someone else has to eat the
9 cost. If you're in a nursing home --

10 DR. HOADLEY: If it's not in the formulary, no.
11 If there's a copay involved, they don't pay any copay. But
12 if it's non-formulary -- most likely what will happen is the
13 institution will get involved and they will either get the
14 exception or get the drug changed. But it's not that
15 somebody picks up the bill for the existing drug. That
16 person in the institution has more leverage, has more allies
17 as it were.

18 MR. HACKBARTH: Any last comments?

19 Thank you, Jack. Good to see you again.

20 And finally we will have a brief public comment
21 period.

22 Okay, we are done for today. We reconvene at 9:00

1 a.m. tomorrow. We do start with our expert panel so we will
2 want to get started on time.

3 [Whereupon, at 5:07 p.m., the meeting was
4 recessed, to reconvene at 9:00 a.m. on Friday, September 5,
5 2008.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, September 5, 2008
9:03 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, J.D., Chair
JACK C. EBELER, M.P.A., Vice Chair
MITRA BEHROOZI, J.D.
JOHN M. BERTKO, F.S.A., M.A.A.A.
KAREN R. BORMAN, M.D.
PETER W. BUTLER, M.H.S.A
RONALD D. CASTELLANOS, M.D.
MICHAEL CHERNEW, Ph.D.
FRANCIS J. CROSSON, M.D.
THOMAS M. DEAN, M.D.
NANCY M. KANE, D.B.A.
GEORGE N. MILLER, JR., M.H.S.A.
ARNOLD MILSTEIN, M.D., M.P.H.
ROBERT D. REISCHAUER, Ph.D.
WILLIAM J. SCANLON, Ph.D.
BRUCE STUART, Ph.D.

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

2 MR. HACKBARTH: Good morning everyone. We have
3 two sessions today. The first one is an expert panel on
4 imaging services and then the second is on Part D.

5 Ariel, will you introduce our guests?

6 DR. WINTER: Yes, thank you. Good morning.

7 Before we introduce this morning's expert panel on
8 imaging, I would like to briefly review the Commission's
9 work on this topic and recent legislation.

10 First, we recognize the impressive technological
11 progress in imaging, which has increased its importance for
12 diagnosis and treatment and expanded the availability of
13 imaging in freestanding centers and physician offices.
14 While imaging can lead to improved detection and treatments,
15 the rapid growth of imaging services within Medicare,
16 geographic differences in imaging use, and variations on the
17 quality of providers have all raised concerns about whether
18 imaging is sometimes used inappropriately.

19 Over the last several years, the Commission has
20 focused on improving both the quality and payment accuracy
21 for imaging services and I'll summarize this work over the
22 next few slides.

1 In our March 2005 report we recommended that
2 Medicare set quality standards for all providers who bill
3 the program for performing and interpreting diagnostic
4 imaging studies. In the MIPPA legislation the Congress
5 mandated accreditation for all providers who perform
6 advanced imaging. There are still no standards, however,
7 for physicians who interpret the studies.

8 We also said that CMS should improve Medicare's
9 coding edits to reduce unbundling of imaging services and
10 reduce the technical component payment for multiple imaging
11 services performed on contiguous body parts. The technical
12 component payment covers the cost of the equipment, non-
13 physician staff, and overhead. In 2006 CMS adopted the
14 second of these recommendations and it did so in a budget
15 way, that is there savings were redistributed to other
16 physician services.

17 Finally, we made two recommendations to modify the
18 physician self-referral law, also known as the Stark Law. I
19 won't spend time describing these but they are referenced on
20 the side and I would be happy to take questions on them
21 later.

22 We also spent time looking at how imaging services

1 are paid under the physician fee schedule and found that
2 payments for certain services may be inaccurate. We
3 determined that MRI and CT services may be overvalued
4 because CMS may be overstating the per service cost of
5 imaging equipment. We also found that CMS's method of
6 adjusting for geographic differences in input prices may
7 overpay for imaging services in the areas of high input
8 costs and under pay in areas with low input costs.

9 The Deficit Reduction Act of 2005 had two
10 provisions that reduced payment for many imaging services
11 beginning in 2007. In the first provision, Congress
12 mandated that savings from the multiple imaging procedure
13 payment reduction be returned to the Trust Fund. As I
14 mentioned a few minutes ago, when CMS adopted this policy
15 for 2006 the savings were redistributed among other
16 physician services in a budget neutral way.

17 In the second provision the physician fee schedule
18 rate for the technical component rates may not exceed the
19 hospital outpatient rate for the same service. In other
20 words, the outpatient rate acts as a cap on the physician
21 fee schedule rate. For example, the 2008 fee schedule rate
22 for MRI of the lumbar spine would have been \$488. But

1 because this is higher than outpatient rate of \$344, the fee
2 schedule rate is reduced to the outpatient rate.

3 CBO estimated that these provisions would save
4 about \$500 million in 2007. We estimate that this would be
5 about 5 percent of imaging spending on that year.

6 Now we'll switch gears and look at growth in the
7 use of imaging services relative to other physician
8 services. We're looking here at cumulative growth in the
9 volume and intensity of services per beneficiary from 2000
10 through 2006. Over this time period the use of imaging, as
11 indicated by the red line, increased almost twice as fast as
12 all physician services, as shown by the purple dotted line
13 in the middle. Imaging grew by 10 percent per year on
14 average between 2000 and 2005. This growth slowed to 6.2
15 percent between 2005 and 2006, as you can see from the bend
16 in the red line, but this is still much higher than the 3.6
17 percent increase in all physician services in that year.

18 We're looking for your guidance today in
19 developing our future policy agenda on imaging issues.
20 We've invited three experts to discuss their recent research
21 on key issues related to imaging use.

22 The first speaker will be Lawrence Casalino, an

1 Associate Professor in the Department of Health Studies at
2 the University of Chicago. He will present the results of a
3 report that examined the literature on physician self-
4 referral.

5 Next up will be Laurence Baker, Professor of
6 Health Research and Policy at Stanford University School of
7 Medicine. He will discuss his recent work on both physician
8 self-referral and geographic variations in imaging use.

9 The third speaker will be Bruce Steinwald who is
10 Director of the Health Care Team at GAO who will talk about
11 a recent GAO report on trends in Medicare spending on
12 imaging, the use of imaging in physician's offices, and
13 private sector approaches to managing imaging services.

14 There are detailed bios on each speaker in your
15 binder. After we hear from our three guests, there will be
16 an opportunity for your discussion and questions.

17 DR. CASALINO: It's a privilege to be here and I'm
18 looking forward to the discussion. I will go very quickly
19 through the first few slides.

20 I think the reason that I'm here is that the
21 Robert Wood Johnson Foundation has commissioned a series of
22 so-called synthesis reports and I was asked to do one about

1 a year ago on physician self-referral and physician-owned
2 specialty facilities. This included specialty hospitals and
3 ASCs, but also diagnostic imaging. The report is available
4 online. That's the website. I do want to thank Sarah
5 Goodell, who worked on behalf of the Foundation with me on
6 this project. It's a lot better for her help.

7 I won't belabor this. You're all familiar with it
8 and Ariel just mentioned it. Payments under the Medicare
9 fee schedule have really almost doubled between 2000 and
10 2006. As Ariel said, this is the fastest growing service
11 provided by physicians and the fastest growth has been in
12 advanced imaging like MRI, and CT nuclear medicine.

13 One question is how much of this growth is due to
14 physician self-referral? No one knows for sure but the
15 answer is probably a lot of it. If you consider
16 radiologists not to be self-referring physicians but other
17 physicians -- when a cardiologist receives a payment for
18 doing an imaging study self-referral probably is involved.
19 Then you can interpret these figures.

20 So radiologists' share of Medicare payments for
21 imaging has been steadily going down and that of other
22 physicians -- especially cardiologists and orthopedists has

1 been going up. You see currently down to 43 percent for
2 radiologists and it's up to 25 percent for cardiologists.
3 Over a four-year period that's about a 10 percent increase
4 for the cardiologists and about a 9 percent decrease for the
5 radiologists. Orthopedists and cardiologists performing
6 huge amounts more imaging now than they did a little more
7 than a decade ago, 33 times more for orthopedists.

8 This is a study that just give came out done by
9 Jean Mitchell, who's done a lot of good work in this area,
10 looking at patients of a large PPO in California. This is
11 just a sample of the data in the paper. You can see that
12 the increase in outpatient MRIs for these patients, a lot of
13 it is coming from self-referring physicians, 155 percent
14 increase over a four-year period. Also increasing in
15 hospital outpatient departments when radiologists were
16 collecting the imaging fee but quite a bit less than self-
17 referring physicians. And then there are the IDTFs,
18 independent diagnostic testing facilities. I'll have a few
19 more comments to make about them at the end, but they also
20 increased the amount of MRIs they were providing
21 substantially.

22 This is also a fairly recent article, not exactly

1 from an unbiased source, but interesting Medicare data. You
2 can see again, these are the top three specialties that
3 provided the most outpatient MRI scanning outside of
4 radiology. You can see a huge increase for orthopedists and
5 neurologists.

6 I have primary care physicians highlighted here
7 because I'm not aware of any data on this but it's not
8 likely that very many primary care physicians have MRI
9 scanners in their offices. So if you look at these 58,000
10 procedures that primary care physicians were paid for doing
11 an MRI scan in 2005 you have to think that these are from
12 some forms of leasing or per click arrangements, the kind of
13 things that some people are quite suspicious of.

14 There is, as you know, a proliferation of
15 arrangements, leasing per click under arrangements between
16 hospitals and physicians, and then a variety of arrangements
17 that I really don't know of any data on -- in fact there's
18 very little data on any of this -- between IDTFs and
19 physicians, ways to get physicians money for working with
20 IDTFs, let's say. Whether this is payment for referrals is
21 obviously a controversial question.

22 So how much of this increase in imaging is

1 inappropriate? Nobody knows for sure and there's different
2 ways of defining what's appropriate. The way that health
3 policy analysts would like to define appropriate is in
4 compliance with guidelines, if there are any. For a
5 physician in the office or a patient -- and I was in this
6 position for 20 years -- appropriate may be if it has some
7 chance of doing the patient benefit, very little chance of
8 doing them harm, and the patient wants it it's hard for me
9 to tell this patient in front of me you can't have this. I
10 think most physicians in practice would still argue that
11 that's the definition of appropriate. That obviously has
12 very different implications for how much imaging is going to
13 be done.

14 So we do know, in terms of how much is
15 inappropriate, that there's a lot of interregional variation
16 so someone's probably doing too much. We know that there
17 are some tests -- there's way too much imaging done too
18 early for lower back pain, for example. There are lots of
19 studies, old and now some new, that show that self-referring
20 physicians do order a lot more images. Both cross-
21 sectionally and longitudinally there have been studies where
22 suddenly physicians get a chance to get paid for imaging and

1 they start ordering more.

2 Health plans state that -- and a little bit of
3 this has been published -- that when they institute various
4 procedures that make it harder for physicians to order
5 imaging or get paid for in the rates go down. Again, I know
6 from experience it doesn't really take you at any time to
7 order an image and very little to interpret it whereas it
8 does take you time to see patients. So if you feel squeezed
9 for income, it's quite an easy way to increase it by just
10 ordering more imaging. And you don't have to be a raving
11 cynic or a bad person to do this. It can just be on the
12 margin, it can be quasi-unconscious probably. But it's a
13 very easy way. You can order images without limit. You
14 can't see patients or do surgeries without limit.

15 Effects on quality, very little data available.
16 There's a little data to suggest -- and I believe this is
17 probably true -- that both on the technical and on the
18 interpretive side, the professional side, that in general in
19 primary care offices the imaging probably isn't done as
20 well. There is one study that showed that -- a small study
21 but for chest and extremity films the primary care
22 physicians' interpretation of films that were done in their

1 offices was validated by radiologists about 90 percent of
2 the time. But then when they had other radiologists look at
3 the films and also had the actual clinical diagnosis of the
4 patient, what happened, they actually saw that a little bit
5 over a third of the time but there's a disagreement between
6 the radiologist's reading and the primary care doc's
7 reading, the primary care doc was right. And these were
8 usually fractures of the extremities -- and I had this in my
9 office -- when you know there may be a problem if there's a
10 subtle fracture, you may be more likely to pick it up than
11 the radiologist. I'll come back to that in a moment.

12 There's no data on this that I'm aware of but it's
13 plausible to me, at least, that when specialists -- say when
14 an orthopedist is interpreting an MRI of a knee -- my guess
15 is that they're probably pretty good at it because they do a
16 lot of it. So there may be less of a quality problem there,
17 if you think there is a problem, then there is in primary
18 care offices where as primary care physicians we just don't
19 do that much of any one kind of imaging, most primary care
20 physicians.

21 There's a recent OIG study of IDTFs that showed
22 almost all of them not complying with Medicare requirements.

1 You could argue that some of the things that the OIG dinged
2 them for were kind of picky, but a lot of weren't. 13
3 percent of the procedures were performed by unlicensed
4 technicians, for example.

5 Just one other side thing on quality, this is a
6 New England Journal article quite recently, estimated that 2
7 percent of cancers -- fairly soon estimated that about 2
8 percent of cancers in the United States will be a
9 attributable to CT scans. That doesn't mean the CT scans
10 were inappropriate but it's something to think about.

11 It's a different question to talk about whether an
12 imaging procedure is appropriate and whether it's performed
13 in an appropriate setting or whether it should be done by
14 self-referral and I think it's important to distinguish
15 those.

16 There has been talk of Medicare doing prior
17 authorizations. I'm going to just end with some quick
18 editorializing here. I actually just wrote another report
19 on what I think Medicare ought to do to be a value-based
20 purchaser. And I initially put this in but then I took it
21 out for some of the reasons that you can imagine.

22 I don't necessarily disagree with this as a

1 recommendation. I would say that thought should be given at
2 least to not making it a blanket requirement for all
3 physicians but just -- I know MedPAC is doing some work to
4 try to profile who the high-cost imagers are. And if they
5 could be identified, those should be the ones who should get
6 prior authorization. It would be much more cost effective
7 to do it just for them than for everybody and there would be
8 probably less political backlash. Because again, I can tell
9 you from experience, if you think that you're an efficient
10 physician and you have to go through this and it's costing
11 you time and money, and it just seems like a useless hassle
12 you really hate it but you actually know some guys in your
13 community who you wouldn't mind seeing it done to.

14 [Laughter.]

15 DR. CASALINO: I think that's really true. Now
16 that doesn't mean you won't get backlash from organized
17 medicine and various specialty societies.

18 Should one size fit all in terms of self-referral
19 on imaging? I don't think so. At a minimum you can have
20 these kind of categories. In primary care physician offices
21 -- I'm saying small or medium as opposed to bit
22 multispecialty groups. A bit multispecialty group can have

1 great equipment and have radiologists and probably not have
2 so much of a problem in terms of quality. You still have
3 the self-referral incentive to worry about.

4 But I think in a small office on balance the
5 quality technically and interpretive isn't going to be as
6 good. But that doesn't mean that the net quality won't be
7 better. So again, if you have an 80-year-old woman with
8 congestive heart failure, who may have pneumonia and the
9 nearest place to get an x-ray is five miles away and it's
10 hard to get her in and out of a car and you really want to
11 know if she has pneumonia then, doing that x-ray in your
12 office -- or you want to know if someone has a fracture that
13 you can take care of -- doing that film in your office
14 offers, I think, a lot of not just convenience but
15 potentially quality benefits because you can do things right
16 there, you know what's going on, patients love it.

17 I think if standards were promulgated for primary
18 care offices so that we could feel fairly confident that the
19 technical and professional sides were being done well, I
20 personally think it's a pretty good thing. You still have
21 the self-referral incentive. How do you deal with that?
22 Maybe with the prior authorization policy that we just

1 talked about.

2 Specialty offices, I would say basically the same
3 thing.

4 Lease and per click arrangements, I think it's
5 important to understand that the benefit that I just rushed
6 through of having things done in the physicians' office is
7 not true for lease and per click arrangements. I don't see
8 really any potential benefit of any kind to anybody from
9 those, except from the referring physician and the place
10 that's doing the films. And I wouldn't be sorry to see
11 those go.

12 And just to finish up these, to me at least -- and
13 I haven't been able to find anybody who says differently --
14 IDTFs are mysterious. It's very hard to tell how many there
15 are. No one knows really who owns them. They mostly do
16 imaging. About 85 percent of what they do is imaging.
17 They've increased their share of advanced imaging up to
18 about one-quarter of all that gets done from 3 percent in
19 1995.

20 The OIG did a report a few years ago that -- it's
21 kind of buried in there but if you do the math you can see
22 that they found that about a third of the imaging was

1 unnecessary or hadn't even been ordered by any physician as
2 far as they could tell in some cases.

3 So I think that why should we have IDTFs? First
4 of all, I would say more needs to be known about these and
5 it would be a great subject for a study by MedPAC or GAO or
6 whomever, including just who owns them and who refers to
7 them if one could figure that out.

8 Why should they exist? Only if they provide some
9 kind of quality or efficiency or convenience advantage. And
10 maybe they do, in some places. Frankly, I don't have an
11 opinion about that. I just don't have any idea and I'm not
12 sure anyone knows enough to have an opinion.

13 I think that the steps Medicare has taken recently
14 to ban that kind of leasing arrangements that IDTFs have
15 with physicians can help eliminate some of the less
16 desirable self-referral incentives but I do think more
17 should be known about these.

18 With that, I will pass things on.

19 DR. BAKER: Good morning. It is a pleasure and a
20 privilege to be here to share some results of work that I've
21 been involved in over the last couple of years, mostly in
22 the last year, related to various aspects of imaging

1 diffusion and imaging ownership by physicians, looking at
2 mainly the effects on utilization and spending.

3 I've brought pieces actually of three or four
4 different projects and I will try to summarize what the
5 results from some of those are and would be happy to take
6 questions or talk about more specific aspects of them at a
7 later point in time.

8 The first question that I have some results to
9 share with you on has to do with the effects of expanding
10 imaging availability on the use of imaging. So as we put
11 more MRI scanners in, as we put more CT scanners in around
12 the country, what effect does that have on utilization and
13 ultimately on Medicare spending?

14 There has certainly been a lot of diffusion, a lot
15 of increase in the number of units available. These are
16 estimates that we have made of the number of CT scanners and
17 the number of MRI scanners in the country based on some
18 industry data. 5,300 approximately CT scanners in the U.S.
19 in 1995, up to 8,300 by 2004, so plus 3,000 CT scanners over
20 a 10-year period. 2,400 MRI scanners up to 5,800, so about
21 doubling the number of MRI scanners over a 10-year period.
22 A fairly dramatic growth given the kind of parameters you

1 usually see in medical technology change over time.

2 This has gone along, of course, with increases in
3 utilization. This is data on the number of CT scans in blue
4 and MRI scans in red/maroon for Medicare fee-for-service
5 beneficiaries. So we've more than tripled or just about
6 tripled since 1995 the number of CT scans and MRI scans that
7 are being done. We're at about 600 coming up on 600 scans
8 per 1,000 -- 600 CT scans per 1,000 beneficiaries per year
9 now and almost 200 MRI scans per 1,000 Medicare
10 beneficiaries per year. So dramatic growth.

11 Is there a relationship between the availability
12 of scanners and utilization? There certainly is. This is a
13 plot from just a basic analysis we did that used 318
14 metropolitan statistical areas, so 318 dots up there. On
15 the x-axis, the horizontal axis, is the change in the total
16 number of MRI units in that metropolitan statistical area
17 between 1994 and 2005. You see quite a lot of geographic
18 variation. Some places added 100 scanners. A lot of places
19 were adding 25 to 50. And there were some places that
20 didn't add very many at all, and so there's quite a bit of
21 change there.

22 On the vertical axis is change in the total number

1 of MRI claims in the Medicare fee-for-service population and
2 you also see quite a bit of geographic variation there. The
3 two are quite closely related. So the plot follows a nice
4 upward sloping pattern. We fit the regression line there.
5 And if you look at that regression line long enough you will
6 conclude that every additional scanner added is related to
7 or associated with about 800 additional MRI procedures for
8 the Medicare population.

9 I could show you the same figure for CT scanners.
10 It would show the same pattern but the coefficient would be
11 even bigger. Every additional CT scanner is worth about
12 2,500 additional CT procedures for the Medicare population.

13 This, of course, ends up affecting spending. In
14 one analysis we did a couple of years ago we looked at
15 changes in the outpatient MRI scanner availability in
16 different MSAs and came to the conclusion there that each
17 additional outpatient MRI scanner would drive up Medicare
18 imaging spending in the average MSA by about 2 percent.

19 Now 2 percent is a vague number so I did a back of
20 the envelope calculation in real dollars. Just using some
21 general estimates of the average cost to Medicare of an MRI
22 scan, if you put an outpatient scanner in it generates 800

1 additional procedures. Without trying to be too precise
2 about it, a rough estimate is that that will cost about
3 \$500,000.

4 So if you were to take the 5,000 scanners that we
5 have now and add maybe 100 scanners, it would end up about
6 \$50 million in additional Medicare spending on imaging,
7 based on just an extrapolation, a back of the envelope
8 calculation from the kinds of numbers we've been putting in.

9 Of course, the policy questions are not just about
10 spending. They are about the value that you get from
11 spending. It's certainly an important point that needs to
12 be considered in any kind of discussion. There are
13 certainly benefits -- I say probably on the slide and I
14 should say certainly -- some benefits from expanding imaging
15 utilization.

16 We've been involved in one study that looks at the
17 use of CT for carotid angiography. So if you have a problem
18 with your carotid arteries it can be diagnosed with CTs
19 these days instead of using a catheter-based more invasive
20 diagnostic test. The use of CT reduces side effects risks
21 and it looks like this is a useful thing in that increased
22 use of CT for carotid angiography is associated with

1 expanded availability of CT scanners and the kinds of things
2 that we just talked about. So putting more of these pieces
3 of equipment in does look like it generates benefits in this
4 one case, and I'm sure in others as well.

5 But as we were just talking about with Professor
6 Casalino, and has been noted in quite a number of places,
7 there are also reasons for concern that expanding the
8 availability of the pieces of imaging equipment will also be
9 associated with less clearly beneficial utilization. And
10 back pain is one good example that's up on the slide.

11 So just to quickly summarize that line of
12 research, we certainly find lots of evidence that expanding
13 availability is associated with expanding utilization and
14 expanding spending. Perhaps that is not a shocker. It
15 would, in some sense, be surprising if expanding
16 availability was not associated with expanding utilization
17 and spending.

18 So why, in some sense, bring it up? I bring it up
19 because I think it's a crucial point for consideration of
20 how one might think about managing expanding spending and
21 utilization on imaging. If we're going to talk about ways
22 to manage, ways to influence, ways to improve the efficiency

1 of the imaging sector in the U.S. health care system we have
2 to do that in the context of a world in which we've greatly
3 expanded the availability and which continued expansion of
4 the availability will put continued pressure on to utilize
5 the machines and utilize the equipment that we've put out
6 there. The effects, just the associated effects that go
7 with expanding availability are very important drivers of
8 utilization independent it seems of the kinds of things that
9 we've tried to do in the past few years to slow down
10 utilization. Just availability is an important driver.

11 We've also been engaged in some research and now,
12 turning to the second piece of the talk, we've also been
13 engaged in research on physician ownership of imaging
14 equipment and the use of imaging, looking at some of the
15 issues that are associated with physicians who acquire or
16 lease MRI equipment.

17 As we were just talking about -- I can do this
18 slide quite quickly. As we were just talking about there's
19 been a dramatic increase in this over time. I have up there
20 the share of physicians observed to be billing Medicare for
21 technical components and global fees associated with MRI and
22 broken into orthopedists and neurologists, the two

1 specialties that do this the most often. You can see on the
2 left, in the blue, the share of orthopedists who look like
3 they've acquired or leased an MRI machine over the years --
4 1999 on the left to 2005 -- go up quite a bit. It's about a
5 quarter of physicians by 2005. For neurologists, similarly
6 an upward sloping line. Only about 10 or 11 percent but
7 still a dramatic increase over the last seven or eight
8 years. So quite a bit of change in what looked like
9 physician ownership or leasing arrangements in these two
10 specialties.

11 These, of course, are not the only specialties and
12 ownership and leasing arrangements are not the only
13 arrangements under which these kinds of equipment is --
14 well, looks like it might be acquired or create some
15 financial incentive. So there's certainly been a lot of
16 change in this area.

17 Our question is what effect does acquiring MRI
18 have on the use of MRI? We come at that -- this is kind of
19 a techie slide. Let me just summarize.

20 We come at that by trying to find episodes of care
21 -- for patients who see an orthopedist or see a neurologist,
22 we find what look like index visits, so new visits,

1 outpatient visits, and we try to track forward then from
2 those visits whether they get an MRI within seven days.
3 We've also done other takes on how they get an MRI.

4 We classify each episode according to whether the
5 first physician, the orthopedist or neurologist, that the
6 visit looked like they had acquired MRI by the time of that
7 index visit. So if you have already billed Medicare for a
8 technical component and it looks like you've acquired MRI at
9 the time of that visit, we will call you a visit to a
10 physician who looks like they have acquired MRI. If you
11 haven't ever billed for a technical component, we'll say no
12 and do the analysis on that basis.

13 This is the tip of an iceberg really. We've done
14 lots of other things to try and characterize and think about
15 but I'll stick to that definition for the results that I'm
16 going to show you today.

17 So this is just a graph of the share of visits
18 that are made to orthopedists or, on the bottom,
19 neurologists that look like acquired MRI. You see those
20 going up over time, hitting about 25 percent in 2005 for
21 orthopedist visits. So about a quarter of the orthopedist
22 visits in Medicare are made to an orthopedist who looks like

1 they have some acquisition ownership or leasing arrangement
2 with MRI equipment and about 10 or 11 percent of the
3 neurologist visits by Medicare fee-for-service patients are
4 made to neurologists who look what they've acquired or have
5 some arrangement with MRI equipment.

6 Doing a simple analysis, we can break all of those
7 visits into two groups: bright green visits which are made
8 to physicians who don't have MRI and dark green visits that
9 are made to physicians who do have MRI. We can graph and I
10 graph on this figure the share of those visits that have MRI
11 by any provider within seven days. If you visited a
12 neurologist with no MRI equipment, about 9 percent of those
13 visits will have an MRI done by someone in the next seven
14 days. 14.5 percent of the visits to physicians who own MRI
15 equipment will have an MRI done within the next seven days.

16 For orthopedists, the effect is a little bit
17 smaller, the numbers are a little smaller, 4.7 percent and
18 7.5 percent so an increase of about 2.8 percent there that
19 are associated with visits that are to a provider who owns
20 the equipment.

21 This result is like results that have been put out
22 by other folks over quite a long period of time that suggest

1 that financial self-interest that ownership arrangements are
2 associated with increases in use. But there have been
3 criticisms that have been made of these kinds of analyses.
4 One of them is that the providers who are most interested in
5 doing MRI will be the ones who buy the MRI anyway, and so
6 it's very hard to know the causal effect of owning MRI in
7 these kinds of cross-sectional studies. So we wanted to fix
8 that in our work. So we went on and did some additional
9 analysis.

10 This is, in some sense, the next step which is to
11 take the same physicians now before and after they look like
12 they acquire a piece of equipment and redo the analysis so
13 that we adjust, in some sense, for the characteristics of
14 physicians for the preferences that they might have about
15 using MRI equipment or referring MRI scans.

16 Here you see essentially the same result survives
17 but the effect is a little bit smaller, the magnitude of the
18 relationship is a little bit smaller. So in the light blue
19 visits that are made to neurologists who will acquire but
20 before they acquire and the darker blue visits made to
21 neurologists who acquire after they acquire. You see there
22 about a 3 percentage point increase in the probability of

1 getting an MRI if you go to a neurologist after they
2 acquired compared to before. For orthopedists it's about
3 2.7 percent more likely to get an MRI.

4 Also, this is an advance, a methodological advance
5 in some sense but it's also not entirely satisfactory
6 because there are general trends toward more utilization
7 over time and there may be other variations across the
8 patient groups associated with different physicians. So to
9 do the full blown analysis we needed to run some regression
10 that would adjust for time trends and adjust for other
11 characteristics. You can see some description on the slide
12 of the kinds of things we adjusted for. There are
13 demographics, there are the diagnosis codes of the patients,
14 spending by the patients, comorbidities, years and month of
15 the visit to try and adjust for a bunch of things. We do
16 this -- for those of you interested in the techie aspect of
17 the analysis, we do this using a fixed effect model which
18 controls for physician fix effects and other time trends.

19 The result then is on this slide which
20 unfortunately isn't in a pretty colored graph. It's a very
21 academically looking slide. You can see for orthopedist
22 visits on the left, the cross-sectional result, that initial

1 result, was plus 2.8 percent in the probability of getting
2 an MRI if you went to a provider who looked like they had
3 acquired MRI. When we did the pre/post that changed to plus
4 2.7 percent for the orthopedist visits. When we do the
5 full-blown analysis it's plus 1.5 percent so it's a
6 reduction in the effect but still a positive and
7 statistically significant effect.

8 You see the same thing for neurologist visits, the
9 cross-sectional results which parallels a lot of the earlier
10 literature and then two attempts to do more precise or more
11 refined analysis where we get to about a 2.2 percent
12 increase.

13 So that's the details, in some sense, of the
14 results. What are the main points of the results? We
15 guess, after quite a bit of work to try and control for and
16 adjust for as many things as possible, the result that
17 acquiring MRI certainly does change physician practice
18 patterns. If you go from before you have a relationship or
19 before you look like you've acquired or leased a piece of
20 equipment to afterwards you will see changes in the number
21 of referrals, changes in the ways that the equipment is
22 used.

1 The effects are statistically significant although
2 they are smaller than some of the other effects that have
3 been found in previous work. They are still relatively
4 large though. If you do this on a percentage basis it's
5 about a 25 percent increase in the probability of getting a
6 scan after a provider acquires a piece of imaging equipment.

7
8 The back of the envelope calculation in these
9 samples, if you were to increase the share of visits to
10 providers owning MRI by 10 percentage points, which would be
11 a reasonably large increase but not out of the ballpark
12 given what we've seen over the last few years, you would get
13 about 4,000 more MRI procedures from orthopedists and about
14 2,500 more from neurologists.

15 We've done some work on the effects on Medicare
16 spending. The question there is if you look before and
17 after someone acquires MRI at the average cost that their
18 patients incur, the average Medicare spending their patients
19 incur over 30 days following the visit what happens to
20 spending? If you just thought about, say in the case of
21 orthopedists a 1.5 percent increase in the probability of
22 getting MRI and that MRI costs you something like \$600 --

1 which is an average that we calculated vaguely, is a little
2 over \$600 in our data that Medicare spends on an outpatient
3 MRI procedure -- then you would see \$10 or so, roughly
4 speaking now and not trying to be overly precise but a
5 ballpark figure, \$10 or so increase in average cost. We see
6 about plus \$16 in spending for these patients which says
7 that there's more going on, that MRI is associated with
8 other things that the providers are doing, as well. So you
9 see a \$16 increase there and about a \$60 increase for
10 neurologists' patients, much larger than would be associated
11 with the cost of just the MRI themselves. So there's an
12 effect on costs that includes the MRI but also probably
13 includes other things.

14 These numbers don't include what looks like it
15 will be a small offset in outpatient spending. So
16 outpatient Medicare spending will decline, the dollars, the
17 numbers I just showed you were physician spending.

18 So if you do a back of the envelope calculation on
19 that data, if you increase the share of visits to providers
20 owning MRI by 10 percentage points, you'd get about \$4.4
21 million in additional spending from orthopedists, about \$6.8
22 million in the neurologists. Big numbers although not

1 necessarily as big as the effects from capacity. If you
2 were just to increase the number of MRI scanners in the
3 first bit of work by 100 scanners you would get maybe \$50
4 million in additional spending. Here, pretty large
5 increases in the share of physicians who are owning the
6 equipment generate four or five, maybe a little bit more
7 depending on how you slice the numbers. But not 50 million.

8 So how do we conclude? Expanding imaging
9 availability is an important driver of utilization and
10 spending. Expanding provider ownership is also a driver of
11 utilization in spending. The big question, of course, is
12 are we better or worse off expanding utilization of these
13 procedures can be beneficial to patients? There are
14 certainly lots of cases in which that appears to be the
15 situation but it's not clear that they always are or that as
16 we expand further we will continue to make inroads into the
17 most useful places. And so it's certainly important to
18 consider the benefits and the potential for less beneficial
19 utilization, a set of considerations on which I don't have
20 data to present to you today.

21 What our policy response is, I actually will not
22 spend a lot of time on this since Professor Casalino and the

1 next speaker also is going to speak about this. But it may
2 be that limiting options for physician financial self-
3 interest may be a useful set of approaches. Prior
4 authorization may be a way to better channel and improve
5 efficiency. Standards, accreditation and credentialing and
6 maybe other capacity management would be ways to think about
7 how many of these things are out there chasing Medicare
8 dollars and generating some pressure for expanding
9 utilization.

10 With that, I will conclude.

11 MR. STEINWALD: While Ariel is setting up, Mark, I
12 brought my laser pointer. I'm not going to use it. I think
13 there's a good chance I would blind Arnie Milstein. I know
14 he's a lawyer in addition to a doctor, so I'm going to leave
15 it on the table.

16 [Laughter.]

17 DR. MARK MILLER: For your information. this is a
18 long-standing point of contention between Bruce and I, the
19 laser pointer thing, that GAO gets them and MedPAC doesn't.

20 [Laughter.]

21 MR. STEINWALD: Hey, it's your tax dollars at
22 work.

1 I'm here to report, as Ariel said, on a recently
2 published study. That's the title of the study and its code
3 number. It's readily available on the GAO website if
4 anybody would like to download it.

5 The study was requested, it's a bipartisan request
6 from Senators Rockefeller, who chairs the Subcommittee on
7 Health of the Senate Finance Committee, and Senator Gordon
8 Smith, who is the ranking member of Senate Aging.

9 In their request to us they emphasized two things.
10 One is some concern about the payment changes effected or
11 about to be effected by the Deficit Reduction Act that Ariel
12 referred to. They also referred to MedPAC's work and asked
13 us to build on MedPAC's work to provide them even more
14 information on imaging trends and spending and to help them
15 consider what Congress might do to address the issues
16 related to imaging.

17 As you know, they did at least partially address
18 some issues in the recently enacted MIPPA, Medicare
19 Improvements for Providers and Payers Act -- oh patients,
20 yes of course. Sorry.

21 [Laughter.]

22 MR. STEINWALD: Three research objectives, I won't

1 go over them here. To look at the trends through 2006, look
2 at the relationship between spending growth and the
3 migration of services to doctor's offices and then what
4 practices have private organizations used to try to manage
5 imaging and spending in benefits.

6 I won't go into detailed scope and methodology.
7 The important things there are we split imaging services
8 into advanced and standard imaging, as you have done in much
9 of your analysis, and also made the distinction between the
10 technical component and the professional component. The
11 technical component, as you know, is the test itself. The
12 professional component is the interpretation of the test.

13 We did a whole bunch of interviews, as well. This
14 is not a random sample. We sought private plans that were
15 active in managing imaging benefits. We interviewed
16 radiology benefit manager companies. We interviewed CMS and
17 its contractors and several stakeholder organizations,
18 including several medical specialty societies and two
19 organizations listed there that are not necessarily happy
20 with our work.

21 Our findings: rather than just read the slide I'll
22 go to the next one that shows it graphically. Basically

1 over the 2000 and 2006 period, that's the increase in
2 standard imaging, x-rays, mammograms and other standard
3 imaging advanced at a more rapid pace. In our data advanced
4 spending overtook standard in about 2004. Even though there
5 are far more standard imaging procedures, obviously advanced
6 are much more expensive and therefore now contribute more to
7 spending than the standard imaging does. The total
8 basically over that six-year period doubled from about \$7
9 billion to about \$14 billion.

10 I emphasize that this is just Medicare Part D. In
11 terms of total imaging spending, including the rest of
12 Medicare and private sector I've seen estimates as high as
13 \$100 billion or so for total imaging spending.

14 Almost all of that spending increase has been due
15 to volume of tests and the complexity moving from more rapid
16 growth in advanced imaging. There are other reasons for the
17 increase. Over that time period the number of fee-for-
18 service Medicare beneficiaries increased and we were only
19 looking at fee-for-service Medicare. That is not true for
20 2007. There is actually a decrease as more beneficiaries
21 moved into Medicare Advantage plans. But over this period
22 there was an increase.

1 There are also these separately billed ancillary
2 items that aren't subject to RVUs. They are the
3 radiopharmaceuticals and other products that are necessary
4 often to provide in conjunction with advanced imaging. And
5 they're not trivial. So they contributed some to the
6 increase. And then over that period there is a small net
7 increase in the conversion factor, which was the least of
8 the contributors to spending growth.

9 Our second finding relates to the association
10 between the growth in spending and the migration of services
11 to physicians' offices and IDTFs.

12 Graphically that's the pie chart for 2000, about
13 \$7 billion. And even then the highest proportion was
14 physicians' offices. But moving to 2006, you can see the
15 migration out of hospital settings into doctors' offices and
16 into IDTFs.

17 We also observed that in many specialties -- this
18 is consistent with Larry and Laurence -- I can't call them
19 both Larry I was told -- consist with their findings that in
20 many specialties more and more revenue is being obtained
21 through imaging as opposed to therapeutic services.
22 Cardiology kind of stands out. Cardiologists get more than

1 one-third of their Medicare revenue from imaging services
2 and other specialties are less pronounced but this trend is
3 similar.

4 And then finally, the geographic variation that
5 we've all referred to. There's not much of a pattern here.
6 The lowest is Upper New England and then moving into the
7 other areas of the country it's hard to discern a distinct
8 pattern geographically that distinguishes high and low.

9 Finally in the highest category we get to Florida,
10 of course, and its partner in crime, Nevada. I don't have
11 an explanation for Nevada. But suffice it to say there's
12 still a substantial variability in imaging spending per
13 beneficiary across the U.S.

14 So having examined some Medicare data, we then
15 sought to determine what is the private sector doing to
16 manage imaging spending, knowing that trends are similar
17 there. Again, I won't read the slide but the bottom line is
18 that they were doing lots of things so the plans that we
19 talked to. Most predominantly, they were using prior
20 authorization to manage the imaging benefit in addition to
21 credentialing and prior notification and the other things
22 that you all have already talked about. Of those that used

1 prior authorization, the vast majority used radiology
2 benefit manager firms to implement their prior authorization
3 program.

4 CMS, for its part, uses a retrospective approach.
5 Now CMS has identified imaging as -- I think they call it a
6 vulnerable area or an area that produces vulnerability to
7 excess Medicare spending. It has directed its contractors
8 to give special emphasis to looking at imaging claims.
9 However, it is, in essence, post-payment claims review, what
10 some people call pay and chase. They pay the claims and
11 then try and figure out which are the claims that they
12 shouldn't have paid and then try to get the money back if
13 they can.

14 So all of this led us to the following
15 recommendation: the combination -- by the way, we framed our
16 study in terms of Medicare's fiscal sustainability over the
17 longer term. I'd like to point out at this time that I am
18 now Medicare eligible. I'm still a Federal employee but I'm
19 hoping that one day if I need an MRI there's going to be
20 some money there to pay for it.

21 So within the context of needing to get control of
22 Medicare spending and observing the rapid growth in Medicare

1 Part B and in particular imaging and in particular advanced
2 imaging services combined with the migration to doctors'
3 offices where there's less oversight of appropriateness of
4 care and the substantial geographic variability, all
5 combined led us to the recommendation to CMS to address the
6 rapid growth they should consider more front end approaches
7 to managing the imaging benefit. That could include prior
8 authorization and privileging but not necessarily limited to
9 those techniques.

10 CMS's response to our recommendation, which is
11 published in our report, and you're welcome to read it, if I
12 had to characterize it using one word I would say they were
13 skeptical. They didn't disagree but they said well, you
14 know, Medicare is really not like the private sector and if
15 we were to implement something like what the private sector
16 is doing there are other concerns that we would have to
17 address like they emphasized, for example, proprietary
18 systems don't work very well in a public program. They
19 emphasized that there's an appeals process that could
20 overturn decisions. And so they expressed those concerns.

21 Our response to those concerns was we didn't deny
22 that they were legitimate concerns but we did say that we

1 don't think that post-payment claims review is going to get
2 the job done in a benefit that's growing as rapidly as this
3 one and that some front-end approach, it seems to us, to be
4 appropriate. The concerns that they put forward need to be
5 addressed but it seemed to us that they could be. And we're
6 anxious to see, of course, whether CMS does decide to do a
7 more front-end approach to managing the imaging benefit.

8 MR. HACKBARTH: Thank you, lots of material for
9 discussion. I suspect we'll have lots of questions and
10 comments. We've got, I think, 40 minutes left for
11 discussion.

12 Could I just see the hands of people who want to
13 get in the queue? Why don't we just go around and give
14 everybody a chance.

15 Before we do that I'm going to take the
16 prerogative of asking the first question. Maybe we ought to
17 give Ron the second opportunity --

18 MR. EBELER: Your hand wasn't up.

19 MR. HACKBARTH: I've got the microphone though.
20 Maybe we ought to give Ron the second chance to respond to
21 the partner in crime allegation.

22 Here's my question. Jack and I were talking about

1 this before the meeting, before we get to policy approaches,
2 I want to focus on the evidence that we've got a problem.
3 Clearly, there is evidence of rapid growth, evidence that
4 ownership is associated with still more growth. Ultimately,
5 the question we want to ask, though, is whether cost per
6 episode is increasing. We've often heard that well yes,
7 more is happening in the physicians' office but that's a
8 substitute for things that might have happened previously in
9 the outpatient department. Or yes, more is happening in the
10 physician office but that allows for more accurate diagnosis
11 and treatment, which means that maybe more costly treatment
12 is avoided. It seems to me the way you get at those issues
13 is look at the effect on cost per case while trying to
14 control for quality.

15 I'd like to ask the panel if you're aware of
16 research that approaches it that way? And what the findings
17 are?

18 MR. STEINWALD: I'll start. I believe you had
19 your own estimate and ours was consistent of the amount of
20 the growth in Part B that's simply substituting for another
21 setting. I think the evidence is that it continues to grow
22 in the other settings, even though there's some

1 substitution. I think your estimate was around 25 percent
2 and ours was similar. So there is a bit of that.

3 But on the other side of that issue is how much of
4 this additional growth is associated with additional
5 spending for therapeutic services? So when we look at just
6 imaging by itself I think it's important to recognize yes,
7 there's a substitution effect. Yes, there's earlier
8 diagnosis and treatment, at least in some cases. But there
9 is also evidence of kind of a multiplier effect of more
10 imaging, detecting more conditions, more false positives
11 that need to be followed up, more conditions that maybe
12 don't have a lot of clinical importance but still yield more
13 therapy.

14 So when we see these imaging spending trends, I
15 think we're probably just looking in part of their effect on
16 spending.

17 DR. BAKER: Let me make a couple of comments. The
18 first question you asked was whether there are offsets,
19 whether we expand spending in physician offices say and also
20 reduce spending in outpatient settings or other kinds of
21 spending.

22 Some of the work that we've done does start to get

1 at that. It's a little bit preliminary are so it's ever so
2 slightly dangerous for me to start talking about it as if
3 it's fully done. But I'll say that the work that we've done
4 so far suggests that there are increases -- for the
5 orthopedists and neurologists that we like to study -- there
6 are increases in the physician spending that are associated
7 with acquiring the equipment. They are likely to be partly
8 offset by reductions in outpatient spending. But the
9 offsets in outpatient spending that we measure are much
10 smaller than the increases in the physician spending that we
11 see.

12 So I don't have a number to put on that at the
13 moment but I suspect that the end result when we get to the
14 final report on this research is going to be that there are
15 net increases between physician and outpatient spending.

16 The place that it gets a little fuzzier is when I
17 throw say hospital spending or other high ticket items in
18 which makes the results fuzzy and it's hard to tell then
19 with statistical precision what's going on. So we may not
20 reach a conclusion that we will have total spending
21 including hospitalization with statistical precision.

22 But in the question of physician office and

1 outpatient trade-offs it's going to be positive, I think.

2 You know, there are a bunch of questions that you
3 head toward the become very interesting. And those are the
4 effects of additional imaging utilization on other services
5 and other kinds of spending. So for a carotid artery
6 patient where we might increase utilization and may be more
7 likely to do a CT scan, there are certainly possibilities
8 for offsetting expensive side effects or other kinds of
9 things that go on.

10 For other cases, for a back pain patient we may
11 actually do more imaging and that may lead to more surgery
12 for the patients. And so there's, I think, scenarios to be
13 created on both sides. My guess is that in the end it's
14 going to vary a lot by type of patient and by specific
15 circumstance.

16 So I don't know that we have -- in our work we
17 start to have some of these for particular cases where we
18 started to do some analysis but ultimately I think it's
19 going to require quite a bit of analysis to get a number of
20 different conditions with different clinical scenarios
21 considered so that one can start to see the range of
22 possibilities that are out there. And I don't think we're

1 there yet. We'll start to be there over the next several
2 months, I think, in our research group with a couple. But
3 ultimately it's going to require more than that.

4 DR. CASALINO: I would just add three things
5 quickly. One is that it may be in some cases that there
6 could be increased spending for the episode but still it
7 would be increased quality. It's not necessarily increased
8 spending for the episode and you don't get any benefit for
9 it. That won't always be the case.

10 I think the most important thing I would add is
11 that, as you know, this will really probably -- when this is
12 studied, as Laurence just implied, it will vary a lot, I
13 think, what the findings will be by type of episode. So if
14 you're doing an imaging study that has a decent chance of
15 detecting a treatable cancer early, that can increase
16 quality and might actually save some money. Or if you could
17 find carotid or coronary artery disease earlier than you
18 otherwise would, that could actually save some money.

19 If you're doing imaging of low back pain or of
20 someone with an injured knee and you're getting MRIs, that's
21 probably not -- I find it -- I can't really think about how
22 that is likely to save money on an episode. And it's

1 probably not going to improve quality most of the either,
2 especially for the back.

3 But then again, from the patient's point of view,
4 and therefore from the physician's there are more subtle
5 quality increases that Medicare might not want to pay for
6 but that is very important to patients. So if someone has
7 severe acute low back pain they actually want to know if
8 they have a herniated disk or not because that does help a
9 little bit -- although not that much -- with them knowing
10 what to expect over the coming weeks or months. It's not
11 going to make any difference in the end, really, to how
12 things turn out that they know or not but they want to know.

13 Similarly lots of people, when they hurt their
14 knee, they actually don't want to wait two months to find
15 out if they have -- what kind of tear they have of their
16 medial collateral ligament. They actually would like to
17 know right away. Again, Medicare may not want to pay for
18 that but from a patient point of view it's desirable.

19 So you can see the kinds of imaging of the low
20 back or the knee, for example, those kind of episodes, I
21 expect that the imaging will just increase the cost of care
22 for the episode with quality increases that are more the

1 subtle kind of thing that I just mentioned than anything
2 that one can really define as a treatment benefit.

3 DR. CASTELLANOS: First of all, thank you for
4 coming. We really appreciated this.

5 I don't think there's any question that we all
6 recognize there's a problem. I think we can beat that into
7 the ground but we all recognize that. The question is how
8 do we deal with the problem? This is what we want your help
9 from.

10 I have a couple of questions for each of you and
11 if you mind if I go over that. Larry, I thought it was a
12 good presentation. One of the things that bothered me a
13 little bit about your talk was that 2 percent chance of
14 cancer. That's the New England Journal article that was
15 written by the group in Colombia. And it was really
16 extrapolated from the Hiroshima data. This is totally
17 estimated over the next 20 to 40 years. The reason I ask
18 you to comment on it is because we shouldn't use that to
19 prevent people from getting CAT scans when it's appropriate.
20 I think the authors in that article say that.

21 I think if the lay public hear that 2 percent it
22 kind of raises a flag. And I think it should be a

1 discussion between the physician and the patient. And quite
2 honestly every medical specialty is looking at that issue of
3 overexposure to x-ray. So I think it's a point to bring up
4 but it shouldn't be a red flag.

5 Larry, I thought your point was good about
6 utilization. We've already started some breaks with the
7 DRA, which started in 2005 but wasn't implemented until
8 2007. Nobody mentioned the results of that. I think the
9 data for 2007 is out and it shows that there's been a
10 significant decrease. It's cut down the rate from 2005 to
11 2006 by over 50 percent. So policy has helped but I think
12 we need more than just policy.

13 I think appropriateness is the word, and I've
14 heard that. Bob Reischauer last year mentioned something
15 very smart and very astute. It's not the site of service
16 where you get the study done but it's the appropriateness.
17 It is just as appropriate to have that study done in my
18 office -- and Bruce, I'm one of the criminals from Florida.
19 I have a CAT scan machine but I can tell you the benefits of
20 it -- is there a financial benefit to me? Yes. I'm not
21 going to say there isn't. But there's a significant benefit
22 to the patient: convenience, early diagnosis, coordination

1 of care, safety. And in my office it's a savings to the
2 Medicare program as opposed to getting it done at the
3 hospital or somewhere like that.

4 So there are some benefits so you don't want to
5 throw the baby out with the bathwater. So I think
6 appropriateness is...

7 Larry, the other comment you all made, and
8 especially with the GAO study, is how can we front end
9 stopping this? It may be necessary to do that. I'm not
10 saying it's not. We were fortunate last year to have a
11 panel of experts on imaging. I don't really recall
12 everything that was said but I went back to get the data and
13 I looked. There was a gentleman from Minnesota who was a
14 primary care physician. I know because I went up to talk to
15 him afterwards.

16 Instead of having preauthorization, which seems to
17 be maybe a stumbling block, he mentioned prenotification. I
18 don't remember his statistics but in his printout thing that
19 he gave out he said prior notification had a significant
20 impact without any denial required.

21 That wasn't mentioned, about prenotification. I
22 really would like any information you have on that. Maybe

1 that would -- certainly from the physician community it
2 would be much easier, it would be less of a hassle and less
3 work. And I don't think any physician wants to do that but
4 I think if we need to do something that may be a little bit
5 more appropriate.

6 Again, thank you for coming. We really appreciate
7 your talk.

8 MR. HACKBARTH: Thanks, Ron.

9 Before the panel answers, I'm a little worried
10 about the time. We've got a half hour and I think almost
11 everybody had a question to ask. I would ask the panel to
12 really try to be brief in responses and probably we'll have
13 to limit ourselves as commissioners to one question. So
14 choose your best one while you're waiting your turn.

15 Go ahead.

16 DR. CASALINO: I can respond very quickly.

17 First of all, basically agree with what the thrust
18 you're saying is. The most important thing for me that you
19 said is don't throw the baby out with the bathwater. If you
20 give me a policy choice of everyone is going to have prior
21 authorization or we're not going to let physicians do
22 imaging in their offices, I'd say great, let's go for the

1 prior authorization. I think it would be a mistake to ban
2 all in-office imaging. I do think there should be
3 standards.

4 Prior notification, I don't know how good the data
5 is. I've had conflicting stories. But it's certainly
6 something that could and should be considered probably.

7 DR. BAKER: It may be a brief comment to agree
8 again with the notion of appropriateness and making sure we
9 do the work to get the quality effects considered well.

10 The one thing that I would just note, you asked
11 about the DRA effects and the changes over time. I think
12 those will be studied for various reasons that I don't want
13 to bore you with. We don't have the newest data yet. But
14 as soon as my group gets them we will work on it and I'm
15 sure others would do that, too. So I presume we will know
16 within a fairly short period of time what happened with
17 those.

18 MR. STEINWALD: GAO is going to come out with a
19 report within a month on the effects of the DRA and some of
20 the information is already out from CMS.

21 Ron, I'm sorry about the Florida remark. The
22 point there is how variable spending per beneficiary is.

1 And as in other context we look at that variability and we
2 say well, then it can't all be appropriate if people are
3 getting a certain level of services and with all the
4 evidence indicating quality and outcome roughly equivalent
5 in the lower spending areas than in the high, we use that
6 information as indirect evidence of a concern for excess
7 utilization.

8 DR. DEAN: I will follow up on Ron's question.
9 The whole issue of preauthorization -- I'm a primary care
10 physician. But you sort of responded to that.

11 But if we're going to get to the appropriateness
12 level that we'd like to have, which we assume we're not
13 there yet, it depends on the development of criteria and
14 guidelines and so forth. And I wonder what your opinions
15 are in terms of how well developed those are? No guideline
16 is perfect and there's always exceptions. And in this area
17 I think there's probably a lot of exceptions. I don't know.
18 I'm just curious in looking at this how well developed are
19 the guidelines in the criteria? And are they useful enough
20 to move us forward in terms of deciding appropriateness?

21 DR. CASALINO: I don't feel that I am familiar
22 enough with the guidelines in each area of imaging to make a

1 useful comment about that. But you know as well as I do
2 that when you're actually out there in the field -- and
3 especially for the more vague kind of problems, not when you
4 know someone has -- they just have a TIA yesterday. You can
5 do guidelines for that. But it's pretty easy for physicians
6 and patients to think the guidelines don't apply to the
7 situation.

8 But I don't have a good answer to your question.

9 DR. BAKER: I don't have a great answer in the
10 sense that we have not ever tried to survey the literature.
11 Plus I'm an economist. So when I read guidelines I read
12 them with a very different viewpoint than a physician.

13 We have, in some cases, been able to go and, as an
14 economist not necessary training in all the details, we have
15 been able to go, in several cases, to the literature and
16 find things that look clear enough to me to do analysis on.
17 Back pain is one example. But we've never done a systematic
18 study to know if we're there for all the different
19 conditions that are out there.

20 MR. STEINWALD: The specialty societies are
21 working on it. I can't tell you how far they've gone. But
22 if you go to their websites, the American College of

1 Radiology and Cardiology, you'll see at least some evidence
2 that they're investing in the development of guidelines.

3 MS. BEHROOZI: My comment and question is about
4 imaging so I guess maybe it's mostly directed to you, Bruce.
5 I was surprised that a minority, I guess, of the plans that
6 you talked with have privileging in place while virtually
7 all of them had prior authorization. In our plan, which
8 serves a few hundred thousand health care workers, we
9 recently instituted both prior authorization and privileging
10 -- and part of the reason that we did them together was
11 because prior authorization, while we talk about it in here
12 as a useful tool to manage inappropriate utilization, out
13 there it's called denial of care.

14 So when we were messaging to our members and
15 getting them to accept this new regime, the theme was the
16 right procedure at the right time from the right provider.
17 And privileging really is, for us it was lower hanging fruit
18 administratively. It's not that only radiologists can
19 perform imaging procedures. But by specialty there certain
20 groups of codes that we will pay for. It might be outer
21 extremity fractures in a primary care physicians' office,
22 that could be included given the evidence.

1 And especially in light of how privileging
2 addresses more directly it seems some of those quality
3 assistance and some of the issues about the arrangements
4 like the per click and leasing deals, I wonder if you have
5 any impression of why it's not utilized more or why you
6 wouldn't emphasize it more in a recommendation to CMS?

7 MR. STEINWALD: I don't have anything bad to say
8 about privileging. And let me emphasize that our survey of
9 the private plans wasn't a random survey, and so you
10 shouldn't take the proportions of plans that use any
11 technique as representing a national proportion.

12 As certainly many of them do use privileging and
13 maybe that's a trend that will go forward. But all we did
14 was observe that of those that are really attempting to
15 manage the benefit, the vast majority of them are using
16 prior authorization, sometimes in conjunction with
17 privileging as your plan does. And many of them though also
18 are using instead prior notification. Profiling is another
19 technique. So there is a range of techniques at play but in
20 the groups that we talked to the one that is clearly the
21 most prevalent is prior auth.

22 MR. BUTLER: Okay, I'm pretty passionate about

1 this particular subject not just because of the cost issue
2 but because of some of the patient care issues. I would
3 start by saying that it's easy to jump to bad guys or greedy
4 guys or whatever but you first have to recognize the
5 spectacular advancements that's been made in imaging.
6 What's available is just unbelievable.

7 You know what? We all love it. The consumers
8 love it and the aging baby boomers, we have tremendous
9 appetite for this ourselves so there's a lot of demand out
10 there as it is.

11 And I would point to the inpatient hospital side
12 where we live under fixed rates. And if you looked, I
13 suspect, at for example use of CT in the inpatient side when
14 we have all the incentives to do less rather than more, I
15 don't know if it's going up as fast as the data that you
16 show here but it's escalating a lot. We are putting CT
17 scanners in our ERs and it's not in our financial interest
18 to do so but it's right for patient care. So there's a lot
19 of demand out there that really is pretty independent of the
20 self-referral types of issues.

21 Now having said that, let me just comment on two
22 kinds of groups where I've seen this in more than one

1 setting myself. Let's take the large orthopedic group that
2 owns their own MRI, that has board certified radiologists
3 involved in reading the exams, that has a first-class
4 service. It's kind of hard to say that that's necessarily a
5 bad arrangement. It's great for patient care from both the
6 quality and a service standpoint. It's a question about do
7 you put some governor on the volume side? And how do you
8 address maybe some payer mix issues where they refuse to
9 treat certain kinds of low-paying patients? But that's a
10 very different kind of scenario for me from the primary care
11 side on the other end of the spectrum.

12 And Bruce, you're an advocate of paying primary
13 care physicians more, I know, but they got into this dilemma
14 because they're looking for other revenue to support a tough
15 office situation. So it's not just the per click
16 arrangements but it's also bone density and things like that
17 that they've put in their offices that isn't always high
18 quality.

19 But the worst of all is where I see a primary care
20 group that is on the campus or next to a hospital having per
21 click arrangements with MRI freestanding operations that are
22 as far as 15 miles away, and then they're getting real

1 income for the leasing or the per click arrangements. Those
2 things are the things that really ought to be -- there's no
3 reason that we shouldn't close those loopholes as soon as
4 possible.

5 So two different examples but I think you have to
6 begin to separate some of these and due pick off some that
7 are early opportunities.

8 MR. HACKBARTH: Any reaction from the panel?

9 DR. CASALINO: I would just say that I agree. I
10 haven't yet heard -- as I hope I implied in my presentation
11 maybe there are good arguments for per click arrangements
12 and similar kinds of things but I have yet to hear one. And
13 I think you have described it very well.

14 MR. BERTKO: A quick question probably for Bruce.
15 I've been on site with one of the biggest RBMs and their
16 claim was that for some of the most expensive procedures
17 their denial rate was almost always upheld. I was wondering
18 whether you looked at the rate of appeals and appeals
19 overturned for any of those RBMs you might have visited?

20 MR. STEINWALD: No, we didn't try to independently
21 validate what we were told by the plans and the RBMs. But
22 it's very interesting. In fact, when our report was in

1 draft we had two organizations review it in our office. One
2 was AHIP, American Health Insurance Plans. The other was
3 AMIC, the Access to Medicare Imaging Coalition. And you can
4 imagine they have different views of prior auth.

5 What AHIP said is that they believe that the rate
6 of outright denials is very low and becomes lower over time
7 as the prior auth radiologists work with the physicians who
8 were requesting prior authorization. I don't have a
9 statistic but it's very, very low. And they see prior
10 authorization more as an educational tool as well as a cost
11 control tool.

12 AMIC sees it very differently, sees very little
13 education benefit. It says that the reason for outright
14 denials being low is that doctors get tired of jumping
15 through hoops and they withdraw their request, as opposed to
16 waiting for it to be denied.

17 So who's right? I suspect a little bit of both
18 but I can't cite you any statistics.

19 DR. KANE: I have one question which is actually
20 two but I'm going to combine it into one.

21 In a way, it's a bit -- I guess the question is to
22 what extent is imaging growth any different than what we saw

1 10 or 15 years ago in physical growth and rad growth when
2 physicians start to self-refer? And what is the threshold
3 at which somebody decides this is too much?

4 We've done it before, it's kind of a whack-a-mole
5 problem. You take away one source service that you can
6 self-refer to and then another one pops up. I'm just
7 wondering, should there be some standard level of evidence
8 at which self-referral is no longer allowed? And that
9 wouldn't necessarily pick on imaging. There's other types
10 of services.

11 I guess the other part of the question is all of
12 these different methods, how much of these problems would go
13 away if Medicare patients who were not poor had to pay the
14 20 percent copay out-of-pocket?

15 I'm sorry, that was two questions.

16 MR. STEINWALD: I don't know.

17 DR. BAKER: I don't think there are direct studies
18 of the latter question on imaging, particularly. There are,
19 certainly, bits of economic evidence that suggest that if
20 you made patients pay more for this they would use less.
21 And one could start to build from there a case that there
22 would be some effect. But I wouldn't even want to begin to

1 speculate about how big that would be at this point.

2 Is imaging different? I think it's a good point
3 that you make. There are certainly differences in spending
4 on different kinds of things and it seems to me that when
5 things get expensive we start to look at them. We spend a
6 lot of time on MRI but there's also self-referral for x-ray
7 and that gets less attention other than in the global
8 imaging kinds of calculations. But one would find the same
9 kinds of effects for x-ray in our work. If you buy
10 an x-ray machine you use more x-rays, as well. We just
11 don't spend time on it because actually they're only
12 reimbursed by Medicare -- well, for 5 percent of the cost of
13 an MRI or something like that.

14 It's a good point and it seems to me that it's the
15 dollars.

16 MR. STEINWALD: And imaging really does kind of
17 stand out. I appreciate your remark about at being other
18 services at different points in time. But when we look at
19 it it's partially an affordability issue as well. It may
20 well be, as Larry said, there are some services that are of
21 benefit to patients for different reasons other than
22 strictly speaking clinical benefit. At some point, Medicare

1 I think needs to, as you well know, look at its spending
2 trends from an affordability and financing standpoint as
3 well as clinical appropriateness.

4 DR. SCANLON: I really appreciate this because I
5 think it really highlights beyond the question of getting
6 the prices right and deciding who are the right people to
7 provide a service. You really need to look at the
8 individual services that are being provided.

9 My question would be shouldn't we give post-claims
10 review a decent chance to work? Bruce, you characterized
11 the current situation has pay and chase. I think we could
12 review and then decide to pay as one option.

13 The other thing that I think that we need to think
14 about, and this is maybe in part CMS's response, Medicare is
15 different. It operates with very skimpy administrative
16 resources and it has to operate in a world where everything
17 is transparent. I think those two things are very important
18 to consider when you think about prior authorization
19 because, as Mitra said, it's got a bad reputation already.
20 And if Medicare starts to do it badly it only continues to
21 tarnish the reputation.

22 So the question that is giving post-claims review

1 a decent shot would involve improving the resources that are
2 available to do this, doing it in some ways in an
3 enlightened way. Maybe pick up on Larry's idea that we're
4 going to target this to particular providers. Not everybody
5 is going to have post-claims review. Not everybody's going
6 to have to submit additional documentation. But we're going
7 to expand what was now under focused medical review in the
8 imaging area in a very broad way so that we actually can
9 deal with the kinds of trends that we're concerned about.

10 MR. STEINWALD: No question about the skimpy
11 resources. And if CMS's response to our recommendation had
12 been we think it's a great idea but we need the resources to
13 implement, our response back to them would have been we
14 think you should have them. But of course, that's not the
15 dialogue that occurred.

16 As far as giving post-payment claims review a
17 chance, obviously we didn't criticize CMS for highlighting
18 imaging as an area for focusing on post-payment claims
19 review. We said that that's a good idea but of course
20 that's more fraud-oriented than appropriateness-oriented.
21 Maybe it will have an effect and we will know that within a
22 few years.

1 I would hate to wait for several years to
2 implement a more front-end approach if that's what the
3 implications of giving post-payment claims review a chance.
4 I think our position would be to do both in conjunction.
5 And if CMS needs more resources for a more front-end
6 approach, I think we believe they should have them.

7 DR. CASALINO: I'm sympathetic to what you say
8 about the problems with prior authorization. I'm not so
9 sympathetic of Congress not spending \$1 to get \$5 but that's
10 another debate.

11 But I don't have much optimism that post-claims
12 review could do it. If you're doing it just on claims you
13 might detect some fraud but I don't think it would get at
14 the broader problem.

15 I think if you start to demand documents, that
16 gets labor-intensive and it's much more intense than prior
17 authorization because here you have people who have provided
18 a service and now you're saying you won't pay them so it
19 even multiplies the problem.

20 So I think it's an interesting point but I would
21 be surprised if it would do it.

22 DR. MILSTEIN: In the GAO report one of the

1 findings I found very compelling which Bruce didn't have a
2 chance to draw out was that the commercial HMOs that have
3 put these pharmacy benefit management firms in into -- have
4 implemented them, if I'm going to quoting this correctly,
5 have experienced a 50 to 75 percent reduction in imaging
6 studies compared to their pre-implementation state. I
7 assume I have that approximately right?

8 MR. STEINWALD: I didn't emphasize that other than
9 I think I said that the plans that are doing it believe they
10 have achieved savings that warrant the added cost. But
11 since we didn't independently try to verify their claims, I
12 didn't think I should emphasize that.

13 DR. MILSTEIN: My question is as follows: the
14 more precise the control tools one wants to apply in either
15 assuring quality or appropriate utilization, as a general
16 rule the more burden they tend to impose both for those
17 applying the controls and those subject to controls. So
18 there's a trade-off between precision of control and amount
19 of burden in implementing it or being subject to it.

20 And I think prepayment review against guidelines
21 is very precise. Essentially you're attempting just to pick
22 off those services that don't meet guidelines. But they

1 unfortunately bring along with them a non-trivial
2 implementation burden both for those being reviewed as well
3 as those doing the review.

4 I wondered, obviously Medicare has begun to put
5 its toe in the water with respect to low administrative
6 burden but obviously blunter tools. I'm thinking of things
7 like the code creep automatic offsets that have been applied
8 I think to the Medicare Advantage plans and perhaps hospital
9 DRGs. I don't know, but that's an example of a blunt tool
10 but it has low administrative burden both on those doing the
11 implementation and those being judged.

12 I wonder if any of you could comment on the pros
13 and cons of something similar in relation to self-referring
14 physicians with respect to imaging? That is, based on
15 research that might still need to be a little bit more
16 refined, if we can infer what the incremental use is of
17 physicians who are self-referring relative to their peers
18 who do not own the equipment, what would be the pros and
19 cons of simply a fee adjustment to offset the detected
20 percentage increase that is purely associated with owning
21 rather than not owning imaging equipment?

22 MR. STEINWALD: Well, I find it hard to respond to

1 that. Again, in Medicare a fee adjustment of that kind
2 would probably require statutory change, and it could be
3 quite difficult to both design and implement. And so I'm
4 not saying it's a poor idea. I think getting the prices
5 right, as Bill said, could be service and physician
6 practice-oriented specific. But I think very hard to
7 implement, especially if statutory changes required.

8 MR. EBELER: Thank you very much for your
9 presentations.

10 As I hear the sum of them and move to policy, it
11 sounds like one would think about some targeted approaches
12 possibly looking at inappropriate arrangements. I think
13 Peter flagged some of those. Some of you mentioned them.
14 Prior authorization may be targeted to places where we have
15 particular concerns. It sounds like an interesting package.
16 It's difficult obviously technically in a lot of ways.

17 For everybody to put that in context of other
18 things that we've talked about both yesterday as in other
19 Commission things, none of these sector-specific constraints
20 are fun. And when we look at just imaging it's sort of like
21 why are we picking on imaging? I guess to go back to the
22 context chapter yesterday, we are sort of looking at

1 everything. And sort of as the Commission processes this,
2 it's sort of looking at this in the context of the total
3 cost discussions we're having. And I think particularly
4 within the physician community the growth here implicitly,
5 and in some cases explicitly, constrains sort of fees for
6 all the rest of physician services. So this is not -- just
7 that total cost context, I think, is important.

8 Second, I would be curious of any of the panel's
9 recommendation about other -- sort of the broader way arrays
10 to deal with this. We're talking about utilization now but
11 I think just the last two questions -- one would look at
12 this growth and say we probably still have a fee problem
13 here. When you have this kind of growth one suspects that
14 one is overpaying. We've also talked a little bit about the
15 Resource Use Measurement project that we talked about
16 yesterday, getting information about total resource use.

17 If you could elaborate beyond the particulars here
18 about the breadth of tools one might use to get to some of
19 these problems.

20 MR. STEINWALD: Actually you, MedPAC, have done
21 work in this area and have come to the conclusion that a lot
22 of the fees that are set for new technologies assume a level

1 of usage that may be accurate when they're in the early
2 diffusion stage but inaccurate once they more thoroughly
3 diffuse. I think your work in that area is very apropos of
4 imaging as a technology that's advancing and diffusing very
5 rapidly.

6 One of the interesting things about that
7 advancement and diffusion is how suitable the new
8 technological advances seem to be for doctors' own offices.

9 So this whole issue about well, what's an
10 appropriate level of use is sort of setting dependent, too.
11 On the other hand, one could argue that the payment level
12 ought to be at the efficient level of use. And if a given
13 practice is unable to achieve that level of use, that
14 doesn't mean that the payment rate should be higher.

15 But you've done the work on this area I think
16 that's most definitive.

17 DR. CASALINO: Conceptually, I don't think this is
18 -- politically this is a hard problem to fix. Conceptually,
19 there's always going to be problems as long as we're in a
20 fee-for-service system. But even in this present system I
21 think most of the problem could be taken care of in terms of
22 cost and quality if the conditions -- if there were

1 standards for what you had to do to do imaging things. And
2 certainly Medicare could do that.

3 Consider prior authorization, especially for --
4 this is technically harder and politically as well -- but
5 for the high users. Ban some of the more obviously abusive
6 arrangements like per click. And take a good look and see
7 what's going on with IDTFs. And I don't know if there need
8 to be any policy changes there or not.

9 Personally, I think those things are -- well, you
10 know better than I do whether they're doable. But I think
11 if they were done they would reduce the cost problem a lot
12 and we'd also have much higher quality overall of the
13 imaging that's done in the country.

14 DR. BAKER: Let me take a slightly more concerned
15 view of the ability of just standards and other related
16 control mechanisms to be effective over the long run because
17 the technology is evolving quickly. Because as we put more
18 of these things in the idea about what's appropriate
19 practice will change over time. And so I would actually
20 think that you probably need to do things beyond that to
21 really make progress.

22 So without knowing exactly how the DRA fee changes

1 and so have affected things, I don't want to take a strong
2 point of view. But I would certainly believe that changes
3 in fees could be a way to change the incentives here and
4 would probably have a noticeable effect on things. I think
5 there's just lots of economic evidence from other places
6 that that's something that you could consider. But it would
7 be very informative to see how some of the last couple of
8 years have played out with the DRA fees as a starting point
9 to start to understand that better.

10 DR. CASALINO: If it may, I just want to emphasize
11 that we do need to see how that plays out because if you
12 lower fees for physician visits you may -- well, there is
13 some data on what happened with that. But because it takes
14 you no time to order a scan, as long as you're making some
15 money on it, if your fees are cut you may get fewer people
16 buying machines. But the people who have machines, they're
17 not necessary going to do fewer scans because their fees are
18 cut. They may do more scans. But we'll see what the data
19 shows.

20 DR. BAKER: That's a good point.

21 DR. REISCHAUER: Just elaborating on a couple of
22 things that have already been talked about. And Bruce might

1 have answered this question but we're all concerned that
2 financial incentives might lead to inappropriate
3 utilization.

4 My first question in listening to the
5 presentations was why hasn't somebody tried to compare the
6 level and growth of imaging in fee-for-service Medicare with
7 that that occurs in capitated plans? And that might not
8 come up with what's necessarily medically appropriate but it
9 would be what's politically feasible and medically threshold
10 there. And maybe the data aren't available and, Larry,
11 maybe you've looked at it and know the answer.

12 But going to Jack's point about the payment
13 levels, one would think it must be too high. Having sat on
14 this Commission for nine years, any time that I see a
15 tremendous expansion in service delivery in a certain area,
16 an increase in the fraction of services provided by the
17 private sector, and the development of innovative financial
18 arrangements, bells begin going off and you think well,
19 we're probably paying too much.

20 This is a very difficult area because of the
21 nature of the costs of the services which a huge chunk of it
22 is a capital cost. And so the way you reduce your per

1 service cost is to increase the volume. One would think
2 well, then maybe we should either set prices assuming a
3 very, very high volume or we should have the prices vary
4 with the total volume of images for both Medicare and other
5 providers that this machine serves. But that gets you into
6 then a whole bunch of other problems.

7 And I come back to where I think I've been for a
8 long time, which is is there any way out of this except
9 bundling and capitation to get the incentives right?

10 [Laughter.]

11 DR. BAKER: The first question is easier to answer
12 about why haven't we compared capitated settings? And it's
13 a data issue. It's that there's a lot of data on non-
14 capitated settings on utilization and there's not a lot of
15 data on capitated settings. There are a few that we have
16 made some not too energetic attempts to analyze and failed.
17 So one of these days somebody will have some data and there
18 will be a chance. But it just hasn't been done.

19 DR. REISCHAUER: I think people like Jay might
20 have the data if we ask for it. Somebody should.

21 DR. BAKER: It's not that it's impossible. It's
22 just that it's not the low hanging fruit in the area that

1 people have looked at.

2 As for other bundling kinds of incentives, it's
3 certainly the case that those kinds of incentives would
4 change the game a lot and would probably lead to the
5 development of efforts to be more efficient in a way that
6 would happen much faster, in my view, than with fee-for-
7 service kinds of arrangements. I'll just say that much.

8 MR. GEORGE MILLER: Again, I enjoyed the
9 presentation. I thought it was very well done.

10 I was struck by your comments about IDTFs and the
11 fact that they were somewhat unknown. That causes some
12 concern to me.

13 Do you have -- can we give you a challenge to get
14 more information? I can only give you anecdotal information
15 as a hospital CEO. A firm came into our community and told
16 us they were coming and that they would be going to all of
17 the primary care physicians and take and suck business out
18 of the outpatient and inpatient hospital setting to do that
19 if we were not interested in partnering with them. And I
20 think this particular growth or this particular area has
21 some major problems.

22 And so from a policy standpoint, what would you

1 recommend how to approach this particular issue?

2 Now I realize my statement is one person
3 anecdotally but I suspect that more of this is going on,
4 particularly since you couldn't find out a lot of
5 information about who owns them and their method of
6 operating.

7 DR. CASALINO: I do think they need to be studied
8 and I think it's the kind of thing that would be hard for a
9 non-governmental person to do. Laurence or I can't really
10 go out and demand -- first of all identify IDTFs and
11 secondly demand that they tell us who owns them. But maybe
12 Bruce can, or whomever.

13 So I do think it's an area that, much as I'd like
14 to study it, I think that's an area that maybe has to be
15 done by someone with some mandating authority. And I think
16 it should be done.

17 It's hard to make policy when you don't know about
18 them.

19 MR. GEORGE MILLER: Part of your policy
20 recommendation is that we eliminate per click
21 recommendations, that would include IDTFs, as I understand
22 the way they operate or the way they told me they would

1 operate.

2 DR. CASALINO: Yes, but I agree. I have no idea
3 how common per click arrangements with IDTFs are and I don't
4 think anybody does. But that should be known.

5 MR. GEORGE MILLER: They take Medicare dollars.

6 DR. CASALINO: Yes.

7 MR. STEINWALD: Indeed, they do.

8 DR. CROSSON: I want to compliment all three of
9 you for bringing us a very good mix of data and judgment
10 because that's what we have to use to try to make our own
11 judgments in the end. All three presentations are very
12 good.

13 A lot of the ideas that I had had for questions
14 have already been asked and answered.

15 I would just make one comment on Bob's comment. I
16 do think that since where we're going to end up is likely to
17 be some very targeted recommendations, the idea of trying to
18 understand more thoroughly with the use of benchmarks what
19 the ideal practice or the range of appropriate practice
20 would be is possible. And I think there are benchmarks that
21 we could use from both the prepaid group practice community
22 but also the somewhat larger multispecialty group practice

1 community where the physicians are not necessarily paid in a
2 way that would act as an incentive for increased utilization
3 of imaging, salaried physicians and the like. And Dr.
4 Baker, right next to you is Dr. Casalino who has the NSPO
5 database which is one of the largest databases on the
6 characteristics of those practices. So there is, I think,
7 some room there.

8 I did have one specific technical question for Dr.
9 Baker and it has to do with the question of whether the
10 impact that you showed of self-referral could be understated
11 a bit. I noticed that you chose a period of seven days
12 after the initial office visit and the performance of the
13 imaging procedure. It strikes me as a bit short. When you
14 did a calculation of total costs later on you used 30 days.

15 I wondered why you chose seven days and whether or
16 not you have some concerns that that might, in fact,
17 understate what you were examining?

18 DR. BAKER: We chose seven days because we had to
19 pick something and we had to make the analysis work. So
20 we've actually done it seven days, 14 days, and 30 days. As
21 you go from seven to 30 you increase that estimate slightly.
22 So from the orthopedists it's 1.5 percent at seven days.

1 It's probably about 1.8 percent or 1.9 percent maybe at 30
2 days. So there's not a lot of action out there but there's
3 some. And one of the things that we started to be worried
4 about was just other things happening out past that visit so
5 we thought seven was a little cleaner to present. But
6 there's no reason that that has to be the case. It could be
7 that all of that is associated with that index visit and
8 that's a real estimate.

9 There are other somewhat technical reasons that
10 the estimates could be slightly understated. There are
11 other things that you could have raised that I will just
12 maybe in the interest of time not spend a lot of time and
13 effort on. But there are a couple of reasons, notably that
14 the control group in our analysis for time trends include
15 people who are billing to IDTFs who may have some increased
16 use also. So our control group is not a perfectly clean
17 control group of people who don't have any incentive at all.
18 And so that may lead us to also slightly understate the
19 effects, probably not by a lot but maybe by a little bit.

20 DR. CHERNEW: That was really fascinating. I will
21 try and be really brief. I recognize given this and
22 everything that we have to do something in the short run and

1 we have to work with the tools and the framework that we
2 have. But my overall opinion is going forward we need to
3 begin to think about diseases and patient groups, as opposed
4 to services. I was encouraged as we have to address these
5 things in the short run to try to think of ways to think
6 about diseases and patients and not services because there
7 is such a heterogeneity in this. I just think, thinking on
8 the surface level, it sometimes becomes somewhat
9 counterproductive.

10 I will go on the record because I'm told we have
11 to go on the record that I'm skeptical of prior auth. I
12 could be convinced otherwise. But for the reasons the Bill
13 said and others, I think having prior auth work well in
14 Medicare for a range of reasons I would need to be a little
15 more convinced of.

16 Which leads me to my question, which is how much
17 of these services could be bundled in an episode? How much
18 of them would define their own episode? How much of this
19 increase is in a new person getting one image versus one
20 person getting more frequent images for the same thing? I
21 think to think about this in this bundling way -- and I very
22 much agree with what Bob said -- I need to understand more

1 if these are just within an episode we're just doing more
2 imaging or if all of a sudden we have just have a whole
3 bunch of new episodes that are going to be defined by the
4 fact that there is now this image that was done?

5 Sorry.

6 MR. STEINWALD: It sounds like it would be useful
7 information to have, especially as you continue your work on
8 bundling, to know how much of these advanced imaging
9 services are going to be captured in a bundle. That would
10 be obviously very useful information. We don't have it, or
11 at least I don't.

12 DR. BAKER: All I can say from our work is that
13 there does seem to be plenty of expansion with a fixed
14 definition of what an episode looks like. So an index visit
15 to an orthopedist following a period in which you haven't
16 had any orthopedist visits, start with an outpatient E&M
17 code and go forward, there is plenty expansion of imaging
18 holding that definition of an episode fixed over time, we
19 see lots of expansion in imaging. Whether there would be
20 other episode definitions that would start to shed light on
21 your question more broadly, we have certainly not explored
22 but it seems to me to be a very interesting question.

1 MR. STEINWALD: Just to add a little bit, we see a
2 lot of the growth in imaging services in cardiology and
3 orthopedics, both specialties that are -- where episodes
4 occur. So I can't directly answer your question but I
5 suspect that a lot of that growth in those two specialties
6 is within episodes that would be captured, at least in part,
7 through some bundling technique.

8 DR. MARK MILLER: Let me just say something
9 quickly here. I'm not going to go into it because we don't
10 have much time. We have some work going in the background
11 using episode groupers and that type of thing for a couple
12 of reasons and may be able to get at some of what you're
13 asking.

14 DR. STUART: I would simply like to reiterate a
15 point I made yesterday, and that is that CMS has recently
16 promulgated a rule that requires that MA plans provide a
17 complete 100 percent reporting of event level data and that
18 this is an opportunity or presents an opportunity for MedPAC
19 and others to provide the kind of benchmark data that Jay
20 has mentioned and that Bob has mentioned if that data become
21 available. So there's nothing that says we don't know the
22 quality of the data, we don't know when it will be

1 available.

2 But it's just something that ought to be on our
3 radar because this is one of a number of different kinds of
4 studies that MedPAC could undertake that would help us get
5 inside that black box of MA.

6 DR. BORMAN: Just trying to look at this in some
7 sort of bring it back together way, cohesive way, for me as
8 a surgeon and not an economist. I see this as having
9 basically three pieces and I have some questions about how
10 the pieces interrelate. One is sort of what I might term
11 the technical piece. And that really is the facility, the
12 utilization, the equipment, the delivery, kind of not the
13 clinical appropriateness part. You've alluded to the
14 previous work here about 50 percent utilization versus
15 higher percentage time of utilization of the equipment. It
16 seems to me that that may, in fact, continue to be some low-
17 hanging fruit on the technical side.

18 Also, sort of on the provider side if you will,
19 there's the appropriateness piece which your presentations I
20 think helped inform very nicely.

21 And I see that as having two pieces. There's sort
22 of an immediate potentially low-hanging fruit piece. The

1 American College of Cardiology, for example, has very nice
2 guidelines. We had their presentation before. They have
3 very nice guidelines about some things. You've identified
4 cardiology as one of the explosive growth areas by
5 comparison -- maybe for good reason but explosive growth
6 area. Why are we not in a position to take those good
7 guidelines that they have addressed and implement them as
8 some sort of screen?

9 It needs to be done, as much as possible, in an
10 automated way for all the reasons that people have alluded
11 to Medicare, difficulty to deal with, potentially
12 preauthorization things. And with Larry's point about
13 protecting the 80 percent of people that are doing the right
14 thing. But there may be some very ready to roll guidelines
15 that could identify some egregious things that could, in
16 fact, go forward.

17 I think on a more strategic level what I hear, to
18 some degree, is going on is we have a payment system to
19 physicians that grew out of an era that was dominated by
20 hospital-based care. And in the RBRVS practice expense,
21 back when it was developed, didn't really include owning a
22 lot of equipment, not big-ticket equipment like MR machines.

1

2 So this, to me, says to some agree we've outgrown
3 the practice expense component of the fee schedule. And are
4 there some creative ways to move that outside? Looking at
5 this over the longer term, is that part of the long-term
6 solution?

7 And then finally on the beneficiary/consumer side,
8 what I heard loud and clear that bothers me very much is the
9 safety issue. And I think that that again should be low-
10 hanging fruit. I have a bit of problem with accreditation
11 versus privileging. But I think accreditation ought to be a
12 no-brainer and low-hanging fruit.

13 And there are some basic standards about radiation
14 safety, training of technicians, shielding of patients and
15 things that every patient is entitled to with every
16 radiologic study. We ought to stand foursquare behind that
17 kind of thing now. And that brings benefit to the
18 beneficiary right now.

19 So I see this as a three-pronged thing, sort of
20 thinking about the piece we've already recommended about the
21 utilization, a second piece of big picture does practice
22 expense belong in the RBRVS for these kinds of things,

1 implementing guidelines that are ready to go now, and let's
2 make it safe for the patient. And are there other things
3 that we could do or could you tell me what you think about
4 the practice expense piece particularly, how that
5 interdigitates with what you've shown us?

6 DR. BAKER: I have not thought enough about that.

7 MR. STEINWALD: It's always good to think before
8 you speak.

9 DR. BORMAN: You maybe wish I had.

10 MR. STEINWALD: That only works if you can think
11 of something to say.

12 DR. MARK MILLER: I know you're struggling with
13 this. I think really, particularly the last one you said,
14 that's in our -- that's in our -- I mean, if you guys want
15 to pick it up, too, knock yourself out.

16 MR. STEINWALD: I was going to hand it right off
17 to you.

18 DR. MARK MILLER: I sort of felt that was coming.
19 And if I had a pointer, I'd get the --

20 [Laughter.]

21 DR. BORMAN: Should we all chip in and buy you a
22 pointer?

1 DR. MARK MILLER: It's a thing between he and I.
2 Let me deal with it.

3 I think that one kicks into our court. There has
4 been work done by Ariel and Nancy on the practice expense
5 component and this Commission has raised this issue of the
6 utilization rates and how that's built in. We talked about
7 things like surveying. But the other thing -- and this came
8 up but I want to make this point clearly to everybody in the
9 room -- the other way you can think about this is what
10 should be the standard? What is an efficiently run
11 practice? And set the use rate at that level and make the
12 payments on that basis.

13 And that also, by the way, has a price effect
14 which was, in part, discussed here as well. But I think
15 that one falls on us at the moment. We probably have the
16 most work on it and something that we can very much bring up
17 with the Commission and work through with you guys in the
18 next few months.

19 MR. HACKBARTH: On the third piece, the
20 accreditation piece, we had made recommendations I guess two
21 years ago that there be an accreditation process applied to
22 these services for both the technical and professional

1 components. In MIPPA, as I understand it, Congress picked
2 up the technical piece and is requiring a process of
3 accreditation, which I assume will include safety issues, as
4 well.

5 MR. STEINWALD: For advanced imaging.

6 MR. HACKBARTH: Yes, for advanced imaging, thank
7 you.

8 We're out of time. Great job. We really
9 appreciate your investing the time and look forward to
10 working some more on this issue. I'm sure it's going to be
11 around for a while.

12 [Pause.]

13 MR. HACKBARTH: The next presentation is on Part D
14 and a discussion of our work plan for the coming year.

15 MS. SUZUKI: Good morning. Rachel and I are here
16 today to talk about our work plan for Part D. Even though
17 it's just the two of us up here, we wanted to acknowledge
18 our colleague Joan Sokolovsky, who's been central to our
19 Part D work.

20 Medicare's Part D benefit is now in its third
21 year. The program now has more than 25 million enrollees
22 and an annual benefit spending of about \$50 billion. During

1 the past three years we have reported on various aspects of
2 Part D, including how the market for private plans unfolded,
3 how beneficiaries chose among plans, and trends in plan
4 enrollment, benefit design, formularies, and premiums.
5 We've relied on information from CMS and data gathered
6 through beneficiary surveys, focus groups, and interviews
7 with relevant stakeholders to report on these.

8 The Commission has been recommending that we and
9 other Congressional support agencies get access to Part D
10 data for a long time. The recent change in Medicare law
11 will give us and other agencies access to this data and, as
12 Mark mentioned to you yesterday, we just received the 2006
13 claims data.

14 The claims information will significantly expand
15 the types of analysis we are able to conduct and will allow
16 us to better analyze issues related to cost, quality, and
17 access. Over the next few months, we will be working hard
18 to understand the data and also get a handle on whether
19 program's initial startup difficulties and data reporting
20 issues may have affected the quality of the 2006 data.

21 The potential agenda for Part D research is
22 extensive. We've identified topics of interest group by

1 those that did not require analysis of claims information
2 and those that do. In many cases, projects that do not
3 require claims information are already underway and we are
4 hoping to report some of the findings in the March and June
5 reports.

6 Most projects that require claims information are
7 not yet underway and they will take longer to analyze. We
8 do not expect to have results that could be included in the
9 March 2000 report but once we have a handle on the 2006 data
10 we will begin answering basic questions about Part D with
11 these data and we'll bring our analysis to the Commission as
12 soon as possible.

13 Next we'll discuss the research topics in these
14 two categories in a little more detail. We've identified
15 four major areas of research that do not require claims
16 information. The first area is our usual analysis of Part D
17 marketplace, monitoring trends in plan enrollment, benefit
18 design, formularies, and premiums using the same data
19 sources that we've been using in our past March reports to
20 Congress.

21 The second area is the Medication Therapy
22 Management or MTM programs. Part D requires plans to offer

1 MTM programs for beneficiaries with multiple chronic
2 conditions and high drug costs. One example of an MTM
3 program is when plans pay pharmacists to speak with
4 beneficiaries about the drugs they're taking and discuss
5 safety issues and promote better adherence. Currently there
6 are no standard performance measures to evaluate the
7 effectiveness of the MTM programs. We are looking into
8 various MTM programs under Part D and in the private sector
9 to explore best practices.

10 The third area is beneficiary-centered assignment.
11 Yesterday you heard a presentation by Jack Hoadley on this
12 topic. We plan to explore this and possibly other
13 approaches that may minimize the disruptive effects
14 associated with changing plans.

15 Finally, we plan to look into the effects of using
16 specialty tiers and the role of biologics. We've already
17 touched on plans' use of specialty tiers in our past work.
18 Remember from our presentation last fall that most Part D
19 plans now use a specialty tier for drugs that cost \$600 or
20 more per month. Enrollees pay a 25 percent to 33 percent
21 coinsurance for these drugs and cannot appeal those cost-
22 sharing requirements as they can for drugs on other cost-

1 sharing tiers.

2 These drugs are often for serious conditions like
3 rheumatoid arthritis and multiple sclerosis so their Part D
4 cost-sharing is often in addition to cost-sharing for other
5 medical services. NORC and Georgetown University is already
6 working to help us understand which drugs are on specialty
7 tiers using formulary data.

8 Many of the therapies and specialty tiers are
9 biologics which are newer therapies that are more complex to
10 produce than simple drugs. Biologics are a relatively small
11 share of spending today but we expect that share to grow
12 faster than for other kinds of drugs over time.

13 Because of features built into Part D Medicare may
14 end up paying for a higher proportion of the cost of
15 biologics than for other types of drugs. Therefore, the
16 Commission may want to consider issues related to biologics
17 and follow on biologics.

18 I'm going to turn it over to Rachel, who's going
19 to talk about topics that do require claims information.

20 DR. SCHMIDT: I'm going to go through a pretty
21 extensive list that could easily keep us busy for the next
22 several years.

1 The first project is already ongoing. We've
2 contracted with Dr. John Hsu of Kaiser Permanente's Northern
3 California's Division of Research to look at Part D risk
4 adjustment. This project is already underway because Dr.
5 Hsu obtained Part D claims information directly from several
6 insurers. He's using those data to see how the predictive
7 power of risk adjusters changes when you add information
8 about an enrollee's past prescription drug use and whether
9 there are ways to do this without diluting plans' incentives
10 to control drug spending. He's also looking at how well the
11 risk adjustment factors perform for low-income subsidy
12 enrollees.

13 Shinobu told you that we received 2006 claims
14 information from CMS just this week. We are literally just
15 looking at the files. So we're obviously just beginning to
16 do that.

17 But getting these data out is a really complicated
18 task. CMS has been working hard to do this and they're
19 still preparing some additional files that both we need and
20 external researchers need as well to analyze these claims
21 information a little more thoroughly. This is going to be
22 an ongoing process. We also hope to get 2007 data from the

1 agency sometime either at the end of the year or perhaps
2 early next year.

3 We're going to use those data to analyze some
4 basic questions that we all want to know about, such as
5 those on the slide: the number of enrollees who are reaching
6 the coverage gap, average out-of-pocket spending and the
7 drugs and drug classes that are used mostly widely by the
8 population.

9 Another topic that we think will be important is
10 geographic variation. Remember that at the Commission's
11 planning retreat last summer you decided that you would like
12 the staff to look at geographic variation on a topic by
13 topic basis. So here's an example of that. For Part D, we
14 want to know whether there's as much variation in drug
15 spending as has been observed in Part A and Part B spending.

16 Shinobu described the issue of specialty tiers and
17 the fact that we already have some work underway on that
18 issue using plans' formulary information. But if, in
19 addition, we start using claims information to look at that
20 topic, another avenue of research would be to identify the
21 enrollees who use the drugs on specialty tiers, look at
22 their levels of out of pocket spending, whether they're

1 hitting the catastrophic cap, and those kinds of questions.
2 So claims will help us better analyze some of the questions
3 about equity that surround specialty tiers.

4 In past work, we've talked about special groups of
5 beneficiaries that we want to keep an eye on. Enrollees who
6 receive low-income subsidies are one example because CMS
7 reassigns some of them to different plans each year. We've
8 also talked about beneficiaries who live in nursing
9 facilities and how Part D works in their context. With
10 claims information we could look specifically at these
11 groups and see whether they've continued on the same
12 medications or whether they've switched to a different drug
13 in the same therapeutic class. We'd also like to know how
14 many have discontinued therapy but we'll have to be careful
15 there because all that we have are Part D claims. We won't
16 know, for example, if someone started buying drugs on their
17 own or off-formulary, outside of the Part D plan. The goal
18 here is to look at their access and medication adherence.

19 Claims will also help us identify all sorts of
20 beneficiaries who are spending at the levels that put them
21 into the coverage gap and how they respond to paying for the
22 full price of their drugs out-of-pocket. What are the

1 effects of that higher cost-sharing on adherence to their
2 drug regimens? And more broadly, linking Part D claims to
3 Part A and Part B claims will help us think about whether at
4 an aggregate level there are relationships between adherence
5 to medication therapies and spending for other types of
6 medical services.

7 There's evidence that adherence to drug therapies
8 can help patients control some chronic conditions and keep
9 them out of the hospital but that may not be true for all
10 drugs and all conditions. Also, spending for some types of
11 services like office visits or laboratory use may increase
12 rather than decrease with drug therapy. With claims we will
13 be able to dig a little deeper into those kinds of
14 questions.

15 Medicare beneficiaries who live in rural areas all
16 have access to Part D plans and probably all of them can get
17 mail order pharmacy services. But some have less choice of
18 retail pharmacies because of where they live. With claims
19 information we can look at the utilization patterns of rural
20 enrollees. Do they have lower cost-sharing on average
21 because they use mail order services more extensively, where
22 there's a little benefit to using -- in terms of out-of-

1 pocket spending -- to using mail-order? Or do they face
2 higher cost-sharing because they rely more on out-of-network
3 pharmacies?

4 Several of the projects we have in mind relate to
5 cost and spending. With claims data we will be able to
6 analyze how different benefit designs relate to spending.
7 For example, how much more does an enrollee in a plan with
8 no deductible spend relative to a similar enrollee in a plan
9 that has a deductible? Does the presence of low-income
10 subsidies or enhanced benefits lead to higher spending?
11 Those kinds of questions.

12 The Commission has talked before about the fact
13 that Medicare Advantage prescription drug plans may have
14 greater incentive to keep their enrollees adherent to drug
15 therapies than stand-alone plans because MA plans are also
16 at risk for Part A and Part B spending. Now we don't have
17 Part A and Part B claims for enrollees of MA-PDs, although
18 Bruce has talked about the encounter data, but we may also
19 be able to look at whether prescription drug utilization
20 patterns are systematically different between MA-PD and PDP
21 enrollees.

22 And finally, we plan to build one or more price

1 indexes so that we can monitor changes over time and average
2 prices that beneficiaries pay at the pharmacy counter for
3 Part D drugs. This would help us monitor changes in average
4 prices for specific plans as well as for the Part D program
5 as a whole.

6 That's our list of topics that we think are going
7 to be important to address in order to help the Commission
8 evaluate the Part D program more thoroughly and we look
9 forward to your questions and comments.

10 MR. HACKBARTH: Thank you.

11 DR. MARK MILLER: I should emphasize two things
12 really quickly. I just want to say again how much we
13 appreciate the efforts of CMS in getting the data to us.
14 And this agenda will take a really long time.

15 DR. STUART: You've done a wonderful job on this
16 chapter. As someone who has been working in this area for a
17 number of years, one of the things that the delay in the
18 data have done is that it's given us a couple of years to
19 think about all the different kinds of studies that we'd
20 like to do. And so trying to put that in an agenda is a
21 challenging prospect.

22 The one suggestion that I have here is that

1 because the nature of the data will only be available from
2 CMS and they will be coming through a porthole known as
3 ResDAC, it would be I think useful for MedPAC to monitor the
4 access to Part D data on behalf of both other Federal
5 agencies as well as private researchers. And that would
6 help when you see the kinds of projects that have been
7 proposed and approved, we hope, we will have some sense of
8 where your research agenda falls within the larger research
9 agenda of the private sector as well as other Federal
10 agencies. And I think that might help you as we go forward
11 on this.

12 The other thing that I would mention in this
13 regard is that there is some question in terms of the
14 availability of certain data elements to the private
15 research audience and it's really too soon to say yet
16 whether that's going to be problematic. But monitoring that
17 I think would also be helpful, because there are just way
18 too many questions to be answered just by MedPAC and it
19 would be useful to put this in that larger context.

20 The only other comment that I would make -- I have
21 a number but in the interest of time I'm going to restrict
22 myself to the MTM evaluation which you've indicated can be

1 done without claims data. I would suggest that there is a
2 real potential in this program for doing some good in terms
3 of improving the quality of medication management,
4 particularly for those with very complex disease. And an
5 evaluation of this I think really does require claims data.
6 And so I would put that in your list of studies that if you
7 had claims data.

8 Now I know that the actual information you have
9 about what is done within MTM service contacts is limited or
10 nonexistent, but at least know who has been administered
11 these services and to look if that has had any effect on
12 both their utilization of Part D as well as Part A or Part B
13 services.

14 And then finally, I'd also suggest that you look
15 at the mechanisms by which MTM services are targeted. This
16 program was set up without a lot of prior information in
17 terms of what is the best way to target utilization
18 management services. And frankly, some of the targeting
19 mechanisms that are used today in terms of identifying the
20 number of chronic diseases that should be used, we know
21 there's a lot of variation out there in the market. But all
22 of them are based upon a threshold of drug spending. And

1 we've done some work on utilization of medication by
2 Medicare beneficiaries with diabetes and we actually find
3 that those that have high drug spending tend to have fewer
4 problematic issues with respect to adherence and other
5 things compared to some people that have lower spending.

6 And so using drug spending may, in one sense, be
7 counterproductive. You might want to look at other types of
8 spending. So looking at the ways in which this kind of
9 service could be better targeted, I think would be a good
10 study for MedPAC to entertain.

11 Thank you.

12 DR. CHERNEW: I first will echo what Bruce said,
13 that there's going to be so much private study of Part D and
14 things related to Part D that the more you can find
15 activities other people are doing, you may be able to target
16 what you want to do better in the light of that. Certainly
17 I'd be willing to talk to you. I know a lot of different
18 things that are going on.

19 The only comment I will make is again I want to
20 echo as much as you can to think about things in sort of a
21 clinical orientation, as opposed to not. So an example
22 would be specialty drug tiers. I don't know a lot about

1 them but I would just be very aware throughout that some of
2 the things if you have to pay 30 percent could be really bad
3 and others could be really good. If you have a general
4 conclusion specialty drug tiers make people pay a lot, it's
5 very hard to assess what we should think of that because
6 there are certain situations where you think this is a huge
7 amount of waste and when I hear people are paying a lot and
8 they don't have access to certain things I think great,
9 we're doing our job. And other times when I hear the exact
10 same sentence, I say this is a travesty. We have a program
11 that requires beneficiaries to have access to good care and
12 they can't do that if they have to pay 30 percent.

13 So I'm much less interested in broad statements
14 about certain things like specialty drug tiers or many of
15 the other things or out-of-pocket payments as being good or
16 bad as opposed to understanding clinically what we want the
17 people to have and what they don't.

18 So just like I said in the imaging where I was
19 very concerned that we saw imaging was going up -- and I
20 think a lot of people echoed this point -- is that good or
21 is that bad? Having the separation in that nuance I think
22 is really important to be maintained throughout all of the

1 work.

2 DR. CROSSON: Rachel, thank you. I'm looking
3 forward to this. I think this is going to be a valuable
4 piece of work.

5 I want to emphasize the point that you emphasized
6 and that is the opportunity to look at the relationship
7 between benefit design and cost and quality. To me that's
8 the center of this. Part D has an unusual benefit design.
9 It was sort of bumped into in the night as a design issue.

10 What we've observed subsequently is a couple of
11 things. One is that the cost of the Part D is a lot less
12 than what was anticipated. It's not clear exactly why that
13 is and what relationship that might or might not have to the
14 benefit design. It's also unclear as to what the impact of
15 the set of benefit designs that are out there have on
16 quality. As Mike said, probably some of them are salutary
17 and some are not.

18 So it seems to me that the more that we can
19 understand about this the better not just for the
20 possibility that we could make recommendations to improve
21 Part D but that we might, in fact, learn more about
22 variations in benefit design that could extend to other

1 parts of the Medicare program and begin to add that as part
2 of the list of perhaps more impactful changes that we might
3 want to consider to answer the question that we discussed
4 yesterday, which is what among our recommendations actually
5 match up to the size of the problem that we described in the
6 context chapter?

7 MR. GEORGE MILLER: Thank you, Shinobu and Rachel,
8 very interesting reading. I'd like to pull out just one
9 part of it and just ask a question about disparity. And
10 that's in dealing with Part D and the program, if under the
11 design and the special subpopulation groups we had the
12 opportunity to look at disparities, particularly in health
13 care in general. As an example, Afro-American men who have
14 the same insurance, Medicare, do not receive the same
15 standard of care for catheterizations in one study that I
16 read.

17 So will you have the opportunity to look at that
18 type of data? Will you drill down as it relates to drug use
19 and see if a subgroup like minorities or poor will receive
20 the same drug benefit or receive the same efficacy of drugs
21 to treat different diseases?

22 DR. SCHMIDT: That's a good question. We do have,

1 in addition to claims information, some enrollment
2 information from CMS that does tell us about race. And we
3 can look at geography, as well, as another angle on that.

4 It's not a perfect measure but to the extent that
5 we find it's valid, yes, I think that we will try and take a
6 stab at that as well.

7 MR. GEORGE MILLER: Thank you.

8 DR. MARK MILLER: Was that one of the extra files
9 that we still hadn't --

10 DR. SCHMIDT: No, we do have that one.

11 DR. MILSTEIN: One of the potential uses of the
12 actual claims data that wasn't on the list really would be
13 some kind of a reference to all of the episode-based
14 analyses that we have underway on which a lot of our
15 recommendations hopefully for this year will depend. I
16 think Nancy and other commissioners have made the point that
17 episode-based analyses minus drug data are potentially, at a
18 minimum, attackable if not potentially exposed to wrong
19 conclusions.

20 And so I wanted it to ask -- maybe this is not for
21 you but a combination also a question for Mark -- is the
22 degree to which it's possible for the Medicare A and B data

1 that we've already mobilized for purposes of doing our
2 episode-based and quality analyses, whether it might be
3 possible to at least take the subset of the beneficiaries in
4 that sample for which we do have Medicare claims data and
5 accelerate the prioritization of merging that data in and
6 moving ahead with analyses even if it has to exclude a
7 certain percentage of our episode-based analyses for which
8 we don't yet have Part D data that's passed the screens. In
9 other words, we could at least focus in on the subset for
10 which we have screened Part D data and move ahead with more
11 robust episode analyses for a whole variety of uses that
12 will be relevant to our March and June reports.

13 DR. SCHMIDT: There are some technical issues we
14 need to work through with respect to doing those kinds of
15 merges. I can understand your sense of urgency behind that.

16 One thing we've learned from CMS, for example, is
17 that in drug it's less common to have UPIN or NPI prescriber
18 ID than a DEA number. And that could or could not -- we do
19 not know yet, be a complication in terms of trying to
20 identify the physician who was actually doing the
21 prescribing in the grouper kinds of analyses. So that's
22 just one kind of technical point that we need to work

1 through.

2 MR. BERTKO: First, Mark said it correctly, that I
3 think, Rachel, you and Shinobu have 10 years of work ahead
4 of you here.

5 And then secondly, I'd to make a disclosure. I'm
6 on the John Hsu team. It's in my little part, but I'm a
7 reviewer on there.

8 A couple of comments. The first one is the 2006
9 data is somewhat unstable because of the enrollment patterns
10 in the first part of the year. So good to start with, good
11 to draw some things with. But from what we've seen so far
12 the 2007 data becomes much more stable, even though there
13 was a little bit of reallocation of the low income, the rest
14 of it was fairly stable.

15 Secondly, and this kind of goes to Arnie's
16 question, the big question that Mike, Bill and I asked on
17 the 2004 Technical Panel was do drugs save money on A/B
18 costs? And this is the perfect time for a natural
19 experiment if you can go that far but that might be five
20 years of work in and of itself. And I would just encourage
21 you to think about it not only in the way you've listed it,
22 which is the adherence one, but even beyond that. I would

1 point out that as we collectively think about plan design,
2 Mike's done work in value-based insurance design, as well as
3 Arnie? Knowing, for example, that statins were always cost-
4 effective it might be useful to say statins are always free
5 in the coverage gap or something like that, and drawing out
6 those things as opposed to broadly saying everything is
7 available in the coverage gap.

8 And then adherence I think is a big, big issue
9 across the board. And there are perhaps 20 questions on
10 adherence that you could ask, from whether it's the coverage
11 gap or how long people actually are adherent when they've
12 got clinically chronic conditions, things like that.

13 And then lastly, not only on the low-income risk
14 adjuster but the part of moving from the current risk
15 adjuster which uses A/B data to predict to moving to a Part
16 D data to predict Part D, I think would be a vast
17 improvement at least in theory. And I think having had a
18 preview of John Hsu's work, it's already evident that this
19 is good.

20 So I would look for us to at least be ready to
21 think about that some time and maybe prod CMS to moving a
22 little faster than I think they're moving today.

1 MR. BUTLER: I guess I'll just make the same point
2 in a different way, as I first looked at this. We divide
3 our organizations into subcomponents and we end up with
4 silos that kind of suboptimize performance sometimes within
5 those silos. So where we do with Medicare, we've got A, B,
6 and D, that are set up. And so the tendency is to do the
7 early research just within the D column.

8 I think we ought to, because it's there and it's
9 new and it's just how we set things up. So I wonder if
10 there's a way over the years that this is covered that we
11 just make sure that we kind of just look at the balance, the
12 percentage that is sitting within the D column versus the
13 A/B/D collectively to make sure that that is getting
14 appropriate focus. Because I think a lot of us would
15 believe that in the end that's where the biggest opportunity
16 is, maybe, not just in the D column by itself.

17 DR. REISCHAUER: John made the basic point that I
18 was going to make, which is 2006 is a very uncertain year,
19 both for the reasons you mentioned. But it's a new program
20 both for the PDPs and the beneficiaries. And so I would
21 hope that, first of all, we get the 2007 data in a timely
22 fashion.

1 Secondly, that it's in the same format so that you
2 could quickly do some very rough checks on what you find
3 out. Because the worse thing in the world would be for lots
4 of conclusions for all researchers coming out of 2006 data
5 and Congress going wild about the problems associated with
6 it, and then it turns out it's not really a huge issue.

7 I was wondering whether for people in the coverage
8 gap and adherence issues there is any way of getting --
9 whether they are fulfilling prescriptions through
10 drugstore.com or some other way totally outside of their
11 PDP?

12 DR. SCHMIDT: We haven't really explored
13 collaborating with other external sources of data. But I
14 guess I'm a little bit skeptical on how we could pull that
15 off, frankly.

16 DR. CHERNEW: Because they have their true out of
17 pocket cost requirement to get to the catastrophic coverage.
18 They don't have to but it behooves them for someone to keep
19 track of what that is. Otherwise, the catastrophic won't
20 potentially -- if you don't think you're ever going to
21 there.

22 DR. STUART: I'd be dangerous about making

1 assumptions here. The answers should be available from the
2 Medicare Current Beneficiary Survey next year. And so I
3 would check with Frank Eppig to see if you can get
4 information about the way drugs are going to be coded in the
5 2006. Now that's 2006, so that's problematic, as well.

6 But because of the way MCBS has traditionally
7 collected drug information, you should be able to identify
8 non-Part D drugs during the time that the person was in the
9 doughnut hole. The drug use data isn't nearly as good as
10 what you're going to get from Part D but at least it's going
11 to be something that would allow you to know whether you've
12 got a missing data problem.

13 DR. SCHMIDT: Mike, on your true out of pocket
14 point, Elizabeth Hargrave reminded me yesterday that
15 actually if they go completely and buy an off-formulary
16 drug, the true out of pocket is not going to capture that.

17 DR. CHERNEW: [off microphone] I understand but it
18 would be true if they were buying off-formulary drugs --

19 DR. SCHMIDT: Right. If it's a covered drug but
20 they're 100 percent coinsurance, we would get that.

21 DR. MARK MILLER: [Off microphone.]

22 MR. HACKBARTH: Any others? Okay, thank you very

1 much. Good job.

2 Now we'll have a brief public comment period.

3 Sharon, you know the basic ground rules well.

4 MS. McILRATH: For the new people, I'm Sharon

5 McIlrath with the American Medical Association.

6 On the imaging presentation, just a few quick
7 points. There is one other way that could be used to try to
8 determine or help with the appropriateness issue, which is
9 the claims edits that would get at things prior to payment.
10 There are several thousand of those now but maybe you would
11 want to look at those and see if there is another way you
12 could use that.

13 There also is a demonstration of the use of
14 appropriateness guidelines that is being set up as a result
15 of MIPPA. There are two of them, actually. One will
16 definitely be using the cardiology guidelines.

17 And then just in terms of what happened in 2007,
18 the final data is now out and people get use that. But in
19 the future you might want to think about another file that
20 we get in March or April every year from CMS which is 96
21 percent complete data. It's everything through December.
22 That data did show that there was a 23 percent reduction

1 average in the price, much heavier than that on the PET
2 scans. In addition to that then there was a vast reduction
3 in the growth, down to 5 percent, for the advanced imaging
4 services.

5 And one other thing, there was a slight shift back
6 into the hospital outpatient department from physician
7 offices. But just as a future thing to think about when
8 you're looking for data earlier in the year, that file might
9 be something that you'd want to take a look at.

10 MR. HACKBARTH: Okay, thank you. We're adjourned.

11 [Whereupon, at 11:27 a.m., the meeting was
12 adjourned.]

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